MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

and

Via GoToWebinar

Thursday, September 29, 2022
10:04 a.m.

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DR. CHERNEW: Welcome, everybody, to our second September MedPAC meeting. We have a lot of interesting topics for this next two days and we are going to start with one that I think is going to attract particular attention, which continues our work on supporting safety net. And in this particular case it is going to be safety-net clinicians.

So Geoff, I am turning it over to you.

MR. GERHARDT: Thanks, Mike. Good morning, everyone. Today's session, as Mike mentioned, on supporting safety-net clinicians continues work from last cycle that developed a method for identifying safety-net providers and deciding whether Medicare funds should go toward supporting such providers. Before I begin, I want to remind the audience that they can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

Our safety-net work started with a request from the House Ways and Means Committee to examine access to care for vulnerable beneficiaries. We explored a number of
ways of identifying beneficiaries who have difficulty accessing care, including those who live in rural areas and those with multiple chronic conditions. We chose to focus on low-income beneficiaries because we found that beneficiaries with lower income consistently use more health services and have more challenges accessing care compared to other Medicare beneficiaries.

While some providers have strong balance sheets and are quite profitable, there have also been concerns about the financial stability of providers who serve a high number of low-income beneficiaries. However, supporting safety-net providers through large across-the-board increases in Medicare payments is not financially viable. Therefore, we strived to develop a way to target safety-net funding to providers serving low-income Medicare beneficiaries.

Today's session will cover the following topics. First, I'll review the conceptual framework developed last cycle, and which appeared in the June 2022 Report to Congress, that lays out how we identify safety-net providers and helps guide decisions about whether new funding to support those providers is warranted.
Second, I'll review the definition of low-income beneficiaries that is used by the safety-net framework.

Third, we will look at how physicians and other clinicians fit into the safety-net framework.

Next, I will present several policy options for how Medicare payments could be increased to clinicians who furnish care to low-income beneficiaries.

And finally, I will raise several policy and operational issues about the policy options for Commissioners to consider and discuss.

First, let's review MedPAC's safety-net framework that appeared in the June 2022 Report to Congress.

The June report outlined a two-step process that is based on the premise that safety-net providers should be defined on the characteristics of their patients rather than the type of facility they are, where they are located, or some other criteria.

In the first step of the framework, our goal is to identify safety-net providers. The second step is deciding whether new Medicare funding is warranted to support them.

The goal of having a two-step framework is to
allow us to broadly identify safety-net providers while recognizing that new Medicare funding is not warranted in all situations. This balances the desire to support safety-net providers with the reality that Medicare has limited financial resources.

We identify safety-net providers as those who treat a disproportionate share of Medicare beneficiaries who have low incomes and are less profitable than the average beneficiary, or the uninsured, or those with public insurance that is not materially profitable. The underlying premise of defining safety-net providers this way is that providers who treat a disproportionate share of such patients could be financially challenged because their patients cost more to treat or they receive lower revenues for treating similar patients.

These financial challenges could lead to negative outcomes for beneficiaries, such as having difficulty accessing care if providers close or choose not to treat certain types of patients.

Having identified safety-net providers, the second step is deciding whether new Medicare funding is warranted to support these safety-net providers. Medicare
should only spend additional funds to support safety-net providers if three criteria are met.

First, there is a risk of negative effects on beneficiaries without new funding, such as trouble accessing care.

Second, Medicare is not a materially profitable payer in the sector. If Medicare profit margins are already high in a given sector, it suggests other solutions beyond adding new Medicare funding are likely more appropriate.

And third, new Medicare funding is only warranted if current Medicare payment adjustments cannot be redesigned to better support safety-net providers.

Since our framework is dependent on the income level of beneficiaries, one of the key issues is how we determine which beneficiaries are considered low income.

We define low-income beneficiaries as those who receive full Medicaid benefits, partial Medicaid benefits — meaning Medicaid pays for their Medicare premiums or cost sharing through one of the Medicare savings programs -- or those eligible for the Part D low-income subsidy, or LIS.

The low-income subsidy provides assistance with
Part D premiums and cost sharing to beneficiaries who are eligible for full or partial Medicaid benefits or have incomes below 150 percent of the federal poverty level and have limited assets. Because both full and partial dual-eligible beneficiaries automatically receive the LIS, we collectively refer to our entire low-income population as "LIS beneficiaries."

We will now look at how the framework applies to clinicians.

In the June report we applied the safety-net framework to acute care hospitals. Unlike hospitals, physicians and other clinicians do not submit cost reports, so information about their revenues, costs, and profitability is limited. Therefore, we have to make inferences about clinician profitability based on what we know about revenues for low-income beneficiaries.

Clinicians are prohibited from collecting the 20 percent cost sharing from beneficiaries who are eligible for full Medicaid benefits and those are dually enrolled in Medicaid through the Qualified Medicare Beneficiary program, known as QMB-ies.

We also know that 42 state Medicaid programs make
reduced cost-sharing payments or do not make any cost sharing payments for services furnished to many LIS beneficiaries. We estimate that the combination of these two policies results in clinicians not collecting $3.6 billion in revenue that they would have otherwise received.

Finally, some clinicians are serving a disproportionate number of low-income beneficiaries. For example, 15 percent of clinicians had more than 50 percent of their fee schedule claims associated with LIS beneficiaries.

The framework's second step is to determine whether clinicians should be given enhanced financial support. Surveys indicate that low-income beneficiaries have more difficulty accessing care from clinicians compared to other beneficiaries. For instance, 12 percent of fully dual-eligible beneficiaries and 18 percent of partial duals reported having trouble getting needed care, compared to 6 percent of the non-LIS population.

While we cannot measure profitability directly, treating low-income beneficiaries tends to generate less revenue than other Medicare beneficiaries. Since there is no reason to believe that the cost of caring for low-income
beneficiaries is less than treating other beneficiaries, we infer that low-income beneficiaries are less profitable and may present financial challenges to clinicians.

The final step in this process is to determine whether Medicare already has policies that directly support safety net. While the physician fee schedule does have some add-on payments, such as the health professional shortage area bonus, targeted financial support for safety-net clinicians does not currently exist.

Since the safety-net framework indicates that many clinicians are safety-net providers and additional support from Medicare may be warranted, the next several slides walk through options for implementing a safety-net add-on payment for clinicians.

One potential approach to supporting safety-net clinicians is to implement an add-on payment for services that are furnished to LIS beneficiaries and paid under the physician fee schedule. For each service furnished to an LIS beneficiary, Medicare would calculate an add-on adjustment based on a specified percentage of the full fee schedule payment rate.

Instead of varying the adjustment percentage to
reflect a provider's share of low-income beneficiaries, a uniform payment adjustment would apply to all clinicians. The aggregate amount of the add-on payments for each clinician would vary according to the volume and pay rate of services he or she furnishes to LIS beneficiaries.

The envisioned add-on payments could vary on two dimensions: the percent used to calculate the add-on adjustment, and whether the add-on adjustment should be based on a single percentage for all clinicians, or whether they should be higher for primary care clinicians than non-primary care.

Because the fee schedule does not have existing bonuses or add-ons aimed at safety-net clinicians which could be repurposed, the framework calls for the safety-net add-on to be funded by new Medicare dollars and not implemented in a budget neutral manner.

This slide provides some options for how a clinician safety-net adjustment could vary across the two dimensions that I just mentioned.

Under Option 1, fee schedule payments for services furnished to LIS beneficiaries would be adjusted by 5 percent, regardless of the clinician's specialty.
Option 2 has the same uniform approach to the payment adjustment, but fee schedule payments for LIS beneficiaries would be increased by 10 percent rather than 5 percent. Options 3 and 4 use different adjustment percentages depending on whether the clinician specializes in primary care or another specialty.

Here we provide a numerical example of Option 2. This assumes a clinician is furnishing a service to a fully duel eligible beneficiary where the full fee schedule payment rate is $100. Assuming that the beneficiary has reached their Part B deductible, Medicare would pay $80 to the clinician who billed the service, which is the payment rate minus 20 percent cost-sharing.

In this example, the provider is prohibited from collecting cost sharing from the beneficiary and the state's Medicaid program will not make payment for any cost sharing, so Medicaid's contribution is zero.

A 10 percent safety-net add-on means the clinician would receive an additional $10 for this service, bringing the total payment to $90. This is less than what the $100 the clinician would have received if the service had been furnished to a non-LIS beneficiary, but more than
what he or she would have been paid in the absence of the safety-net add-on. Under a scenario where either the beneficiary or Medicaid program paid the full cost-sharing amount, the clinician would receive a total payment of $110.

To give a sense of what impact these options would have, we used fee schedule claims from 2019 to estimate average add-on payments for different types of clinicians and the total increase in payments for both groups. This table just addresses the effect of making add-on payments in fee-for-service. I'll talk about applying the add-on in Medicare Advantage later in the presentation.

As you can see, we estimate that total add-on payments in Option 1 would increase revenue for primary care clinicians by an average of $780 a year, and non-primary care clinicians would receive an average of $1,040 annually. Total add-on payments for Option 1 would be approximately $1.2 billion.

I won't walk through the financial impact for each option, but I would point out that total add-on payments for a given clinician would depend on how many
LIS beneficiaries they treat and what services they provide. On average, clinicians receive about one-quarter of their fee schedule revenue from services furnished to LIS beneficiaries. Clinicians who receive a higher-than-average share of their fee schedule revenue from treating LIS beneficiaries would receive a proportionately larger amount of add-on payments.

There are several policy and operational issues raised by the proposed safety-net add-on. One issue is how large the add-on adjustment should be. Because the 20 percent cost-sharing doesn't get paid for many low-income beneficiaries, a 20 percent add-on seems like a natural limit for the adjustment. A smaller adjustment would be less costly, but may not be as effective in addressing financial challenges faced by some clinicians.

Another issue is whether to apply a flat add-on to all clinicians or to vary the add-on by specialty. Average total compensation for primary care clinicians is lower than most specialists and they tend to serve a higher proportion of low-income beneficiaries. On the other hand, some specialties have a relatively high portion of claims from LIS beneficiaries and low-income beneficiaries can
have difficulty accessing specialty care.

Commissioners also need to think about whether
total payments, including the safety-net add-on, should be
permitted to exceed the fee schedule's full payment rate.
Given state and beneficiary-level variation in cost-sharing
policies, capping total payments could be administratively
complex.

Another issue for Commissioners to consider is
whether and how a safety-net clinician policy should be
applied to Medicare Advantage. Like their fee-for-service
counterparts, LIS beneficiaries enrolled in MA report
having more difficulty accessing clinician services than
non-LIS enrollees. CMS could use the same basic
methodology we have been talking about in fee-for-service
to make add-on payments to clinicians in MA, provided that
plans submit accurate encounter records for clinician
services.

To ensure that clinicians receive the full
benefit of any add-on, aggregate payments would be made
directly to providers instead of going to the MA plan. And
like the add-on payments in fee-for-service, we assume
safety-net payments in MA would not be included in Medicare
Advantage benchmarks.

That being said, it is not clear how treating MA beneficiaries with lower incomes affects clinician revenue.

While we can assert that treating fee-for-service beneficiaries who are low income generates less revenue for clinicians because of restrictions on cost-sharing, we lack reliable information about how MA plans deal with cost sharing for dually eligible enrollees.

Before I turn things over to Mike, I want to put a series of questions on the screen that we would like commissioners to consider during today's discussion.

First, should staff continue to develop a clinician safety-net policy along the lines of what I presented today? If so, what is the appropriate magnitude of a safety-net add-on adjustment for clinicians?

Should certain types of clinicians, like those who specialize in primary care, receive a higher add-on adjustment than clinicians in other specialties?

Should aggregate payments for a given service be permitted to exceed the allowed payment rate under the physician fee schedule?

And should a clinician safety-net add-on apply to
services furnished to LIS beneficiaries enrolled in Medicare Advantage?

Thank you and I look forward to your discussion.

DR. CHERNEW: Great. That was terrific.

So we are going to start with Round 1. I am going to let Dana run the queue. But I just want to emphasize, Round 2 I anticipate will be a very rich discussion. What that means is please treat Round 1 as Round 1, so we can get to Round 2 with enough time.

So with that, Dana.

MS. KELLEY: Jonathan.

DR. JAFFERY: Thanks, Dana, and Geoff, this is great, a great chapter, and a really great presentation. It was concise and teed up a whole bunch of things for discussion.

So my question is, you know, on Slide 16 and I guess the table on page 27, Table 5 in the chapter, you looked at the impact on the primary care and non-primary care providers for different options. And I wondered if you had any information on that that's a little more granular.

In the chapter you had Table 3 on page 19, which
shows there is quite a bit of variability in terms of the percent of LIS beneficiaries that are served by different specialties. I think in the top 20 it ranged from basically half for nephrologists down to 6 percent for dermatology. So you could see where that average is really quite variable. I don't know if that might inform some of our thoughts about the four options. So I don't know if you have any more granularity on that.

MR. GERHARDT: I mean, there certainly is a lot of variation, and I think if you look at the table that breaks down the specialties you can see the tremendous amount of variation there. There was an earlier table in the report, Figure 3, that shows that a relatively small percentage of clinicians -- and this is overall -- a lot of their claims are from LIS. There is a much larger percentage that have very few claims from LIS beneficiaries. So both when you look at on a specialty basis or across all clinicians there is a ton of variability, yes.

I think the way that this policy has been set up is that the add-on payment would scale. I mean, it would correspond with how much of your revenue, how much of your
allowed charges are for LIS beneficiaries. So those that are on the top scale, top end, would get a lot of add-on payments, where those that don't serve many or have very little revenue from LIS beneficiaries would not get very much. So there would be sort of this scaling that would occur under the policy on its own merits.

DR. JAFFERY: Sort of self-adjusting that way.

MR. GERHARDT: Yes, because we are not scaling the percentages themselves, you know, to how a given provider's patients are LIS, or we are not having a cutoff point. There is no cliff involved here.

DR. JAFFERY: Right. Maybe analogous to when we think about boosting up payments for all E&M services, thinking that people who have serving more of that E&M base, cognitive work, even if they're specialists, are adjusted.

MR. GERHARDT: Correct.

DR. JAFFERY: Okay. Thanks.

DR. CHERNEW: So I think we should read Larry's question now because I think his question is exactly on a variant of this point.

Larry had a Round 1 question.
[Off-microphone discussion.]

DR. CHERNEW: I understand. We will work through the queue, but right now -- well, Larry's -- I'll read. So Larry's question was, which I think very much relates to this, could the staff provide us with an annual mean and an amount per clinician by quintiles rather than the mean amount?

I don't think we actually need to have an answer to that question. I think the answer is yes. The staff could.

MR. GERHARDT: Yes. I believe we can.

DR. CHERNEW: Right. And now I think we can go to the queue, and I actually had Lynn -- yeah, Lynn does have Round 1 questions, so --

MS. BARR: You missed me in the queue, but that's okay. I got in last night.

[Laughter.]

MS. BARR: No, I'm just kidding.

At any rate, I have five questions. So, Geoff, great work. I am really excited about this chapter. We talked about the difference a little bit in rural versus urban, right? And you're focused on the
physician fee schedule, right, and there was a recommendation in the chapter that we didn't need to consider rural health clinics and FQHCs because they're paid more, right, you know, than the physician fee schedule.

And so my question about that is, how are you thinking about that? Because it's really still the same copay issue, right? And so have you looked -- I mean, all -- we're addressing that the physicians are not getting a copay, and rural health clinics are cost-based reimbursed. So I was wondering what are you -- you know, so they're not getting their copay. So they're getting less than cost. So what was the thinking behind that?

MR. GERHARDT: I think the thinking generally is that on a per-service basis, like FQHCs get paid at generally a higher rate than for an equivalent service under the fee schedule, and so they weren't quite in as much need as when, you know, the clinicians are being paid piecemeal basis, where the payments are not connected to cost in any way, and so, you know, the argument for extending policy to FQHCs, RHCs. But we wanted to initially focus on this, this tranche of physician fee
schedule services because they are not connected to cost in any way. The payments tend to be lower on a per-service basis, and there's just a lot more dollars sort of in the system at stake there.

MS. BARR: Okay. I'll address that and then in Round 2. Thank you.

And my next question is, as we look at -- how is the data confounded by LIS enrollment? And so, you know, when you're looking at the data, we've been told that half of the patients that are eligible for LIS are not enrolled. Do you see that evenly across the board? I'm wondering, you know, because there was such a high number of disabled patients, is it because if you're disabled, we make sure you're in LIS? You know, whereas, maybe as a physician, if you're in LIS -- and I don't -- you know, I might have to give up a co-pay. I'm as less likely to enroll you. Are MA plans more likely to enroll? So I was wondering, is there anything to be seen in the data about those various effects on the data of who's enrolled in MA versus not and disabled versus not?

MR. GERHARDT: Are you talking about people who are eligible to enroll in one of these programs but have
not for whatever reason?

MS. BARR: Right, right.

MR. GERHARDT: Yeah, I mean, I think that's always, you know, a concern when you're talking about Medicaid beneficiaries. There are certainly studies that have been done that show people -- more people are eligible for the program than actually are enrolled, and --

MS. BARR: Is there a difference in MA versus fee-for-service?

MR. GERHARDT: I am not aware. I mean, we can talk about --

MS. BARR: That was kind of one of -- I was really wondering like, you know, is there -- as we think about MA -- okay.

And my next question is related to the beneficiaries themselves, and so the comments about 29 percent of LIS beneficiaries delayed care because of cost. So there's nothing in this policy that really addresses the problem for the beneficiary, and I was wondering, as you look at these stark numbers of the disparities, you know, of access to care and the impact on the beneficiaries, is there something that we should be thinking about in this
policy that's specific for the beneficiaries?

MR. GERHARDT: I mean, this policy does not get

at beneficiary cost, per se. It's really more about the

fact that in a lot of these situations, the provider is not

receiving the cost sharing --

MS. BARR: Right.

MR. GERHARDT: -- because they're not allowed. I

mean, there's some evidence --

MS. BARR: They're not allowed, right.

MR. GERHARDT: -- that some do ask their

Medicaid beneficiaries for copayments.

MS. BARR: Right.

MR. GERHARDT: But under the law, they're not

supposed to, and the fact that all these states are out

there that have these lesser-of policies where they don't

themselves make the payments. And this policy is kind of

focused on the policies from a clinician perspective, not

necessarily a beneficiary perspective.

MS. BARR: I was just curious. Is the answer to

fix the payment for the physicians, or is the answer to

provide Med Supp for the patients? And then you solve -- I

don't know what the difference in the cost of that. You
know, could you consider -- is there -- you know, is there
a way to address both issues with a different mechanism
other than a payment update?

DR. CHERNEW: Just to level-set, we're trying to
understand how one feels about the four options to make
sure -- we just want to make sure that we were asking in
Round 1 that you understand what the four options are, and
in Round 2, you can give your opinion on the four options
or whatever else for that matter.

[Speaking off mic.]

MS. KELLEY: Amol.

DR. NAVATHE: Thanks.

I wanted to clarify one point based on what I
think Lynn's first question is. When we're defining low-
income benes here for the work, we're not requiring Part D
enrollment, however, right? We're talking about
eligibility for the LIS?

MR. GERHARDT: [elision]

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1 This exchange has been redacted for accuracy. In this work, the
Commission has defined "low-income beneficiaries" as those who are
enrolled in Part D and receive Part D’s low-income subsidy (LIS),
either because they receive full or partial Medicaid benefits (such
beneficiaries are automatically enrolled in Part D and automatically
receive the LIS) or because they have chosen to enroll in Part D and
have applied and been approved to receive the LIS (because they have
DR. NAVATHE: Okay. So there's not a conditionality of enrollment. I think that's just important to realize.

MR. GERHARDT: Not necessarily. I mean, keep in mind, the vast majority of the people we're talking about are in -- they're dually enrolled. There's very few that end up coming into our population group because they're LIS eligible but haven't enrolled in one of the -- you know, as a dual.

DR. NAVATHE: Right, right. Okay. Just to put a finer point on it, there's no -- although LIS, we conventionally think of as related to the Part D benefit, we're not requiring Part D enrollment in the context of this work?

MR. GERHARDT: Right. That's correct.

DR. NAVATHE: So I think that addresses Lynn's first point. Right. Okay.

So my second question, I guess, is -- so, Geoff, when we look at Table 2 and Table 2 where you've analyzed --

limited assets and incomes below 150 percent of the federal poverty level, though they are not eligible for Medicaid in their states of residence). However, not all beneficiaries who would be eligible to receive Part D’s LIS by virtue of their incomes are actually enrolled in Part D.
- and this is from the paper, reading materials -- the specialist billing, I was curious how does that vary by facility versus not facility, basically setting, you know, using a place-of-service code or something like that. And I'll talk maybe a little bit more about it in Round 2 as to why I'm asking, but have we done any of that stratification? Do you have a sense of that?

MR. GERHARDT: We haven't done it per se for this. I mean, we can take a look at that breakdown. I think, typically, somewhere around a quarter of fee schedule payments go to hospital-based, you know, services, either inpatient or emergency room. So I don't know whether that would extend to this. We'd have to look at it.

DR. NAVATHE: Got it. And that might just -- to clarify, that might vary by specialty as well?

MR. GERHARDT: Yes, absolutely.

DR. NAVATHE: When we look at the table proportional by specialty, that would be another dimension that would affect what Jonathan was asking.

MR. GERHARDT: Yes.

DR. NAVATHE: Okay, great. Thanks.
So just one quick -- well, two quick questions. One is for states. I know you mentioned that many states have the lesser-of policies, and I just wondered, like, when you say "many," is it almost all of them?

MR. GERHARDT: Well, we know -- so 42 states have some version of a lesser-of policy. It varies. I mean, states are allowed to set this on their own. So the policies themselves tend to vary a little bit, but also, the payment rate for a given service under these lesser-of policies, some of them are far below what the Medicare payment rate and some are the same or maybe even more. So it does vary.

We're taking those 42 states. We're taking averages of what their payment rates are compared to the Medicare fee schedule rates, and that's what we're using to sort of generate our estimated, you know, foregone cost-sharing payments, if you will.

DR. DUSETZINA: Okay. And the other question I had was thinking about the Inflation Reduction Act's expansion of the LIS up to 150 percent of poverty. My
assumption is that that will bring in a bunch of people. I know there's been an estimate of like only 34 percent of people who are eligible enroll in when they're not automatically enrolled. So can we somehow bring that information in when we're thinking about like how much -- how many people would be affected? Are you able to do that, or is it just sort of a this will be more complicated and more people over time?

MR. GERHARDT: So I am not the Part D expert here. So I'd have to talk to my colleagues about what we might be able to do in terms of thinking about how that policy change would change our study population. Obviously, all this work was done prior to that expansion, but we can give some thought to how the law change might affect our group.

DR. DUSETZINA: Great. Thanks.

MS. KELLEY: Marge?

MS. GINSBURG: Two comments/questions. So, in my mind, there are two sets of issues we're looking at. We've got patients who are at the LIS level who need a lot more care and attention than the fee schedule allows and what they're getting paid, and then on the other hand, there are
the states who aren't paying what I call their "fair share" of the missing 20 percent. And we're combining these two issues together. I just want to make sure we're clear. One has to do with the states that aren't paying enough, and the other has to do with the certain clientele that needs more action.

It worries me a little bit that if we augment payments to physicians, that states will be even less attentive to paying their fair share if they feel that Medicare is going to step in and pick up the gap.

Okay. That was a Question 1 too.

And the other is just a comment on pages 12 and 14. We use very tentative language about we believe it is reasonable to infer that LIS beneficiaries are less profitable than non, and page 14, there's also that same tentative language. And I was just curious why we're so tentative when it's sort of shouting out to us that they are less profitable.

Thank you.

MR. GERHARDT: I think the reason that we are tentative, as you say, is because unlike hospitals and a lot of the other facilities where we have cost reports that
we can look at and we can quantify what their costs are, what their revenues are, what their, you know, share of Medicare and non-Medicare is, we don't have that basis of information for clinicians. Our information about clinicians is much more limited than those sectors where cost reports exist.

So we kind of have to use these other datapoints, particularly the revenue, as you point out, where states are not paying the cost sharing, to sort of work our way into statements about profitability. We make some assumptions about costs being the same or higher maybe.

But, again, some of that is based on data. Some of that is based on assumptions. So, yeah, it's just not as strong as some of those other sectors where we can make more definitive pronouncements about profitability.

MS. KELLEY: Dana?

DR. SAFRAN: I'm laughing because Margie used the phrase "shouting out" at us and --

[Laughter.]

DR. SAFRAN: It certainly is shouting out at us. So, yeah, I just had one Round 1 question, which is, you know, you spoke early on and you had in that
chapter that overall I think your number was 3.6 million not collected, and it's hard to get my mind around this proposed set of policy options without understanding what that impact looks like at the clinician level.

I know, you know, it's highly variable, but can you give us any sense of for an average clinician, whatever that means? What percentage of revenue are they missing out on because of this, or can you put a dollar amount on that? Does it relate somehow to the dollar amounts you're showing us in the policy options? Just can you give us some sense of impact for an individual?

MR. GERHARDT: Yeah. I mean, it's highly variable, as you know. The total allowed charges under the fee schedule are in the high-90-billion range, about a million clinicians that charge. You know, that's 100 grand each. So the thousand, 2,000, you know, it's a couple of percentage points in additional revenue, but your mileage is going to vary a lot, depending on, you know, what kind of specialty you are, what services you furnish, what percentage of your patient panel are Medicare beneficiaries. So we're trying to present these averages, but you're right. At the clinician level, it's really
going to vary.

DR. SAFRAN: So it's a couple thousand dollars probably.

MR. GERHARDT: Yeah. I mean, the impact table shows the per-clinician average, and so I think you're asking how that stacks up to, you know, their total Medicare payments. It's a couple of -- you know, it's a percent or two, give or take.

DR. SAFRAN: Thank you.

MR. POULSEN: All right. I happened to run through this for a whole bunch. We had a couple thousand clinicians that we looked at on this, and I just asked our data team to take a quick look at it. What we found is the highest in our group was 6 percent, and that's in a state that does not have cost sharing.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks. I'll keep this very brief. I recognize we're trying to consider how this plays out in Medicare Advantage, and one thing I didn't see any reference to -- and I'm trying to sort out whether it belongs in this chapter and in our discussion -- is the fact that Medicare provides additional payments to the dual
SNP plans, you know, to care for these patients who are more complex, and I'm trying to figure out -- so we would be adding payments on top of already additional payments, if I'm understanding that correctly. So I think it would be helpful to kind of clarify what's going on in that space.

MR. GERHARDT: Yeah. We can do a little bit more digging in terms of the D-SNP plans and what would happen there. I think we just don't have a lot of visibility into what each plan's policies are regarding clinician payments and cost sharing and whether this would -- you know, how much of an issue is this really in MA, we don't really have a great idea, or how much foregone cost sharing is happening is hard to estimate.

DR. DAMBERG: Yeah. I mean, I agree. I think it's complex to figure out how much of those payments would trickle down to physicians and where they're seeing gaps in terms of their payment rates, but I think it would be helpful to maybe have something in the discussion about that.

MR. GERHARDT: And like I said, I think our working assumption is that if the policy were to extend to
MA, the payments would go directly to the clinicians rather than making their way to the plans to disburse how they see fit. So we do recognize that there is the possibility if you give it to the plans, it won't trickle down to the clinician. So we would envision making that payment directly.

MS. GINSBURG: A quick question about that. Have we ever done that before? Not just we, but is there any other policy that allows Medicare to pay MA physicians directly rather than through the plan?

MR. GERHARDT: I do not know. Maybe Jim does.

DR. MATHEWS: Marge, we don't have a direct physician analog to the extent that I'm aware of it, but there is an analog on Part A where Medicare makes payments -- or indirect medical education payments directly to teaching hospitals that reflect the volume of MA patient days that a teaching hospital serves.

MS. KELLEY: I think that is the end of Round 1.

DR. CHERNEW: Yes. That's the end of Round 1. So now we're going to get into Round 2, and my general sense is we have four options on the table. The most important -- you can say whatever you want, but the most...
important thing for us to take away from this is how you feel -- which do you prefer, if any, you know, why. When we leave, that's what we want to get. So if you have strong reactions or preferences and rationales, I want to get that out.

So now let's go to Round 2.

MS. KELLEY: Lynn.

MS. BARR: Thank you. I am wildly enthusiastic, to quote Stacie, about this chapter and about doing something about this work. And I do support Option 3 of the options that are presented. That's the one that makes the most sense to me and I think is the best way to address the issues that you discuss.

I believe that, you know, this is very -- I've had lots of conversations with lots of clinicians about the issue of not getting co-pays and how it impacts them financially. And I think it's really, really important that we acknowledge this and do that. But this also applies to rural health clinics because rural health clinics are cost-based reimbursed, and they get 20 percent less for that patient, and nobody pays them for that. They can't add that to the cost report. So it's very important
that we also address this.

I can argue that in FQHCs they do get grants to cover uncompensated care, but rural health clinics are just like -- they just have a different fee schedule because there are higher costs. So I do not feel there's any justification for provider-based clinics that are cost-based reimbursed to not get the same support.

And then, again, I'm very concerned about the beneficiaries and the impact of cost. It hurts me to read about 29 percent of the LIS beneficiaries being unable to afford their care. And so I'd like to see if we could consider as an alternative policy what would be the cost of providing Med Sup insurance which then covers the patient's issue and the physician issue in one fell swoop without having to create an alternative policy system to create this new payment model. I would like to understand the relative costs.

Thank you.

MS. KELLEY: Jonathan.

MS. GINSBURG: Can I --

MS. KELLEY: Go ahead, Marge.

MS. GINSBURG: My question links to Lynn's
statement that suddenly occurred to me. So we're assuming
most LIS patients -- we have that broad category -- have
their co-pays paid by, you know, supplemental, Medicaid or
whatever. But the cost-sharing part that isn't is the co-
pays they have for their meds. So when we show in the
chart that 13 percent of LIS patients have a problem, is it
the co-pays for their meds that they're talking about?
Because they shouldn't have any co-pays for the services
they get. It's all medications. Co-pays are relatively
low, usually, but they could still be a problem.

MR. GERHARDT: This policy doesn't contemplate
something like that. I mean, we -- it's focused on trying
to kind of make the clinician whole rather than the cost
sharing for medications. As you say, it's just -- we're
just looking at the services, physician fee schedule
services, so I think that would be sort of a new branch of
thinking about the cost sharing on the bene side for
medications -- if I understand what you're saying
correctly.

MS. GINSBURG: Yeah, I get them confused then,
because the chart shows that, you know, 13 percent or
whatever still have a problem with cost sharing. So I'm
just trying to find out what cost-sharing category they're struggling with, because I just suddenly realized it wasn't logical to me for it to be anything other than meds.

MR. GERHARDT: I don't think that the survey data digs down to that level. It just sort of asks that broadish question. And, you know, there might be other costs that are associated with seeing the doctor that they have to outlay, that their sort of thinking is a payment for the service. It's difficult to know.

DR. CHERNEW: Let me just jump in and try and put some balance on where we are here, because there's a lot of issues, right? So, again, let me say we have three options trying to address a specific question related to explicitly physician payment. There's a portion of that, as pointed out, a motivation for that, as pointed out, relates to money not collected because of some of the policies that were discussed.

However, our goal now is not to solve the broader issue of beneficiary cost sharing or, for that matter, rural health clinics or other things. We can have a broader discussion. Right now this is just in the context of this somewhat narrower view, and my concern is if we
expand -- we've already gone through hospital safety net.  
We can think about other provider types. So I want to keep 
this within the bounds of safety-net clinicians, and we can 
continue to think about how we deal with that as we get on 
to both the problem of beneficiary out-of-pocket cost 
sharing and other provider types.

Did you want to add anything, Jim?

DR. MATHEWS: Very consistent with what Mike 
said. Please keep in mind that the rationale for our 
framework as we developed it over the course of the 
previous cycle was to try and mitigate financial 
vulnerabilities at the provider level that were imposed on 
the providers as a function of their patient panels payer 
mix. So we're trying to ensure that providers who serve 
vulnerable populations can continue to exist in order to 
serve as points of access for these populations.

I would think the question of beneficiary's 
ability to afford their care and whether Medicare should be 
doing more to address that question is a legitimate but 
completely separate issue that is going to involve an 
equally broad set of work above and beyond what we've 
contemplated here aimed at supporting providers.
MS. BARR: Coming in on that point, I understand and I agree, but I do not agree that rural health clinics have any reason to be excluded from this. They have the same exact issues of underpayment for these types of patients. And if we're going to address it for all providers, I don't see how you can exclude rural health clinics because they get a higher rate. That does not include the cost of uncompensated care.

DR. CHERNEW: Got it. Next in the queue, Dana.

MS. KELLEY: Jonathan.

DR. JAFFERY: Thanks, Dana. Again, great chapter. I'm going to try and run through the five questions you pose on Slide 16, not in order because I'll come back to sort of 2 and 3 together.

First of all, yes, this is important work and I fully support continuing to develop it.

Jumping down to the fourth bullet point, I think the complexities that you laid out around the different states, lesser-than policies, and lots of moving targets, good questions, I think, about whether or not there might be some influence on what states do based on a Medicare policy. But, nonetheless, I think trying to game that out,
I think it's okay to permit them to exceed the allowed amount in this situation.

In terms of the safety-net add-on payments to MA, I definitely favor direct payments to providers analogous to, as Jim described, what exists for IME to hospitals. I really worry about what would happen if it's just given directly to the MA plans and how that impacts provider or beneficiary decisionmaking, or anything along those lines. And, in fact, I think, you know, if it was done in some sort of -- I don't know how logistically you might do that, maybe a quarterly lump sum payment, that might actually have some psychological advantages to providers who care for a lot of low-income and safety-net providers.

So then coming back to kind of the meat of the topic and the four options, despite the fact that we're really trying to really focus in on this one topic, I do think there are sort of two issues that come together in this policy proposal in terms of how do we provide more support for clinicians who care for a lot of low-income beneficiaries, and then also are we addressing disparities at all between payments to primary care physicians and specialists?
So those are kind of wrapped into our options. And, you know, to the extent that there are some specialists who do care for lots of low-income beneficiaries, I mean, I definitely appreciate the previous discussion about -- and your points, Geoff, about that kind of self-adjusting. On the other hand, our proposals where specialists are getting only 5 percent, you know, doesn't really cover that cost-share loss.

Now, that said, having said that, I actually am in support of actually trying to decrease that disparity. And so I do like the options where there's a split between primary care and specialists for all the reasons we've talked about in terms of specialists already having more robust compensation because of the history of the payments as we've seen over the last several decades.

But I think even more to the point around that, I think to the extent that primary care has some additional responsibilities to build in this advance ambulatory care model to address health equity and social determinants, I think that giving them extra payments to help support that -- even though some of the specialty providers are addressing some of those things, I think that, you know,
the trends we're seeing in population health and value-based care movements are really designed around primary care doing the heavy lifting around creating those additional models of care. And this may actually help us, you know, help them, primary care, prepare more for advanced alternative payment models and population-based payments even more.

So with that in mind, I guess I don't have huge strong preferences between 3 and 4, but I favor a little bit Option 4, actually. The total add-on payments, maybe I'm being cavalier about what $200 million looks like these days, but I think the additional support to primary care to get them to cover that loss of the co-pay and, again, support the additional capabilities that are required to really care for this complex patient population is warranted and probably overdue.

Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you. So I also am very enthusiastic about this work, and I think the chapter is excellent, so I'm really glad we're doing this. I think we should keep going. And I would say that of the options
presented, I thought that Option 3 to me seemed very sensible. I liked the rationale that that was kind of about what can't be collected when you look at it on average across beneficiaries, so the 15 percent to primary care added on, 5 percent to specialists, felt like a good place.

I am interested to hear more for people's thoughts on the MA question. I'm just not sure I know enough to know whether they should be wrapped in, but I do think that if they are payments directly to the physicians rather than the plans makes a lot of sense.

MS. KELLEY: Jaewon.

DR. RYU: Thanks, Dana. A couple comments.

I'm also in favor of continuing to develop this area of work. I think, yes, there's the co-pay issue or the foregone co-pay payments, but I think the other driver is also equally compelling, which is the higher cost related to taking care of the safety-net population, so to speak. So, you know, I don't think it's uncommon that you would see longer appointment visits. I don't think it's uncommon that you would see social workers in some of the clinics that see high proportions of the LIS population.
And, also, you know, a lot of extra staff time in terms of coordinating with other social programs and so forth. So I think we shouldn't lose sight of the fact that it's not just the co-pay issue. There is a higher cost to taking care of these populations.

For that reason, I support Option 3. I think Option 4 is -- I'm warm to it, but I probably prefer 3. I like the fact that there's an across-the-board component but also a differential component for the primary care providers.

The one thing that I think would be good to see in subsequent iterations is a fine-tuning on who qualifies as a primary care provider. We talked a little bit earlier about, you know, there are some specialties that do a lot of "primary care," whether it's nephrology, cardiology, what have you. And I think just understanding more deeply, you know, would those qualify, what would be the indicators by which a provider would qualify as primary care, I think that would be helpful.

As far as the MA issue, I think I'm also in favor of applying it to the MA population as well, and I like how the chapter laid out doing it directly to the clinicians as
1 opposed to mediate it through the MA plans.
2 And I think one other question that you have on
3 the list of five, should total payments be permitted to
4 exceed the allowed payment amount? I think the answer is
5 yes, and to me that's why it's so important to keep our
6 eyes on not just the co-pay but the increased costs
7 associated with the population, because if you believe
8 that's real, then I think it feels a lot more comfortable
9 to say that the payments can exceed, you know, the allowed
10 payment amounts.

11 MS. KELLEY: Amol.
12 DR. NAVATHE: Thanks. First off, I just wanted
13 to echo other Commissioners in support for this work. I
14 think it's fundamentally very important, and I'm glad that
15 the Commission is taking it on and pushed it forward quite
16 rapidly.
17 I also wanted to just voice support for the
18 overall approach that we're taking here, which is add-ons
19 to the payments for LIS benes specifically as opposed to
20 trying to find some other mechanism for it.
21 I have five comments that I wanted to make, and
22 I'll try to be brief about it. I think they're mostly
centered around one issue, which is I think we also have to be mindful that we are making -- we would be making these adjustments in the context of also pursuing adjustments in the hospital safety-net sector. And so the setting I think actually matters quite a bit, and I think we should be quite thoughtful about what the mechanism here is that we're trying to actually effect change through.

If you imagine that we're paying for safety-net hospitals that have an outpatient facility as well as an inpatient facility dimension, then there are going to be dollars that are moving into the outpatient facility, outpatient hospital care, to hopefully account for the fact that these beneficiaries might need additional resources and coordination and management and what have you.

And so, accordingly -- and I'll also mention that I think work that MedPAC has done and that other peer-reviewed literature supports is that the access gap that we see the most, if you will, for LIS benes, certainly for duals, is in the outpatient setting, so ambulatory care, particularly for specialists but also for primary care. And so if we're really trying to meet that need to keep -- essentially keep them out of the hospital, because duals

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and LIS benes utilize a lot of specialty care, but they utilize that specialty care in the context of having to go to the hospital. And so that's, I think, what in large part what we're trying to avoid here. And so we may want to think about trying to target our targeting, if you will, to that outpatient safety net in a sense. And so that's where, Geoff, I think it would be very helpful for us to look at this and calculate what this would look like if we separated out ER and inpatient billings from other outpatient billings, if you will, or Part B billings, because I think that would help us potentially make each dollar go the furthest.

One of the principles that we have outlined that I wholeheartedly agree with is that we want the dollars that we put here to make a difference for the LIS benes. We want it to improve their access. And we do see, I think on page 23 of the readings, there was a note that primary care access is worse than specialty access for LIS benes. But, again, that's not taking into account the setting of how that access is happening, and I think we want to be mindful of that setting. The mechanism here, in other words, really matters, and I think if I'm an LIS bene and
I'm picking a hospital to go to and that's how I end up seeing a specialist, that's very different than I can find an outpatient cardiologist or nephrologist to keep me out of the hospital from a hospitalization perspective.

So that was the one really major point, which is we need to coordinate with the safety network and we need to think about this in the context of setting.

I definitely want to voice support that we should be careful around -- I support basically the idea of the payments following the beneficiary, but then going directly to the clinician so we can avoid some of these potential issues on the MA benchmark inflation or some element of that. So I wanted to make sure to point that out.

The next comment, on Table 5, I think it would be very helpful to see the distribution of each of these options across clinicians based on the share of LIS benes. And I think we know, again, from the Commissioners, the Commission's work, that there's a large concentration -- in other words, a disproportionate amount of -- sorry, a small share of clinicians take care of a disproportionate number of LIS benes. And so hopefully this targeting will, in fact, address Larry's comment, for example, that are these
going to be meaningful deltas for revenue for a particular practice or a particular clinician? So I think actually seeing what that distribution is will be really helpful to inform which option we might pick, and I think that will, again, vary by setting, which will influence the specialty piece.

So the last point is, since Mike asked us to comment, I think in some sense I in principle support Option 3. I also like Option 2 in a sense if we can be oriented around setting, because I think if we orient that around setting, it will actually -- it will naturally accrue more for primary care because primary care is not doing a lot of facility-based care. And so I think it may be preferable in some way to target the primary care via the setting piece rather than having to set a different rate for primary care versus specialties.

Thank you. Very happy that we're pursuing this work.

MS. KELLEY: Greg.

MR. POULSEN: Thank you. Yeah, I agree with a lot of what has been said already. As I mentioned, I asked our data team to look at a whole bunch of physicians and
see what we saw, and we saw it ranging up as high as about 1 a 6 percent impact. But we saw it taper off pretty quickly 2 to a smaller amount, which I think is a big deal, because I 3 agree with Jaewon's point on the higher cost to serve. 4 5 But I would also like to insert that I think 6 there is a whole lot of psychology here that is not just 7 money. I think it is important that we make it clear that 8 we do not want people to be penalized for serving a 9 population that is already more difficult to care for 10 anyway.

So I really like the idea of doing something. I 11 like the idea of doing something that's simple. I like it 12 being tied to the fee schedule because people get that. I 13 think that makes a whole lot of sense.

I fully agree that there is a market in equity 15 between payments between different practitioner types and 16 that this inequity probably has not been fully addressed by 17 other things that have been done. However, I think it 18 should be addressed globally rather than embroidering 19 around the edge, which I think this would be doing. I do 20 not think that this directly addresses that.

And particularly, I think separating primary from
secondary care is different than separating low-income and high-income populations, and conflating those two, I think, actually ads more challenge and confusion than benefit. So I think that the focus here should be on equity of payment for different populations. Equity between providers should be addressed differently and elsewhere and is in process and has been in process.

I think there is an important corollary to this point, and that is that -- and it has been brought up -- not all specialists are in the same position. Neurology, endocrinology, nephrology are in very different positions than, say, orthopedic surgery.

Second key point, I would suggest that we not differentiate between states based on their Medicaid payment policies. States that have been more generous in the past are probably doing so with a goal of enhancing access, and they should be allowed to continue to do that, even if that means that in some states the total payment exceeds the cost of the traditional Medicare payment.

Let's see. Oh, and that might actually influence some states to reevaluate their Medicaid payment policies, either good or bad. But either way, I think that what we
should do is try and make sure that we encourage access for
the LIS population where we can.

The third point, where I may be the lone ranger
on this, is I feel strongly that this LIS payment
enhancement should not be applied to MA, either directly to
providers or indirectly. I think inserting ourselves
further into the MA provider relationship has the potential
to create a lot of mischief. We could do much more by
incentivizing or, in my preference, requiring that MA plans
pass along a majority of their population-based capitation
payment to providers. Today it is largely a fee-for-
service world, and that is why we are even having this
discussion.

If we look at the original goal of MA it was to
provide incentives to providers, and if we look at
provider-sponsored plans today I think we find much greater
equity in the way that payments are distributed to provider
organizations between primary and specialty care, between
low-income and high-income populations, and it seems to me
that would be a much more effective MA approach than to try
and insert ourselves into a direct payment on top of the MA
payment from the plans to practitioners.
So for me, Option 2 comes closest to what I think is ideal. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I have to also share my enthusiasm for this chapter and your work.

Briefly, to me one of the most important things is not only the money, it is the message, and I think Greg and others have sort of been referring to that. So to me the option that aligns both the money and the message the best is Option 4. We have underinvested in primary care in this country. I understand that if we look at traditional primary care, we do not get at some of the cognitive specialties that Scott and others have mentioned. But just because a policy can't do everything doesn't mean it shouldn't do something.

Option 3 would be fine as well, but I really prefer Option 4, primarily for the message as well as the money. And maybe like Jonathan I am becoming cavalier about the difference in the amount between these two, but it seems like a good direction to me.

In terms of MA, my initial impression was that lump sums to the providers is exactly right. I am now
taking what Greg has said, I would like to think about all
that a little bit more.

But overall I am very enthusiastic about
continuing with this work. Thanks.

MS. KELLEY: Kenny.

MR. KAN: I am enthusiastic about the body of
work here. I really like the underlying messaging and the
thoughtful acknowledgment of pay disparities between PCPs
and specialist and the overall approachable load.

I do not have a point of view yet because I
actually would like to better understand the following.
Number one, the setting issue, which Amol articulated, I am
concerned about double payment to hospitals. Number two,
the MA issue which had been raised in the discussion today.
And then the last issue of how this could get implemented
in the states.

Great work. Thank you.

MS. KELLEY: Dana.

DR. SAFRAN: Thanks. I will add my voice to the
chorus of support for this area of work.

I think that the question I have been sitting
with is what exactly is the problem that we are trying to
solve, whether it is a problem of access or whether it is a problem of fairness or financial sustainability for the providers that serve LIS population, or disproportionately serve that population, or whether it is a problem of the outcomes and quality that we are trying to achieve for those populations.

And depending on which of those things we are trying to solve, I land in a different place. If we are trying to get at financial sustainability or even at access, I find myself struggling to believe that the dollar amounts that we are talking about make an important difference in provider willingness to see LIS patients.

I think I am influenced by an experience that is kind of seared in my brain of being in a meeting with a clinician who, in front of a group of people, opened a piece of mail that was from a Massachusetts Medicaid. It had a check and he said, "Does anybody want this?" because it was just such a trivial amount that he just was kind of insulted by it. And yet I worry a little bit about the lump sum as being so disconnected from encounters that will it actually influence clinician behavior and willingness to see these patients. So I am struggling with that.
I do find myself connecting it up, and I think some of Jaewon and Jonathan's comments pointed to this, to the issue of quality of care, outcomes of care, and the signaling that we want to do about the additional resources it takes to think outside the literal and figurative clinical box to where patients live and work and what they need in order to achieve good outcomes.

So that brings me to some of the thinking we have done in past year around social drivers of health and sort of investing in health equity by beginning to frontload some payments or give differential bonuses for providers who care for a disproportionate share of LIS.

So boiling all that down, I think in my own mind I'm very supportive of differentiating, if we are going to do this, of differentiating the percent that primary care clinicians would get versus what specialists would get. Of these options, I am tending toward Option 3 for many of the reasons described. But I am struggling with whether it should be further differentiated based on fee-for-service versus, you know, an ACO or global budget contract.

So lastly that brings us around to MA. I too am quite undecided there, but I was really struck by Greg's
points, and definitely feel if we are going to extend this
to MA, I agree with others that it should be to the
clinician directly. But listening to Greg and thinking
about how that really muddies the waters between what the
plan's responsibility is and what the clinicians, it does
leave me a little bit leery about having this apply to MA.

So I realize that I'm probably raising more
questions than putting down my own stake of where I think
we land, but I do feel a little bit uncertain at the end of
the day of how much good we can do with this and which
problem we are trying to solve, and I would like us to be a
little more specific about that in order to shape which
option we choose. Thanks.

MS. KELLEY: Robert?

DR. CHERRY: Thank you, and I also want to throw
in my enthusiasm for the report and the presentation. I
think this was very well done, and also for teeing up
really the important questions that the Commission needs to
answer regarding what has been proposed so far.

I would like to take a little bit of a contrarian
approach to many of the Commissioners' comments. I really
favor number 2 as an option, which is the 10 percent option
for all physicians. And the reason why -- and first let me say that I understand the rationale for primary care taking sort of priority here, given the fact that there is so much alignment with population health and value-based purchasing and so on. However, I think that we shouldn't underestimate the need for specialty care, particularly in LIS beneficiaries where the acuity is higher and there may be a need for specialty access.

So I do think the 15-to-5 percent spread seems a bit large and could actually exacerbate access to specialty care, maybe even disincentive specialists from seeing these patients because there is a 5 percent option here.

So I would tend to favor a much more equitable approach. I do think that there is room for that, particularly when you look at the uncollected amounts, which totals about $3.6 billion. So in my mind that is sort of the budget that we are looking at, so I think there is room for a 10 percent or maybe some other option too that increases the amount of a specialist, that it is not too low.

I will say as far as the MA beneficiaries, I think we should definitely include them as well. I have no
concerns or issues with the direct payments. I think it might actually assist in collecting encounter data as well, which we discussed at our last meeting.

And then as far as should we exceed the allowable amounts, I don't really have an issue with that exceeding the amount, in terms of those states that have dual eligible cost-sharing. And the reason why I say that, I think that the Commission should generally sort of be independent of state decisions with regard to Medicaid rates. I think if we put those in sort of a different category and just look at the Medicare rates and what we are trying to accomplish in terms of access to care and equitable payments, then I think it makes the decision a lot easier.

So thank you very much again for a really great report.

MS. KELLEY: Cheryl.

DR. DAMBERG: Great work. Kudos to the staff.

This was a really interesting chapter and I too am going to voice my support for both this work and the Commission taking on this particular issue.

I do think that we should continue to develop the
clinician safety net policy, and I like the fact that this extra payment would be tied to the patient and go directly to the physician. So I very much support that.

I am also supportive of trying to get a better understanding, to follow on Amol's comment, about the distribution of these payments by the percent of LIS patients that any given physician would have. And this comment was made in Round 1 -- I think it was made by Marge -- though I am somewhat challenged about how to think about this in terms of potential unintended consequences, whether states would back off from the copayments that they make in this space. So we need to consider what the implications might be there because this is a very dynamic kind of endeavor in terms of downstream effects.

In terms of whether the payments should exceed the allowed payment amount, it strikes me that if we just take them to the allowed payment amount, we are essentially achieving parity and not really sort of going that extra distance if we think that these patients actually cost more to take care of. So I think we should do a little more thinking in that space.
I too am struggling a bit, and Dana, thank you for laying out your issues so eloquently, in terms of what we are trying to solve for here. I do think that there are legitimately extra costs of caring for these patients, so that obviously falls within payment policy. But I think we should be clear that these extra payments are not going to, as they might under MA, go to address other social determinants, social service kinds of issues that these patients might need to help improve health and health outcomes.

And I guess if we are thinking about trying to have these payments exceed the allowed amount, I don't know whether there is some fine-tuning or whether staff can play out, like would we set a cap on how much they could exceed the payment amount and whether we would want to try to direct again more toward primary care versus across the board.

At this point I am favoring Option 3. I think that primary care really is the front line for addressing a lot of the issues that these patients present with. So I think I will stop there.

MS. KELLEY: David.
DR. GRABOWSKI: Great. Thanks. This is super work, Geoff. In answer to the first question, I am very enthusiastic about continuing with this line of inquiry. I think this is exactly what the Commission should be focused on.

In terms of the different options, I would favor Option 4. Others have made this case already -- Betty, Jonathan, and others -- but I really think there needs to be an emphasis on primary care here, and I think the dollars have to be meaningful. To Dana's point, I don't know if that's still going to get us to a meaningful amount for a given physician, but putting as much into primary care here is, I think, the right step forward. And that would actually be something interesting to model, and I think Greg talked a little bit about that, of what dollar amounts here we are thinking about for a given physician.

I didn't want to take this opportunity -- this is a great example of this disconnect for duals and Medicare and Medicaid and these lesser of policies are really challenging. We have studied them a little bit in the nursing home context, and Medicare's cost-sharing is very strange. For SNF care it kicks in at day 21, but you see
this real difference in states with lesser policies versus full cost-sharing. Lots of beneficiaries go home much sooner in states where they do not have full cost-sharing.

So these certainly influence how providers behave around these patients. I know that is a very different setting but I think it comes up in the physician context as well. So anything we can do to sort of make up some of that gap. I don't have a problem, similar to Cheryl, with exceeding the payment amount or equaling it, but sort of modeling that out, as Cheryl described, is really important.

Final comment. I really came in kind of indifferent about MA, but I was really taken by Greg's comment and really think maybe we want to pull back there. I will stop there and just say, Geoff, great work. Thanks.

DR. SARRAN: Thanks. First, I will reinforce the overall quality of this work and the importance of it. You know, I think in terms of whether the order of magnitude of the dollars going out the door via any one of these proposals is sufficient to create the behavior or change we want to see, I do think there is value in the
signal it sends. So in my mind, whether it is Option 3 or
Option 4, we may achieve much of the value we are trying to
achieve by Option 3 at a slightly lower cost.

I have no problem with the money going on being
above the allowable in certain circumstances because I
strongly agree with Jaewon that the true cost of treating
these beneficiaries is hard to measure but is often
consequentially higher.

On the MA, I noodled on that one a lot since I
started reading this, and I would lean against passing the
money through to MA, Greg's comment. Although on one hand
MA plans, on average, do a pretty lousy job of aligning
incentives with providers--most of them take the easy way
out and just say fee-for-service and find other ways to
make the numbers work--I think we all are agreeing that we
are overpaying. We are certainly adequately, if not
overpaying MA plans today, so why not just get more
directive and more stringent and rigorous about what we
expect in return for what we are paying, rather than
putting more money alongside MA?

I also think if we do the MA direct provider
payment there will be an unintended consequence that is
around the reality that some MA plans pay some providers
the full allowable amount for duals, and if we start
passing this money through those MA plans I would bet you
anything we will immediately change those contracts or work
real hard to change those contracts and say to providers,
hey, we will stop paying you this because CMS is paying you
directly, and that is not an unintended consequence we want
to see.

MS. KELLEY: Marge, did you have a Round 2?

MS. GINSBURG: Yes.

Well, I've changed my mind about one thing.

Initially, I was opposed to the idea of initiating this if
the states were already paying their full amount and the
idea that the physicians would get more than the
combination of state and Medicare funding, but I've changed
my mind. If the states do in fact pay their full share,
I'm fine with us paying more than that, and that's either
Option 3 or 4. I'm not -- I tend to be a little more
reserved, so I usually go for the lower one, so probably be
on -- on No. 3.

And I was -- as many of you have said, I'm very
grateful for the comments Greg made about MA because that
was my initial reaction right off the top.

Now there could be a quid pro quo, if we could start getting information from the MAs that we've been asking for, for the last 10 years or so, about how they do their -- all of their cost stuff. Everything that we've been wanting to know about MAs that we have been unable to get, they start giving us that information. Then we might consider adding them into this, but until that happens, I really don't think we want to do anything that would encourage more business for MAs when we haven't -- when we've learned so little about how they're actually doing their business and what their costs actually are.

Thank you.

MS. KELLEY: So that is the end of the queue. I do have a message from Larry Casalino that he wanted me to read, so I'll go ahead and read Larry's comment now.

Larry favors Option 4. The cost to Medicare is not very high. The amounts paid to the average clinician are too small to have an impact, if you consider as a percent of primary care and of specialist income. It is extremely low, but I think this is perhaps okay for the average physician. Larry would like to see the amounts for
the quintile of physicians who care for the most low-income payments.

And separately, he strongly agrees with Jaewon's comment about the higher cost of taking care of low-income patients.

DR. CHERNEW: Great. So we're about to break for five minutes, and then we're going to come back, and we're going to do the post-acute PPS, but before we do -- Wayne--

DR. RILEY: Sorry, Dana. I sent a hands-up.

I too salute the staff and Geoff for the great work around this. This is critically important that we continue this in parallel with the work on safety-net hospitals, so I salute that.

I tilt strongly to four, for many of the reasons that have been voiced by Betty and Larry just now and Jonathan. Primary care has been undervalued far too long, and just knowing the demographic shifts we're dealing with, the rural issues that Lynn has talked about, and the large asymmetry, quote/unquote, of physician salaries, I think we should, you know, embrace No. 4. Even in terms of its cost to the federal outlay of $2 billion higher than Option 3, $7 billion higher than if we did it 10 percent across the
board for everybody. So I think when you frame it that
way, I strongly favor Option 4.

DR. CHERNEW: We're going to have a Round 1 which
turns out like 1, 2, 1.

[Laughter.]

DR. CHERNEW: But we are then going to break, but
we have -- yeah. No, go ahead.

DR. RAMBUR: I'm assuming that we're not able to
break out physician, nurse practitioners, and PAs in terms
of serving this population. I'm curious, because my
experience is a lot of nurse practitioners and PAs do work
with more vulnerable populations, so just a question.

MR. GERHARDT: I mean, we can and we do break it
out in certain tables. Are you looking for it to be broken
out for a certain --

DR. RAMBUR: No. I'm just thinking that that's
another piece of the story that isn't fully clear here, and
I'm not sure we can make it clear. We have incident-to
billing and other kinds of things.

MR. GERHARDT: Right.

DR. RAMBUR: But my experience is that NPs and
PAs work with many disadvantaged populations, and they make
half of what the physicians and primary care do, so --

DR. CHERNEW: Okay. Great. So this has been a really good discussion. We've heard from all of you. We have a lot to think about. The one thing that I can say with some certainty is no one likes Option 1.

[Laughter.]

DR. CHERNEW: I've heard reasonably strong support from different people for 2, 3, and 4, and a few other nuances there regarding things like non-facility, facility distinctions, and several folks have spoken on the role of MA that I think we will take to heart.

But given that, I think this has been a particularly important and good discussion, so I want to thank you all.

We're going to take a five-minute break for those of you here. Stay logged into this session, and we're going to be back to talk about post-acute PPS in five.

[Recess.]

DR. CHERNEW: We're going to jump in. Dana, you can get us going when it's time to get us going, which is kind of now.

MS. KELLEY: I think whenever Carol's ready to
DR. CARTER: I'm ready. Okay. Hello, everybody.

DR. CHERNEW: We have to --

DR. CARTER: We're not ready?

DR. CHERNEW: Okay. We are now actually really officially ready, Carol, so I'm turning it over to you to talk about post-acute PPS, which has been a road we've been going down for some time now.

DR. CARTER: Yes.

DR. CHERNEW: So I guess the right thing is bring us home.

DR. CARTER: Okay. I think it is get us started.

[Laughter.]

DR. CARTER: Today we begin a series of presentations to prepare a mandated report on a prospective payment system for post-acute care.

Before I get started, I want to thank Kathryn Linehan for her help with this work, and to remind the audience that they can download a PDF version of these slides in the handout section of the control panel on the right hand of the screen.

Today we'll start with outlining why the Congress
was interested in a unified payment system for post-acute care, and then I'll summarize the mandate.

Next, I'll review the Commission's extensive body of work on a unified payment system. Then I'll highlight important changes that have occurred in the PAC landscape since our earlier work was completed and point out the key challenges to implementing a unified PAC PPS.

Finally, I'll outline the analyses we plan to complete for the mandated report. We will begin to present that work at next month's meeting.

Our work and that done by others has found that some beneficiaries who look similar in terms of their condition and comorbidities are treated in different settings — that is, home health agencies, skilled nursing facilities, inpatient rehab facilities, and long-term-care hospitals. But because Medicare uses separate payment systems for each setting, payments can differ substantially.

In addition, there were shortcomings in the home health and SNF PPSs that encouraged providers to furnish unnecessary rehabilitation therapy and to selectively admit certain types of patients over others.
Further, quality measures and patient assessments made it difficult to compare patients, costs, and outcomes across settings.

To begin to make sense of this disarray, the Congress passed the IMPACT Act in 2014 that required the Secretary of Health and Human Services to develop and implement uniform patient assessment items and quality and resource use measures.

It also required MedPAC and the Secretary to design prototype payment systems to span the four settings.

The Congress required three reports on designs for a PAC PPS. We completed the first work in 2016. A second report by the Secretary was submitted to the Congress in July 2022.

The Commission is required to submit a third report, including recommendations, that is due on June 30, 2023.

The Congress required that the designs span the four PAC settings and base payments on patient characteristics not the setting.

Our work on a PAC PPS has been fairly comprehensive and has spanned six years. Much of this work
was done in response to mandates from the Congress. I'll summarize the work over the next few slides, and the paper includes links to the various chapters in past reports.

In our June 2016 report, the Commission supported the rationales for a unified payment system and concluded that it was feasible to design a PAC PPS using existing data.

Based on strong Commissioner interest, we proceeded to build out this policy idea over the next three years and focused on various implementation issues.

The Congress required us to review the existing value-based incentive program for SNFs and to consider a design for all post-acute care providers.

Our work started with identifying key features of a PAC PPS, including:

A stay, using a stay as the unit of service;

An adjustment for home health stays; otherwise, these stays would be way overpaid and institutional care would be substantially underpaid;

A uniform set of risk adjusters;

A targeted rural payment policy;

An adjustment for home health stays that occur
late in a sequence of post-acute care; otherwise, these later stays, which have lower costs, would be overpaid; A short stay outlier policy and a high-cost outlier policy;

We found no need for an additional adjustment for teaching status that IRFs currently receive. We noted that further analysis was needed to assess if there should be an adjustment for providers treating high shares of low-income patients.

The Commission underscored the importance of a design that has uniform features (except for the home health adjuster) and acknowledged that while setting-specific features would yield more accurate payments, they would undercut the purpose of a PAC PPS.

To evaluate the design, we examined three aspects:

First, the accuracy of PAC PPS payments for various patient groups, and we concluded that they would be accurate.

Second, to examine the equity of payments, we looked at the profitability of different types of cases. We concluded that a PAC PPS could increase the equity of
Third, we modeled the impacts on providers and found that there would be considerable redistribution of payments, from rehabilitation to medically complex patients and from more costly to less costly settings.

Given the Commission's interest in moving forward with a PAC PPS, we then undertook a considerable body of work looking at implementation issues.

First, we looked at whether a PAC PPS should be implemented to be budget neutral to the current level of payments. The Commission recommended that the aggregate level of payments should be lowered when a PAC PPS is implemented.

We also examined whether a PAC PPS should be implemented with a transition. Based on analyses of the distribution of impacts, the Commission recommended a relatively short transition to a PAC PPS.

To address regulatory alignment, we proposed an approach that would shift requirements from being based on setting to being patient-centered. For example, if a provider opted to treat patients on ventilators, it would have to meet additional requirements specific to that care.
We also examined the current differences in benefits and cost-sharing and outlined the inherent tradeoffs in aligning them.

In its early work, the Commission noted that a value incentive program should accompany the implementation of a PAC PPS. Otherwise, providers could generate unnecessary volume to increase revenues or lower their costs in ways that would harm beneficiaries, such as stinting on care.

In response to additional congressional mandates, the Commission completed two reports. The first report on the SNF value-based purchasing program included a recommendation to eliminate the program and replace it with a different design. The report on a PAC value incentive program outlined the key decisions policymakers would need to make when designing such a program.

Both reports build on the Commission's principles for value-based payments.

Since our early work, there have been key changes in the PAC landscape that could shape the design and impacts of a PAC PPS.
First, the PPSs for SNFs and home health agencies were overhauled and are likely to have shifted payments towards medically complex care and away from rehabilitation care. The new criteria for LTCH payments have changed the complexion of this sector.

Second, the impacts of COVID-19 have been considerable. Providers' costs, staffing, and service provision changed, and while some of those changes will be temporary, others are likely to be permanent.

Beneficiaries' use of PAC also changed, as they avoided nursing homes, and those who sought post-acute care may have been sicker.

Last, the continued expansion of alternative payment models illustrates the shifts in PAC use that are possible. Participating entities generally shift PAC use to lower-cost settings and encourage shorter stays.

There are many challenges to implementing a PAC PPS. First, aligning regulatory requirements so that providers face the same costs will be a multi-year undertaking. Some of the requirements will be relatively easy to align, while others -- such as staffing and physician presence -- will not be.
The second challenge will be how to address the quality of the function data. We think there's no realistic timely fix for this information, and in the paper we outline strategies CMS could take to dampen the effect of these data on program payments.

CMS will also need to consider how to address anomalies in data from years with large COVID-19 effects. We think there are reasonable strategies to take so that CMS could proceed with its work on a PAC PPS.

A key rationale for a PAC PPS remains; similar patients are treated in different settings with different payments. Our work has shown that a PAC PPS can be accurate and is feasible using existing data. The changes home health agencies and SNFs have made in response to their new case-mix systems are entirely consistent with those that would need to be made under a unified payment system.

Concerns about using data from years that include large COVID-19 effects are relatively straightforward to address by using a more recent year of data when testing a design and with periodic revisions to the PPS. We acknowledge that aligning regulations, cost
sharing, and benefits will be challenging, but we think it is possible.

Now shifting gears, in July, the Secretary issued his report on a prototype design. This report was prepared by RTI International under the direction of CMS and ASPE. At the November meeting, I'll go into more detail about the design and its findings, but I wanted to give you a sense of what's in the report. And there is a link to the report in the paper.

The report includes a prototype design to set payments for all PAC providers. A base rate would be adjusted for the case-mix group assignment, comorbidities, and rural location. The design includes an adjustment for the setting where the patient was treated, and the report states that this adjuster could be modified over time.

The report is clear that the prototype should be updated with more recent data. Data from 2017 through 2019 were used to develop the design.

The report includes estimates of the prototype's accuracy and impacts on payments to providers.

It does not include recommendations or policy options but includes discussions of the topics we have
outlined as key companions to a PAC PPS: a value-based purchasing program, regulatory alignment, and aligned cost sharing. And as I said, we'll discuss the report in detail in November.

To examine the Secretary's prototype, we plan to do the following:

First, we will update our analysis of design features that are needed to keep payments aligned with costs. Then we'll compare those features to the features of the prototype.

We will report the prototype's accuracy and equity of payments and its ability to explain the variation in costs across stays.

We'll also report the prototype's estimated impacts on providers.

Then we'll also outline additional diagnostics CMS should conduct as it proceeds with an updated prototype using more recent data.

We'll present analyses that help assess certain implementation features, such as whether the level of aggregate spending should be lowered when a PAC PPS is implemented and whether there should be a transition.
We'll also review complementary policies that should accompany a PAC PPS.

Here's the timetable for future presentations.

In November, we'll present our analysis of the Secretary's prototype design.

In March, we'll outline additional diagnostics CMS should undertake as it evaluates an updated design and outline the implementation issues. This will be your first chance to review the entire report and to consider a draft recommendation. Given the constraints, we don't envision a set of detailed recommendations but rather one similar to that made in 2016 -- to recommend forwarding the entire report to the Congress.

April will be your last chance to review the entire report, and you will vote on the draft recommendations.

During your discussion today, we're interested in your comments on the proposed analytic plan. Over the next month, we'll want to know if there is other information you will need to get to a recommendation.

And with that, I'll turn things back to Mike.

DR. CHERNEW: It is so good to see the progress
that has been made. I know we're going to be talking about this several other times, but I think we should go through the queue and see where we end up.

MS. KELLEY: All right. I have Lynn with a Round 1 question.

MS. BARR: I want to focus specifically on the rural issues in the report that, you know, weren't quite maybe addressed. So many rural beneficiaries end up in swing beds, and I know that's under a different payment system, and we're talking about a payment system, but we're also talking about a quality system and value-based care system, and we talk about, you know, accountable care organizations. And there's a lot of complexity around this, and I don't want to derail the work. But is there any way to think about how elements of the PPS plan can include swing beds other than the payment side?

DR. CARTER: So what kinds of elements --

MS. BARR: Like quality. So if we're going to -- because they're completely exempt from any kind of quality reporting; we don't do any -- there's no oasis. You know, we have no way of evaluating the quality of care, and we pay a ridiculous amount for this. You know, and so I don't
know if this is appropriate in — you know, someday Mike's
going to give me my own chapter on rural, I'm sure.

DR. CHERNEW: I can't believe that book isn't
somewhere being written on your computer.

[Laughter.]

MS. BARR: 2012 was a good year, but it's been a
long time. Anyway, so just is there any way to think about
— because we have nothing on the value of that care, and
it would be very important, I think, to try to see if
there's an element we could share.

The other piece that came out in this that struck
me was the home health recommendations don't really --
there doesn't seem -- there's a big disconnect, I think,
between the rurals' perception of home health access and
MedPAC's perception of home health access. And I'm
wondering -- and I've been trying to think about this for a
long time, because if you go to Iowa and Michigan, they'll
tell you they have no access. In Texas and Oklahoma,
they've got more access than they need, and so maybe it's
an averaging issue. But there are many, many states — not
in the South, in the South — that have no access to home
health and everyone thinks they do. So is there a way to
dig in more on that access issue? Because if you talk to the rural constituents, they all agree, we have a terrible problem. But if we talk to MedPAC and CMS, there's no problem. And I don't know what the disconnect is, but I think it might be because we're averaging things. And we do know that there are states that have huge overutilization issues in rural and the waste, fraud, and abuse, and that might be skewing the data. So those are my Round 1 questions.

DR. CARTER: So in terms of thinking about the requirements for, say, rural swing bed providers, we can think about including some discussion of that.

In terms of access, that's not really a focus of this report. We're really looking here at a prototype design, so I --

MS. BARR: How do you evaluate equity then in the design if -- I mean, like I said, the constituents say there's a huge problem; no one's recognizing it. So I feel like that disconnect -- how you design -- if you design this, we're still going to have the same problem, unless we're all delusional about the problem. I don't know what the issue is. My data, I saw it.
DR. CARTER: So I can talk to my home health colleague and think about how to include maybe some perspective on whether this payment system redesign would help with that, but I don't think it will be a key -- we won't be able to evaluate whether this payment system's going to improve access. We can tell you what's going to happen, what we would estimate the impacts to be, but that would be kind of by the case type level or at the provider level, but we can try to include -- at least think about how to get at --

MS. BARR: Yeah, the problem is in the paper you say there's not an access issue, and that's been the position. And so I don't know where to get at the data that says, you know, if all the constituents are saying there's an access issue but the data says there isn't, and we're evaluating payment models, how can we be evaluating whether or not this is affecting access when there's a potential data disconnect. I don't know how to solve it.

DR. MATHEWS: Yeah, Lynn, if I could jump in here, just a reminder. Last year, actually, June of 2021, we reported out an update of our prior work on access to care in rural areas where we looked at utilization of
services as a proxy for access. And across the sectors that we looked at -- hospital, physician, SNF, home health -- we found comparable levels of utilization across all gradations of rurality, if that's the right word, until you got to frontier areas.

MS. BARR: Right.

DR. MATHEWS: And at that point, utilization understandably tails off. But with respect to, you know, per capita utilization, with respect to financial performance, we don't see large differences among rural and urban, financial performance under the Medicare program. Those are the things that lead us to conclude that there is not, you know, in the aggregate a problem with rural beneficiaries' access to home health care. I don't know what the industry might be telling you, but --

MS. BARR: And I agree in the aggregate, but I think it's being skewed by we have overutilization in Texas and Oklahoma that's swamping the data. And so I don't know how to get at this. I had this same complaint when we had that chapter, and so I don't know how to get at this. But the constituents, it was our experience, we couldn't get home health in the majority of our rural communities, not
frontier. I don't know where the disconnect is. I don't
want to dominate this, but I'd love to talk to somebody
about it because there might be a way to look at this.

MS. KELLEY: David?

DR. GRABOWSKI: Great. First, thanks, Carol.

This is great work, and I'm really excited we're continuing
our work on the unified PAC.

I just want to confirm a detail. I'm less
familiar with the ASPE work, but all of the coding,
correct, is done in the prior hospitalization? There's
nothing from the assessments once they're at the SNF or
the, you know, OASIS? And so it's all done kind of in the
sort of hospital setting. Am I correct in that in both
ours and their work?

DR. CARTER: No. So some of the -- some of the
information is taken from claims, so like the --

DR. GRABOWSKI: Yeah.

DR. CARTER: -- primary reason to treat and
comorbidities are pulled --

DR. GRABOWSKI: Yeah.

DR. CARTER: -- from claims.

Things like whether a patient is on a ventilator
is during the PAC stay, not in the prior hospital stay.

DR. GRABOWSKI: Right.

DR. CARTER: We did use the hospital data to assess things like -- for measures of severity. Like how -- if a patient stay was in an ICU, how many days were they there?

We ran those claims through the severity of illness adjusted APR-DRGs, as another measure of severity.

So there's some information from hospital claims, but of course, the majority of home health don't have hospital claims. We were trying to use PAC information and then pull from hospital stays when we had them.

DR. GRABOWSKI: Thanks.

DR. CARTER: Yeah.

MS. KELLEY: Robert?

DR. CHERRY: Yeah. Thank you. A great report.

My question is regarding clarification on Slide No. 11. There was mention that one of the challenges implementing a unified PAC PPS system is accurately measuring the functional status of patients, and I just wanted to clarify that statement with our pre-read materials because, in the pre-read materials, the problem
with assessing functional status was incomplete data, whether it's lack of reporting or it's reported but not sort of translating back into our databases. So is that what you're referring to, or are you questioning the actual functional status model that providers rely on to report on? Because there's different models for assessing functional status. Thank you.

DR. CARTER: So we're referring to both. There are some missing data, but we also have done work looking at whether there is inaccuracies or how function is recorded, and particularly when that's used for payment, there are incentives to assess patients as lower than they actually are to set the payment at a higher rate. So we're worried about the quality of the information as well as missing data.

DR. CHERRY: So I think what you're saying is that there is a need also to recommend a functional model. So there's also consistency across --

DR. CARTER: Well, we have consistent measures across the settings. Those already are included in the patient assessments. The four settings now have uniform measures of function. So it's less that -- than some of
the biases that we're a little worried about, and I don't
think that the data are entirely wrong, but there is a --
at least in the work that we've done, there's bias in the
information.

DR. CHERRY: Thank you for clarifying.

DR. CARTER: Yeah.

MS. KELLEY: Amol?

DR. NAVATHE: I realize that we're still looking
at the ASPE model, but I was curious if you have any sense
of why they included the setting, kind of given, in some
sense, this notion of trying to get to a unified PPS.

DR. CARTER: So we'll talk more about that next
month. My sense was the model was trying to accurately
predict cost of care, and including the setting as an
indicator helps with that.

DR. CHERNEW: I'm just going to say one thing in
response, though I don't know the answer to the question.
This is a bigger-picture comment about cost in general.
There's a statistical aspect that if you see a bunch of
costs, you want to predict it, and there is a behavioral
aspect, which is the costs reflect how you pay and a bunch
of things that happen. And so we constantly have this
tension across what we're doing here.

So I agree with your point. It's this aspect of the extent to which setting is designed to adjust for cost per se versus some, for lack of better word, unobserved case mix in ways you can't get it.

But I think we might save a deeper discussion of that for a month-ish.

DR. CARTER: That's right. We'll go into that, and the tradeoff in a model that's fully uniform versus one that isn't, because there are clearly tradeoffs there.

MS. KELLEY: Kenny?

MR. KAN: On the last slide, regarding the timeline -- by the way, I am wildly enthusiastic about this. I definitely look forward to the November analysis, and I like the proposed analytic plan.

Mike actually captured my thoughts. I'd like to better understand the dynamic that he just mentioned in terms of when you were to back-test it. No model is going to be ever perfect when you back-test it, but does it sort of like even out in general? I think that would be helpful for me to understand.

Also curious is that as the society transitioned
from a pandemic to an endemic, I'm curious about, you know, if there's any impact from long COVID. I realize there's not a lot that we know about this, but, you know, perhaps the model may want to be a little bit flexible. So I definitely look forward to learning more.

MS. KELLEY: That's all I have for Round 1.

DR. CHERNEW: Great. So we're going to move to Round 2, and I think, if I'm right, we're going to start with David.

DR. GRABOWSKI: Great. Thanks, Mike, and once again, Carol, this is great work, and I'm very supportive of the direction we're headed.

I wanted to make four comments. The first is a big-picture comment. I think the problem we're trying to solve here is that Medicare is paying a very different rate for similar patients across four post-acute care settings, and that obviously leads to some big inefficiencies and distortions. In that regard, I think the PAC PPS is a real step in the right direction, but I would say I hope it's not our destination. And you say this well in the chapter. It's still based on fee-for-service. It's going to help with sorting individuals to the model that best meets their
needs, but I don't know on a population level that it's
going to do as strong a job as an alternative payment model
might in terms of curbing low value post-acute care. And I
think that's really the problem here.

Yes, I think it's helpful, but it's not sort of
addressing this bigger value issue that we have in post-
acute care. But I do think it can help in terms of the
matching issue. So that's the first comment.

The second comment, however, is beyond just
harmonizing payments, I think there's real value in this
exercise of harmonizing cost sharing, harmonizing quality
measures, and harmonizing the regulations across these
different PAC settings, and I think that's going to have
value wherever this kind of model ends up.

We've had such differences in how we think about
quality. Even the assessment instruments, the OASIS, yes,
and the FIM are so different across these settings that
it's been hard to compare apples against apples in the
past. And so I think there's going to be tremendous value
here in this work, even if we don't get to the unified PAC,
which I hope we do get to.

Third comment, in thinking about my challenge
with unified post-acute care payment, it's always been home
health, and it's different -- and, Carol, you've talked a
lot about that over the years. I'll say the obvious. It's
noninstitutional. It really relies on family caregivers
and paid caregivers as this complement to what you would
get in these institution-based settings, like a nursing
home or an inpatient rehab facility. And so it's always
been challenging to kind of make that comparison because in
the home health setting, we're sort of putting that on the
family. We're bringing the therapy to them but not the
sort of assistance with activities of daily living.

For this reason, I'm a really big fan of that
home health agency adjuster that you have in the model,
Carol. I think that's a super important part of all of
this, but I did want to push a little bit on how we think
about social factors and how we account for them here.

Just very quickly, we did a paper several years
ago with a group over at Mass General where we were able to
leverage their electronic health records, and we looked at
where individuals were being discharged from the hospital.
And we thought, oh, we'll find health characteristics are
the most important predictors. It turned out living alone
was the most important predictor as to whether you went to a SNF and not home, and that's a hard thing to account for here.

I think some of our beneficiaries have the family support, have the ability to kind of fill in the gaps. Others don't, and I think I just don't want this to lead to more sort of distortions in terms of the haves and the have-nots in our system.

Final comment. And you said this well on Slide 10, Carol, that the landscape has really changed -- I don't have to bring us up to speed on COVID -- shifting folks out of SNFs into the home. APMs obviously cut down a lot on utilization.

But I did want to touch on that third point you made about both home health and skilled nursing facilities now have payment systems that much more resemble like what we've proposed here and that they no longer pay based on therapy. They pay based on patient characteristics.

And we've been doing an evaluation of the patient-driven payment model, which is the SNF version of that. It came online just before the pandemic. So we had this very narrow evaluation window, and then the world.
completely changes. It was hard to really tell what was going on, but it came online fourth quarter of 2019. And I think the results are important here.

The one result is not surprisingly. Nursing homes pivoted very quickly. Therapy came way down. That's not going to shock anyone. Patient characteristics, however, went way up, and how much of that is real, we think very little based on the hospital claims. I think a lot of that is up-coding.

The other good news is there doesn't seem like any outcome shifted, so that's sort of supportive of a lot of other work, like the ACO work, that you can really change kind of the amount of post-acute care, the amount of therapy, and not see big results.

But I think the big takeaway here is as we rely on coding from the different post-acute care providers, let's make certain that it's accurate, and that's really the tension, how much we can get from the hospital claims and how much we have to rely on kind of them telling us what the characteristics are, because I'm very suspicious based on what's happened in PDPM that we're going to get back accurate information.
All right. Mike is going to give me the hook here in a second, so --

DR. CHERNEW: I'm not. For those watching at home, I'm not.

[Laughter.]

DR. GRABOWSKI: All right. Well, I have five more comments -- no, no, no.

I'll sum up here and just say that I'm very supportive of this work. These comments shouldn't be taken as criticism, more -- more ways in which I think we can enhance and some things we want to look out for. So thanks again, Carol. Great work.

MS. KELLEY: Greg?

MR. POULSEN: Thanks.

David really got a lot of the key points that I wanted to make. As opposed to being wildly enthusiastic, I'm sort of cautiously positive, honestly, because I think the challenges here are enormous.

I certainly like the goal. Anything that moves us upstream and pays for patient condition as opposed to setting treatment, I think, is a good thing. Obviously, total population payment is by far the most effective in
I worry that we're in a place where we may be finding it very difficult to tease out the different patient beneficiary characteristics. Our current work suggests that we can do this, I think, reasonably well, but maybe, to David's point, I think the coding and other things that this is based on are so variable that I'm concerned that we may not be catching all of it and in a way that's really meaningful.

And the separation that we have of home health with essentially the statement that "Well, home health, the costs are so different. Therefore, we shouldn't put it in the same group" worries me a lot. Because the costs are way different than the other settings as well, and our assumption is they're not justified to be different. And they are justified to be different in home health.

And that troubles me that we may be not making a completely embracing argument around this, and I guess I would suggest to all of us who have been watching all of these areas for a while, the capabilities are increasing dramatically. The things that we used to do in ICU are now often done not only not in an ICU, they're not even done in
a hospital. They're done in a long-term care facility, for example. And that's happened in a relatively short period of time.

The phrase "hospital at home," I think, was a buzzword a little while ago, but now it's reality. There are literally people at home who would have been in a hospital not very many years ago.

So to essentially say, well, home health is different because it costs less troubles me, that if we think that we can accurately and sufficiently capture differences in population based on patient characteristics -- and in those patient characteristics, I would include family support or other social considerations, which clearly are there -- I think, David, you just mentioned that the biggest differentiator in some instances was the presence of family as opposed to clinical differences. To the extent that we can capture all those, it seems to me what we would really like to do is to identify a payment mechanism that's holistic and then identify the lowest-cost setting where that can be provided.

And that should be true across the three institutional settings, but I think it's probably in
sufficient to say, well, but it shouldn't include home health because, oh, by the way, it's cheaper. I think we need to find a mechanism that's more embracing to say why should we not consider the person's total needs, clinical and social, and then allow organizations to find the most effective, cost-effective setting that meets those needs.

As I said, I'm positive about this, but I'd be wildly enthusiastic if we were able to break that down because I think that would take us to a place where we can actually find significantly lower-expense settings and really enhance the whole concept of moving people into the lowest-cost setting that fully meets their needs.

And technology is going to allow us to do things in five years that we can't really even envision today, and the payment mechanism, we should make sure that our payment mechanism proposals don't make that more difficult. They should make that more easy, so thanks.

DR. CARTER: So I just wanted to point out that at least in our work, we're averaging costs. So we pull everybody in together, and so we're not trying to find the lowest-cost setting. We're trying to set payments based on the cost of the average. So I just wanted to make sure
that you understand.

MR. POULSEN: No, I get that.

DR. CARTER: Okay.

MR. POULSEN: I appreciate it.

I guess what I'm saying is, as we look at it, there clearly are significant differences between settings for patients with apparently the same characteristics. To the extent that they really do have the same characteristics, then I would hope that as a policy approach, we would encourage people to find the lowest-cost setting. And that's going to hopefully happen by default.

To the extent that we assume similar characteristics, but the clinicians who are making the recommendation on where people go identify something, we're making that assumption for home health. We're assuming that the clinician is including something that we don't have in the medical record, which is are there people there that can be the caregivers.

There may be things as well that are being made that aren't being captured in the coding as well would be my thought and my worry.

MS. KELLEY: Scott.
DR. SARRAN: Yeah. Excellent work, and I thoroughly support it.

I'm going to largely, I think, reinforce what David's comments were and go perhaps one step beyond that in terms of a point that I don't think we're yet addressing.

So I think the work is really good as far as speaking to how we distribute money between settings, and as David pointed out, the PDPM work was an attempt, I think a good attempt, to try to allocate money based on patient characteristics, the failings of which are around, as you pointed out, the accuracy of the underlying information around which to base that.

But what we're not getting at -- and I recognize, Michael, this may be a little bit out of scope, but I think we should take every opportunity to comment on it -- is not just the distribution of money between settings or between patient types, but it's to me the more important issue of what are we getting for each patient, each beneficiary. Are we getting what we want for what we're paying?

And I think the answer, as we all know, is we're not getting what we should be in terms of the outcomes, and
I think we should -- a quick of background is understanding why that's not happening in these settings to a greater extent than in other settings in the U.S. health care system, and then what can we do about it? And the why is that each of these post-acute settings is extremely benefit- rather than beneficiary-centric and has a set of very rigid business models around how they're paid to a much greater extent than, for example, hospitals, physicians, ambulatory surgery centers, you name it. And I think anybody that's spent time working in and managing those settings realizes that.

So what we can do about it is when we're trying to change a rigid business model, you need a really strong single -- one or two single levers to change it, and the biggest one we don't have, obviously, is how these settings are paid, and not so much the distribution of money between settings but how they're paid for each beneficiary.

And what I'm saying is I think the big opportunity, as we're sort of opening up this space for changes, is changing to a payment system that isn't just an incentive. It isn't just a tweak but substantially pays each of these settings based on the clinical outcomes that
are achieved, consistent with the beneficiary preference, right, so outcomes based on beneficiary preference as well as clinical reality, safety which is -- you know, these are the settings that are the least safe settings in the American health care system by far and an element of a markedly improved service, communication and coordination, which are really pretty poor, by and large, in these settings as far as experience by the beneficiaries or families.

So I'm saying to the extent we can, I think we should strongly opine that since there are going to be changes made in how these settings are paid, take it as an opportunity to change the overall structure and pay much more then based on the right kinds of clinical outcomes, the absence of safety problems, and markedly improve communication, coordination, and service.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you. I am also very supportive of the work that has been done to date. You know, my comments are around some of the methodology used because we did not have much of a choice, and that is the dependency on patient-related
characteristics, you know, risk scoring, cognition, age, et cetera, because we really did not have the data to look at functional outcomes.

And so there is a correlation between patient characteristics and functional outcomes, and you did explore that a bit, at the individual level it may not translate so well. So at the macro level, from a population health perspective and across these different four post-acute setting, the correlation makes sense, but you are probably going to lose it in translation at the individual patient stay where those functional outcomes are really critical in determining whether or not the payment is appropriate, because in some cases if we just rely on patient characteristics there may be overpayment or underpayment, and it could lead to upcoming, what David was implying, as well.

So I do think that at the end of the day it is really necessary to understand in terms of what we are paying for and what we are getting. Those functional outcomes are going to be really critical. But we do not have the opportunity right now to actually tease it out.

So I think whatever we do at the onset it is
probably temporary. You know, we will have to rely on these patient characteristics for now. But I think that the functional outcomes needs to be sort of a mandatory report out at the end of the day, so that we can study it over a couple of years and then refine the payment model accordingly. But I think if we continue to overly rely on the patient characteristics and now have the functional outcomes as a force function then we will continue to probably have a payment model that is not quite as optimal as we would like to have.

DR. GRABOWSKI: Yeah, Robert, I am really glad you raised that because that was something that really struck me as well. We invest this huge amount of money in these assessment instruments across the four post-acute settings. We do millions of these MDSs, minimum dataset assessments, millions of OASIS assessments every year. And the fact that we cannot pull an accurate measure of functioning, it is really kind of depressing that this is not a variable that is usable. So I am with you, that that is really what post-acute care is about, is improvement in functioning, and yet we do not have a measure of. And that is true for quality. That is true for assessment, that
baseline. It is really unfortunate.

DR. CHERRY: I totally agree, because at the end of the day, at the individual level, you want to know, are they able to transition to home in a way that's optimal and improves their quality of life. And we just will not know that until we get that data, and it is really critical that we do.

MS. KELLEY: Dana.

DR. SAFRAN: Thanks, and Carol, thanks for this really great continuation of such important work.

I think my comments really are limited and build on the exchange that David and Robert were just having. David made the comment earlier that this is a kind of stop along the road to value-based payment, full-fledged value-based payment in this area. But I think where we have struggled is the relative absence of robust quality, and in particular, outcome measures for post-acute care, the small sample sizes that plague us in terms of being able to really create a strong accountability model, and the fact that what matters, as this exchange was just showing, is really the functional outcomes, and yet we do not have good, reliable ways to collect that information. We worry
about bias when it is systems-reported functional outcomes for patients. There are so many challenging cognitive issues with patients for getting patient reported.

So all of that has led me to wonder whether one piece of this work -- and I imagine that timeline, which, by the way, I really appreciate having this timeline slide. I would love us to incorporate that as a kind of standard thing for our work. It's so helpful to understand like where we are and where we are going over the cycle with a piece of work.

But anyway, I imagine the timeline might not allow this, but somehow for MedPAC to start to be involved in how are we going to solve this problem, which isn't limited to post-acute care but is very much critical in post-acute care, of being able to have scaled use of patient-reported functional outcome measures in health care accountability models.

You know, there are many barriers, and I am happy to talk with you offline about a framework that I have for what are the barriers. But I think if MedPAC, specific to the past work, were able to even just do some expert interviews, or I don't know if we ever do a convening of
experts, but do a convening of experts of like how do we solve this problem, maybe we start to get some ideas for where to begin and how to proceed from there. And to use the overused phrase of not letting the perfect be the enemy of the good here. Let's just start somewhere. But I think we are stuck on where to even start, and it gets in the way of progressing in value-based payment for this area of care, where it is just so important.

So those are my thoughts. Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks. I'm also very supportive of the work, generally, and Carol, it is an excellent chapter that you have prepared here.

I am struck by the challenges that we have here, and I think David's points, some of them actually kind of brought that into stark relief. If you think about it, we are saying we should be paying for similar patients similarly, and that, of course, depends on being able to identify similar patients.

If we also take a step back and say, if we could design the system perfectly where would we want the system to be, I think we would want the system to be essentially
no overlap between the settings, because we would want to
match the level of acuity to the patient, for the patient
to level of acuity to the setting.

And so our ex-post destination, in some sense, is
that there is no similar patients across these different
settings, which means that it fundamentally depends on our
ability to differentiate appropriately. And I think there
I wholeheartedly agree with Robert and David's response
there, which is we are ultimately very dependent on this
data that we can't rely on, because if we can't actually
differentiate I think we all probably believe that often
claims data a priori, at least it's a very difficult to try
to do that. So we are heavily reliant on these functional
assessment measures that are problematic, as we have
discussed.

It was interesting that the -- and I look forward
to what happens in our analysis of the ASPE report, but it
looks like they are including that in their case mix
adjuster. And so that gives me pause as well.

I think to some extent if I ultimately take a
step back, you asked the question on the slide, you know,
what information would we need to get to a recommendation,
I think in some sense the question is what do we have to believe here about how data like the functional status assessments, how reliable are they going to be and how practical do you think that we can get there with something like a mandatory reporting of it, and then how long is it going to take us to validate that?

I think those are some of the core questions that I think we have to wrestle with to be able to get to this point. Placing it in the context of what Dana said also, which is we do not want the perfect to be the enemy of the good, and David's point that this is a pathway to APMs or an APM-like system, which is really where I think we want to eventually get, so that way we are not necessarily stuck with the burden, if you will, of the administrative parts of the system that I'm describing in some sense.

So I think a lot of challenges, really important work. I think we know that there is a lot of opportunity for the Medicare program to be more efficient in the post-acute care setting. We can't find a more important sector to work on, but I think the challenges are pretty apparent.

So thank you.

DR. CHERNEW: Let me jump in. I have two more
people in the queue. We are going to go a little bit long. We started a little bit late. We have lunch next, so just to give you some idea of where we are.

I will say that this issue about sort of, quote, "case mix adjustment" when we can observe, and functional status, and home support, that plagues how you pay for APMs. That plagues how you deal with MA. And, you know, that's a whole broader discussion. But I will simply say my own personal view is we should keep trying and go into the task with a lot of humility, because it is not going to be something that is solved with a report.

But in any case, I think the first of those two people next is Cheryl.

MS. KELLEY: Yes.

DR. DAMBERG: Okay. You just stole some of my thunder.

First let me say this is really interesting work. I am obviously new to this work, but I found it fascinating, and I think that the Commission should be weighing in on this space and trying to think about ways to pay differently. Particularly I was really struck by the payments are 14 percent higher than costs.
And I think that some of what is proposed here, what I like about it is it will potentially redirect future investment in terms of the types of care settings that communities make available to Medicare beneficiaries, so I liked that. And I agree that we need to be working toward something that is more accountable, value-based, and moving away from fee-for-service.

You know, per Mike's point and many others have made this, the coding is a real challenge. It is not just unique to this setting. And I think, to me, the larger question is what is it that we can do to maybe do more auditing in this space, you know, hold providers accountable for what they actually put down on paper.

And also, I'm sort of eyeing a lot of changes that are going on within health care organizations to collect more information. So whether it's, David, you had access to the electronic health record and there was more detailed information, whether there are opportunities in here to capture more information, that would give us a better sense of whether the person is in the right setting for their circumstances.

And then lastly, I wholeheartedly agree that we
are not where we need to be in the space of measuring functioning, whether it is in the post-acute care space or elsewhere, and that we need greater investment thinking about how to do that and bring that online.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you, and my computer just died so I think that's a message that it's almost time for lunch I just wanted to say how much I appreciate this conversation and the comments from the other Commissioners. I did want to follow up on what Greg said about questioning the lower cost in home health.

I was recalling that the largest expense in most agencies is the cost of the people doing the work -- the nurses, the RNs, the nursing assistants -- and salaries are lower in that setting. And at one time people were willing to do that work, but in the current labor situation will people be continue to be willing to do that work at a lower salary? There is more autonomy and people have been attracted to it.

But as we think about moving more towards value-based payment, many of them are nurse sensitive or even nurse centric. So this idea of is it really less expensive
is just a question, and maybe it is a rhetorical question
we cannot answer, but I just wanted to raise that staffing
challenge and cost. Thanks.

DR. CHERNEW: Okay. So first let me do a very
quick summary of where we are and then I am going to remind
the public that we are interested in their comments, and
then we can go to lunch.

So for the summary, there is obviously a lot of
enthusiasm for this work, or this topic, which is good
since we were mandated to do it. And there has been a lot
of work before, and other people that have been mandated to
do other stuff in this area.

There is train that has been going, if noticed
the dates on those reports before me and before many of
you, and the train is still going to go, and I think some
of the things that Carol mentioned, the Commission has had
recommendations on in the past about specific details
there. So that is sort of the good.

The challenges are, I think, there is reasonable
consensus around the table -- I'm going to use David's
phrase, it's a good step but it's not the destination, or
some version of that. And I think we agree there is sort
of some conceptual type challenges about how you would move
to the broader population-based payments, which if you
follow our APM work you know I'm enthusiastic about. And
then there are sort of technical issues about like what we
can observe and how hard this is to do.

And I think there is this tension about whether
setting is the de facto case mix adjuster. And that is
what I really think the debate here, and the answer is
well, sometimes, for some patients, kind of, but sort of in
some cases no, really not. And certainly with the work we
have done on long-term care hospitals, for example, you can
see that their situations are not long-term care hospitals
and the people can be treated in other settings.

So this is a very complicated area, and so I want
to manage expectations about what this chapter can achieve
in this way, both because it is the culmination of a lot of
work and so we are not sitting here for Report 1, waiting
to get to Report 3. We are sitting here at Report 3,
building off of Reports 1 and 2. And so I want to build
that expectation.

And certainly we are not going to broaden what we
do to get to some of these other big issues, which I think
the discussion here raised. And while we might not put
that in this report, that does not mean we do not think
they are unimportant. Measuring functional health, how we
do case mix in general, how we deal with social supports
and supports sort of at home, these are issues that will be
perennial MedPAC issues, mostly because of the perennial
Medicare and Medicare beneficiary issues.

So that is sort of where we are. I believe some
folks at home may have some thoughts on an interesting
topic, like the clinician safety net work we did or this
post-acute PPS work. And so I strongly encourage the
people that are listening, the public writ large, to send
their comments. You can go to meetingcomments@medPAC.gov.
You can go to the website and there is a place there where
you can leave comments. You can reach out in a number of
other ways. But we really do encourage feedback from the
public on these topics.

So with that I'm going to call this morning's
session to a close. We are going to have lunch, and we
will be back -- Betty will surely be the first one in the
seat -- when we are going to talk about nursing facility
staffing, which is going to be a beautiful segue since your
comment was we could pay what we pay but if there are not
people to do what we need then we have a bigger issue. And
I think that will be a continuation of a broader concern
about just the workforce writ large.

So in any case, thank you for spending the
morning with us, those of you that did, and hopefully come
back for the afternoon.

[Whereupon, at 12:37 p.m., the Commission
recessed, to reconvene at 2:00 p.m. this same day.]
AFTERNOON SESSION

[2:01 p.m.]

DR. CHERNEW: Welcome back, everybody, for our afternoon session. We are going to start today with a discussion of nurse facility staffing, which fits broadly into an interest of ours on workforce, and I'll just say by way of introduction is the health care system only works because of the people that work within the health care system. And we're very aware of the challenges of organizations to finding and hiring those people, the diverse set of skills that are needed in the health care sector, and that we need to dig deeper into understanding what's going on in a whole range of related issues. And that brings us to this particularly important topic, which is about nursing facility staffing.

So I'm going to turn it over to Kathryn. Are you going to start and then Lauren, or Lauren is going to start? Lauren, I'm turning it over to you.

MS. STUBBS: Thank you.

Good afternoon. Today we will be discussing nursing facility staffing. We would like to thank Carol Carter for her contributions in this work.
The effects of the COVID-19 pandemic have renewed and intensified long-standing concerns about the adequacy of nursing facility staffing. The high cost of labor, health care worker burnout, and worker shortages particularly complicate policy discussions around minimum staffing requirements. In today's presentation, we will provide some background on staffing nursing facilities, review both federal and state nursing facility staffing requirements, and update the Commission on recent developments in CMS's collection, reporting, and use of improved nursing staffing data.

This material will not become a chapter in our March or June 2023 reports to the Congress, but parts may be used as background in future work.

At this meeting, we would like to get your feedback on this material and discuss how data on staffing could inform future Commission work on the health care workforce.

To be covered by Medicare, skilled nursing
facility services must be provided in a facility that meets Medicare requirements to provide Medicare-covered, short-term skilled nursing care, and rehabilitation services.

In 2020, 1.2 million Medicare fee-for-service beneficiaries used Medicare-covered skilled nursing facility services at least once.

Almost all skilled nursing facilities are also certified as nursing facilities, which typically provide less intensive long-term care services that Medicare does not cover. Since skilled nursing facility care is generally provided in the same facilities that provide long-term care, we refer to the entire nursing facility when discussing nursing staff. We want to note here that most nursing facility residents are Medicare beneficiaries.

There are about 1.2 million people who work in about 15,000 nursing facilities in the United States. Among those workers are three types of nursing staff that provide care to nursing facility residents: registered nurses, or RNs; licensed practical nurses, or LPNs; and certified nursing assistants, or CNAs. These three nursing categories account for about one half of a facility's cost.

RNs have at least a two-year degree and must
become licensed in their state. They supervise patient care, perform the more complex skilled care services, and assess patients for the need for physician or hospital care.

LPNs are also licensed in their state but have completed less training, usually consisting of a one- or two-year degree program, and work under the supervision of an RN or physician.

CNAs must complete 75 hours of training and become certified in their state. They provide the bulk of bedside care, helping residents with self-care, such as dressing, personal hygiene, and mobility.

While we focus our discussion here on nursing staff, there are many other types of staff who work in nursing facilities.

MS. LINEHAN: The 1987 Nursing Home Reform Act, drawing on recommendations from a 1986 IOM Commission, merged Medicare and Medicaid standards for nursing homes and established the federal licensed staffing requirements that remain the standard to this day. Nursing homes certified for Medicare and Medicaid must have a director of nursing who is an RN; an RN on duty eight consecutive hours
per day for seven days a week; and a licensed nurse, either an RN or an LPN, on duty for 24 hours per day for seven days a week.

Nursing facilities must also have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing facilities are also subject to state regulations. According to a 2022 study that Abt Associates conducted for MACPAC, 38 states and the District of Columbia have more prescriptive minimum staffing requirements than the federal requirements. But states vary in the level of minimum staffing required and whether their requirements specify levels for RNs, LPNs, or CNAs.

Studies have generally concluded that state minimum staffing standards raised staffing levels, though the effects can be small, and improved results for at least some quality measures. However, some unintended consequences have also been observed, including a decrease in indirect staffing and in skill mix, which is the number
of RNs or LPNs relative to CNAs.

Studies also found that staffing minimums may have differential effects on facilities, raising staffing for those with levels below the new requirements but reducing or maintaining staffing at facilities already above the requirements.

In addition to minimum staffing requirements, states have other policies in their Medicaid programs to encourage spending on staffing.

Specifically, 11 states use wage passthrough policies, which require nursing facilities to spend a specified portion of Medicaid rate on staff wages or benefits.

Thirty-two states plus the D.C. have cost-based payment policies that tie a portion of Medicaid rates to the allowable costs of direct care.

In addition, 16 states have adopted value-based payment programs that include staffing measures. Performance on staffing measures either augments the base rates or triggers an additional quality-based payment.

CMS has investigated nursing facility staffing requirements but has not, to date, changed requirements
from those noted earlier. In 2001, CMS issued a congressionally mandated report that concluded residents were at a substantially higher risk of quality problems when they received care in homes with staffing ratios below critical levels.

In rulemaking in 2016, CMS again revisited staffing requirements but was concerned, at the time, that it did not have accurate data to determine appropriate minimum staffing levels. CMS noted that the payroll-based journal, or PBJ data, which CMS had just begun collecting, could assist CMS in evaluating staffing requirements in the future.

Prior to the PBJ data, the Certification and Survey Provider Enhanced Reporting, or CASPER system, was the only source of staffing data on all nursing homes. Concerns about the accuracy of the CASPER data stem from the fact that they are self-reported by facilities and were not subject to routine audits. CASPER staffing data also are reported for a narrow period of time immediately preceding an annual inspection.

One study found that nursing facilities increased their staffing in the period prior to and during annual
inspections in ways that were not representative of non-
inspection periods.

Because of concerns about the accuracy of staffing data in the CASPER system, the Affordable Care Act required CMS to collect nursing facility staffing information based on payroll and other auditable data.

To fulfill the requirement to collect nursing facility staffing information, CMS maintains the PBJ system. The detailed, day-level PBJ data for each provider allow for more consistent and accurate nursing facility staffing data than CASPER.

The publicly available PBJ data contain daily paid nursing staff hours by staffing category and distinguish between employed and contract staff for each facility.

While the PBJ data are auditable and based on payroll systems, CMS and researchers have noted some limitations. Data may not reflect all staff hours worked for salaried staff because they count only paid hours. In addition, the PBJ does not measure the intensity of the workload. For example, during the COVID-19 pandemic, where hours per resident day remained relatively consistent, the
intensity of the workload may have increased. These limitations should be kept in mind when interpreting PBJ data.

In early 2022, the White House announced that CMS will conduct a study of the level and type of staffing needed to ensure safe nursing homes. Consistent with this announcement, in the SNF final rule for fiscal year 2023, CMS announced it will conduct research to determine the level and type of staffing needed to ensure safe and quality care. This mixed methods research, which includes analysis of PBJ staffing data, site visits, and a literature review, is currently underway. Based on this research, CMS has announced its intention to propose minimum standards for nursing facility staffing within one year.

Now I am going to turn to reviewing how CMS currently uses the PBJ staffing data.

CMS uses the PBJ data to publicly report nursing hours per resident day, weekend staffing levels, and staff turnover measures on its Care Compare website. Six staffing measures, adjusted for facility case mix, are included in the nursing facility star rating.
staffing domain.

CMS has also incorporated PBJ data into the state survey process, which reviews nursing home compliance with federal and state requirements. Specifically, PBJ data are used to direct investigations of staffing. However, compliance or a finding of insufficient staffing is still determined in the state survey process using observations, interviews, and/or record reviews.

In its fiscal year 2023 SNF final rule, CMS adopted a PBJ-based staffing measure into the SNF value-based purchasing program. Starting in fiscal year 2026, total nursing hours per resident day will be scored in the SNF VBP.

Now that we've reviewed some background information on nursing facility staffing and the utility of the PBJ data, we turn to our preliminary analysis of PBJ data from 2019 through 2021.

For those years, on the next three slides, we show sector-wide aggregates of total staffing, resident days, and staff hours per resident day, and changes in the use of contract labor. These aggregates can conceal variation in shorter time increments and among individual nursing facilities or
facility subgroups, which we could explore in future work.

MS. STUBBS: Now that we've reviewed some
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facilities or facility subgroups, which we could explore in
future work.

This figure shows total nursing staff hours,
shown as the yellow line, and resident days, shown as the
green line, for each quarter from 2019 through 2021 for all
reporting nursing facilities, which vary by year. We want
to note that CMS suspended PBJ reporting of data for the
first quarter of 2020. So data for that quarter does not
include all nursing facilities, which explains part of the
change you see in the figure.

Staff hours and resident days both declined in
2020. The reduction in resident days is due in part to the
high rates of COVID-19 mortality among nursing facility residents, avoidance of nursing facilities, and declines in hospitalizations and surgeries.

At the end of 2021, neither resident days nor staff hours had returned to pre-pandemic levels, and staff hours continued to decline.

Taken together, changes in staff hours and resident days during the period resulted in small changes in hours per resident day across all nursing facilities combined. Accounting for changes in resident days, nurse staff hours per resident day remained generally consistent, but were lower at the end of 2021 compared to 2019.

Nurse aides, shown in green, exhibited the largest change in staff time per resident day from the first quarter of 2019 to the fourth quarter of 2021, about a six-minute decline per resident day. RN and LPN hours per resident day trends, shown in yellow and light blue, exhibited minimal changes in aggregate, increasing slightly in 2020 before returning to near pre-pandemic levels in 2021.

Consistent with general workforce shortages and the sector's reports of greater reliance on contract labor
during the pandemic, we found that the use of contract staff increased in 2020 and 2021, compared to 2019.

In aggregate, contract staff provided 3 percent of total hours per resident day of care in the first quarter of 2019. By the fourth quarter of 2021, this had nearly tripled to 8.4 percent of total hours per resident day of care.

Increases in hours per resident day for contract LPNs and nurse aides were greater than for RNs. This kind of information, available from the PBJ data and additional analysis, can provide context for sector-wide cost changes associated with reliance on more expensive contract labor.

MS. LINEHAN: PBJ data could be useful to the Commission in examining the nursing facility workforce. For example, as we have shown today, we can examine sector-wide trends in mix of nursing staff types, use of contract staff, staff and staff hours per resident day. We could also examine facility-level variation in these metrics.

Specific to payment adequacy analysis, where we examine access to care, we could examine beneficiaries' access to facilities by staffing level. We could also use staffing data to better understand the relationship between
This concludes our presentation on nursing facility staffing. We invite Commissioner feedback on the background material presented and thoughts on whether and how staffing data could be used in the Commission's future work, either in our payment adequacy analysis or other research on the nursing facility workforce that may be of interest.

And with that, we turn it back to Mike.

DR. CHERNEW: Great. So I'll say this again when we talk about the Part D work later tomorrow, but it's just so exciting to see the data. And it opens up a lot of possibilities.

So we have a very broad charge in this discussion. It's not as focused as, say, some of the other ones were asking about specific options, but that, in some sense, is soothing because we're kind of at the beginning of the mountain. And so your broad ideas are very welcome.

So I think we'll start with Round 1, and if I have this right, Stacie, is starting.

DR. DUSETZINA: Thank you. This is really interesting work.
I just had a question about, I think, the data on Slide 14, and in general, in the PBJ data, are you able to tell -- I saw sick hours were referenced as being part of what you can see in there. I don't know if it can be seen separately, and part of me wondered about unpaid sick time and how that might factor into some of those changes that you saw during the pandemic.

MS. LINEHAN: That's a great question. I think what we referenced in the paper is something that's been noted as a limitation of the PBJ data that I didn't mention, which is that because it covers paid hours, it could include sick time or vacation time that we can't distinguish from working time, but -- so does that answer your question?

DR. DUSSETZINA: Yeah. I think that that's great. I think the one thing that I would be curious about is if policies, especially for lower-wage workers, are unpaid sick time, and then you see dips in hours. Is it because people are out because they're sick, or is it because you've lost those people altogether? But that just was one of the things that popped up, especially given the timing and the pandemic.
I do see also your suspension of data collection. A huge contributor to not knowing.

MS. LINEHAN: And I think there's been some research on looking at staffing declines during -- immediately around the period of COVID outbreaks -- one of your fellow Commissioners has done this work -- that shows, shows those kinds of dips in hours immediately. So that, I think, is support for the hypothesis that's part of your question.

MS. KELLEY: Kenny?

MR. KAN: This is very powerful data. So thank you for doing this body of work.

Do you see like future iterations of this work possibly involving potentially minimum staffing requirements that differ by facilities, or how do you envision it? Any other thoughts?

MS. LINEHAN: I think we're looking for direction from the Commission on where to take this work.

DR. MATHEWS: Yeah. So a couple of things. Not on slide 18, but the one before that, I think we had talked about a couple potential avenues that we could pursue in examining the PBJ data. I do not know at the moment that
we are positioned or capable of making determinations about minimum staffing requirements. But, as Kathryn and Lauren mentioned, CMS has publicly committed to evaluating the current standards and updating them as warranted, and given some of the even basic foundational analytic work that we are planning at the staff level, we think these analyses could help inform CMS's development of new standards where they are warranted. Is that helpful?

MR. KAN: Jonathan?

DR. JAFFERY: Thanks. So, yeah, I think this is a great start, and sort of building on Mike's earlier comment and what Jim was just saying, this is -- we're starting off and trying to figure out how we can use data and what questions we can ask and answer.

I guess my question is about what other information we might have at the state level, and thinking about this not only in terms of sort of staffing requirements that people have already brought up, but clearly, staffing is usually important, but that's got to match to beds. And so I don't know if we have information about all the different requirements and regulations that occur state to state. I'm thinking about -- and, David,
maybe you know some of this. I was thinking about in Wisconsin we have a cap to the number of nursing home beds, and when a nursing home closes, that cap actually goes down. So during COVID we lost, you know, 7 or 8 percent of our beds and the long-term ramifications. And so just thinking about how we're going to make policy suggestions and recommendations at the Federal level when they're so much intertwined with state payment and other policies. Are you able to explore some of that to the level of detail that we might need to know in order to continue this work?

MS. LINEHAN: Well, I think we certainly could look at state-level policies, and they clearly have a role here. And if we did do analytic work where we thought there was a state component, we would at the very least sort of qualitatively describe what state policies are in a particular dimension like the things you're describing, and like some of the stuff that we addressed here with just state variation and among different payment policies. So it's, in my opinion, an unignorable factor here. So I think it would be something we would look at in any work that we did if we see -- you know, if we want
to explore state-level variation, which isn't something we
normally do, but we could consider whether -- you know, to
explain findings, we would need to look at state policies.

DR. JAFFERY: Yeah, I guess that's why I sort of
brought it up, too, because it's not typically what we do,
but it is unignorable. If we're going to pursue certain
things, we want to be eyes wide open on that. Thanks.

MS. KELLEY: Scott.

DR. SARRAN: Yeah, excellent work. Thanks. I'm
wondering, in an ongoing way, what's our ability to use
this data, now that we've got some pretty good -- not
perfect but pretty good data and match it up against
measures of acuity, outcome measures, safety events,
hospital readmission rates for custodial versus skilled, as
well as any ability to source state data on what the
Medicaid per diem payment rates are for long-term-care
residents living in nursing facilities, so we can start to
see how staffing actually correlates with and potentially
results from some downstream measures like the Medicaid
payment rates and results in some other outcomes like
safety events, for example.

MS. LINEHAN: I think part of the work that CMS
is currently doing is looking exactly at that, looking at the relationship between staffing and some quality measures. That's going to help them, I think, get at potentially their recommendation. And then you had another question -- oh, about Medicaid payment rate. I think that's harder to get your arms around than it might seem. MACPAC did some work on this recently or Abt did some work for MACPAC on this, and they presented it last week at their meeting, actually, where they kind of looked at their relationship -- they haven't published anything on it yet, as far as I know, but there was a presentation where they looked at requirements, payment rates, and staffing levels to see how they kind of fit together. So we could share that if there was interest.

DR. SARRAN: Right, because we look at adequacy of payment rates, but we're looking at it through the lens of the skilled component. And as you pointed out, these facilities basically have two lines of business, maybe three if you count private pay in there. And I know if you talk to people who run nursing facilities, they will describe a lot of this work as being in the domain of unfunded mandates, that they see that they're going to be
told to raise staffing to at least a minimum level, but
that Medicaid doesn't pay them enough to do that. So I
think the more we can shine a light on any disconnects that
may exist in those relationships, the better we'll be.

DR. CHERNEW: So let me just jump in and say this
has been a post-acute, particularly SNF, conundrum for as
long as I can remember. And we have a longstanding
although often somewhat troubling view in how we view the
MedPAC/Medicare funding of the post-acute part interplaying
with the Medicaid program, which supports so much of what
goes on in these nursing homes. And so to the extent to
which your point -- and I agree with this -- is
acknowledging the importance of that connection, I think
that is true.

Knowing what that means in terms of Medicare
policy is complex because this is why I think Kathryn just
said MACPAC has a view about what this might mean for
Medicaid policy, although the connection between Medicaid
policy is more complicated because there's a lot of
different states.

So I think in this sense, I think the more we can
know and point out, the better, but at least in terms of
when we get to what we do when we talk about things, we are
going to try and stay in a MedPAC lane, which is
complicated in an industry that relies so heavily on
Medicaid funding.

DR. SARRAN: I mean, our legitimate interest, of
course, for the Medicaid-funded beds is that its own
beneficiaries who are living in those, and their safety
outcomes are --

DR. CHERNEW: Yes, right, exactly. So we'll have
a longer discussion about challenges with fragmentation in
the way we pay for things in this country and how the
different authorities lie. I have no disagreement that it
is problematic if the support for institutions that care
for our beneficiaries is challenged by folks that aren't
Medicare. I might add, just in the sense of
evenhandedness, there's other situations where the
institutions that care for our beneficiaries are supported
by more generous payers which help us, and there's a
symmetry at some level, although it doesn't always pay out
-- you know, some people have different payer mixes, and
that ends up being a big deal. And we do worry about that
a lot.
I think the purpose here, I'll just take from your question, and I just want to say it to be, as we go through the staffing data, to your point, I agree, we have to acknowledge that what's happening is a function of a lot of the funding streams that flow through to nursing homes, absolutely. Absolutely true. When we get to broader ways in how this data is going to be used, then we get into this complicated connection of where's our purview or not. But that might have been more therapy than comment.

MS. KELLEY: Cheryl.

DR. DAMBERG: I had a clarifying question. So I know that PBJ data don't collect information on acuity, but as I think about trying to use this data -- and I'm not a -- I'm looking to David. I'm not the nursing home person at the table. Do we have ways of measuring acuity so we can link other information to, you know, be able to...

MS. LINEHAN: We do.

DR. DAMBERG: Great.

MS. LINEHAN: And the staffing measures used in the star ratings are acuity adjusted, so it is doable and it is done for the star ratings using some staffing measures that are fairly old for the different case-mix
groups. And I can share that if you're interested in how that's done. But the short answer is yes or the sort of short answer is yes.

MS. KELLEY: That's all I have for Round 1 -- oh, Betty, did you want to go ahead?

DR. RAMBUR: One quick question. One quick question in Round 1. Does the staffing data that's available there also include geriatric nurse practitioners that are in-house, either full-time, part-time, or whatever, is that not included?

MS. LINEHAN: It is not included. We've talked about the nursing staffing data. There's also actually a therapy staffing data set that we have not touched. But the nurse practitioners are not included in the nursing staffing data.

DR. RAMBUR: Thanks.

MS. KELLEY: So now that's all I have for Round 1, and now we'll go to David for Round 2.

DR. CHERNEW: Now we're going to go to David for Round 2.

DR. GRABOWSKI: There we go. Thanks, Kathryn and Lauren. I'm super excited we're doing this work. If you
talk to individuals in nursing homes, all they want to talk about, all they do talk about is staff. Right now it's just workforce, and so I'm really glad we're also talking about it. This is really important.

So the first point, I couldn't help but juxtapose this discussion versus our last one before the break. You know, we had really, you know, this functional improvement measure that's terrible and we can't use, and here we actually have the opposite experiment. We for years had terrible staffing data. Now we have this sort of payroll-based journal data, or PBJ, really powerful data, not just that it's improved in accuracy but the types of measures. Now we can measure daily fluctuations. Now we can measure turnover, and so I really think we should take advantage not just of the level of staff, but also all these other features. We're getting a day-to-day measure of who's in the building, and you can see on weekends staffing is lower, on holidays, you know, and it's just really powerful what you can do with this data and kind of looking at turnover, for example.

So that kind of leads into my next point, which is that I think MedPAC and CMS should both use these data
more. Let me start with CMS. I don't know if this would
ever rise to the level of a recommendation, but when I
think about the CMS five-star rating on Care Compare, I
really believe they underweight staffing data on there, and
I think that's an artifact of the really poor historical
data where you had this self-reported two-week lookback
measure. We couldn't trust it, and so it was reported on
there, but it wasn't heavily weighted. They have this
great measure. They should weight that more heavily. I
would be very much in favor of recommending that to CMS.

Also in terms of MedPAC use, I really like the
suggestion in the chapter and also on Slide 17 of how we
can incorporate this into our payment adequacy work. There
were a lot of good ideas there, and these are strong data,
and we should use them more.

Kathryn, I'm really glad you raised, in relation
to Cheryl's question, I believe, that kind of therapy
measures. For our short-stay population, RNs, LPNs, and
CNAs can be kind of tricky because you don't know how
they're allocating their time. But we can look at
therapists, and we've done some work related to the
patient-driven payment model. I think there's more MedPAC
can maybe do around the therapy data. I think there would
definitely be upside there.

Next point is around that great graph you have, and Kathryn already knows what I'm going to say because
I've said it to her twice offline, but I'll say it a third
time here in public, and I apologize, Kathryn, but I just
can't help myself. I really think we have to be careful
about the tone in terms of trends in staff and trends in
residents. If you just look at that kind of crudely, it
doesn't look like there's much of a crisis there. They
kind of trend together. Yes, they're getting more narrow.
But all the qualitative work we've done in nursing homes
suggests the residents -- you know, case-mix is much more
intense today than it was pre-pandemic. Time with
residents, much greater. We had a period of time where
family weren't allowed in the building and able to help out
with care. All of these factors kind of have contributed
to a greater burden. So I want us to be very careful with
language.

Kathryn, you also mentioned the paper we have
where, when there's an outbreak, that leads to staff
shortages. I think this idea that, oh, things at a high
level look similar, I just want to be careful about that and how we kind of talk about that in the chapter.

Another place around tone was I thought we were a little negative on Medicaid wage passthrough policies. These are policies that allow states to target Medicaid dollars directly to staff. I actually think those studies suggest better wages, better staffing when they're implemented. Some of the studies are a little dated, but I just think kind of updating that. And I think what's really challenging about those policies is just some of the leakage, when you have dollars targeted to staff, are there offsets elsewhere? Are they really putting all these dollars directly into staffing? And I don't think it's one to one, and I think that's why a lot of folks have sort of questioned sort of the accountability around those policies and if they're doing what they intended to do.

That really comes to my fifth point which is really around the Biden administration's minimum staffing standard. I think in a vacuum this is a good policy. However, I'd worry about kind of Scott's earlier comment, you know, how much dollars are in the system right now to kind of pay for this and how much new dollars are going to
be necessary. How much of that is going to be Medicare? How much of that is going to be Medicaid? And I think there's issues around transparency that are really important here. How are nursing homes spending their existing dollars? Are those actually going into staff or are they going to other kind of parts of the business? And do we believe that when we put these minimum staffing standards in place, nursing homes can kind of find the money to just staff up to those levels, or do we think there's going to be new dollars? I think we're probably going to need some new dollars ultimately if these are meaningful staffing standards. And I think that becomes a MedPAC issue if that entails Medicare dollars.

I promise, my final comment, is really around the issue of immigration. We have a working paper right now suggesting that in those parts of the country that have seen increases in immigration, they have better staffed nursing homes and better quality. I don't think immigration is the only answer to the staffing crisis in nursing homes, but it is a big part of it. We need to do everything we can -- I know that's outside the purview of MedPAC, kind of in a broad sort of set of things we can
control, but I think that's a really important point that I
wanted to raise here, that any kind of limits to
immigration are really going to limit our staffs.

I'm going to stop there, but once again, I'm very
excited about this work and look forward to seeing how it
progresses. Thanks.

DR. CHERNEW: Tying together that comment and
Scott's comment and our payment -- for people watching,
this is not about our payment update recommendations,
although we will get to payment update recommendations.
And there is a challenge, which you alluded to briefly,
about if there's a problem in staffing in SNFs, which is
related to staffing in nursing homes more broadly, to what
extent is it our problem? And I don't mean to say it that
way because I think obviously, as Scott pointed out, it is
clearly our problem. There are beneficiaries that are
Medicare beneficiaries, and we are concerned about them as
people, not just concerned about them during their SNF
stay, right? So that makes it our problem.

On the other hand, we have payment adequacy rules
for how we think about what Medicare's paying and others
are paying, and we have struggled with how to deal with
that in particular ways. And I don't have -- so, again, when we get to the -- when we actually get to implementing, where the rubber hits the road, when we come to our payment recommendations, this will arise. I think what is uniformly true is this will give us insight as to what's going on that we otherwise didn't have. How we react to that is a broader, more complicated issue.

Anyway, sorry.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. I'm very enthusiastic about this and appreciate the comments.

In the time that I have, I'm going to talk about this particular piece, but also sort of the broader piece, because at least I hope that our aim not just as a Commission but as a nation is that we create a system that any one of us would be very happy to work in, and that any one of us would be very happy to be a resident in. And we are very, very far from that.

It might surprise you to know that I've only been tepid about minimum staffing ratios. I think it's actually necessary, but it's a regulatory response to a market flaw in that the people actually providing the work are not
providers getting paid directly; they are staff. And so there is always this incentive to keep the staffing as low as possible.

And so to that end, wouldn't it be amazing if we tripled the salaries of CNAs and we really had competitive jobs for those individuals and they didn't actually have to quit to go to Walmart, because I think people are out there. I heard what you said about immigration, and on the one hand, I don't disagree. On the other hand, I'm very troubled that we're unwilling to create a world that any of us would be happy to work in, whether we're foreign-born or here. So that would be my goal.

One thing I'm very concerned about is that skilled nursing facilities and nursing homes compete for RNs, not just in that market but across the market, and we pay them much less. So if you are a new graduate and you have student loans, you're certainly not going to think about going to the beleaguered local SNF with all this responsibility where you will quickly be a charge nurse. So I think we really need to get those salaried so we're not depending on altruism, whether economics is the solution.
I tend to agree with David about the minimum loss ratios. To me that's actually a very appealing idea if it's done correctly. Do we actually get the revenue in the hands of the people doing the work? And I looked at some of the studies that were cited. One was looking at the years 1996 to 2002. They found a 3 to 4 percent increase in CNAs and no drop in percentage of RNs, and another time when others were dropping. But those studies did not say the impact on wages. I mean, the point is I don't know exactly how much of a difference it made in terms of competitive salaries, so I think that's really important.

We've talked about value-based purchasing in different settings. What if a portion of that score actually went back to the nurses and the nursing assistants? That would be quite a different model.

And then, finally, I wanted to throw out the idea of adult-gero nurse practitioners. There's a fair amount of data that there's less readmissions to hospitals, better outcomes, and maybe we should recommend something really bold like graduate nurse education funding that goes to nursing homes to help prepare geriatric nurse practitioners. There is a specialty there. In my
experience of working with many, many students over 20 years, many nurse practitioners are very interested in this population. In my time in Vermont, of the 30 nursing facilities, 10 had GNPs that were precepting students and the students loved it. But did they go into it afterwards? No, because the salaries are too low.

So I know not everything can be done with the data, but the data can really be a pointer dog to getting us to where we need to go.

MS. KELLEY: Greg.

MR. POULSEN: Thanks. I really, really appreciated the comments of both David and Betty. I think Betty's comment that we would love to have these be places that we would all like to work or be cared for I think is really good, and really, really good information. I have not seen such cohesive information presented before and it is really, really helpful.

I'm afraid what I'm going to say is going to be at least, in one sense, a penetrating glimpse into the obvious, which is this is really exciting, hard to find money, hard to find people, and that it makes it really difficult place to look.
But the second one, which I think may be something that I haven't seen talked about in this context is that this may make this a particularly difficult time to have this discussion because 10 years from now it will be different, 10 years ago it was way different. But I think we are on the cusp of seeing real, safe alternatives to human beings for some of the services that are required in these settings. And we are seeing it in the acute care setting but there is no reason that that shouldn't be transferrable to having telehealth, monitoring, support services, things that provide multiplication of the skills and capabilities of the human beings that are there.

And some of it, I think, really does address making the place both a more enjoyable place to work and a more productive place to work, but also potentially a safer place for people to receive care. And we're seeing things that can really make an assistance in terms of ambulation, falls, exercise, med administration, dietary, and other things, which consume a nontrivial part of caregivers' time in these settings.

And so as we are thinking about it, I hope that we will broaden our thinking a little beyond just human
beings and look for the needs that are addressable for other people, for the residents, in ways that will be meaningful. If done well, I think it's something that we are a little behind a couple of the leading countries in the world on. Japan may be the example I'm most familiar with, in terms of being able to substitute certain kinds of technologies for humans on these kinds of examples.

And we have seen the obvious concern, I think, that at least was in my mind is that that may be able to meet some clinical needs but it may fall short on some of the social needs.

But I think some of us, I suspect many of the organizations that we work in, in this room, have seen the ability during COVID to use technology to bring people into facilities virtually, not only because they couldn't visit physically, for COVID reasons, but also -- and I think this one is actually exciting -- we have seen families visit patients more frequently than they did before because they didn't have to combine it with a significant trip in order to get there. And so we have seen some of our patients get more family visits than they've ever gotten before. We don't have experience in nursing home care, but I wouldn't
be surprised if that were true there, were it available.

So again, I guess my thought would be as we contemplate all of these things we ought to factor in the evolving technology and capabilities that we haven't seen before, which may be able to address both some of our staffing shortages as well as the staffing expense. So thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: I want to thank the staff for a really interesting chapter. I know it was a lot of work to pull this together, and I am very appreciative.

I am going to stay in my lane, as Michael reminds us. Yes, I think there is potential to use this when we get to discussions around payment adequacy, but I think in the very near term I think there are ample opportunities for the PBJ data to either be used alone or in combination with other pieces of data to give us a better understanding of the relationship between staffing and quality of care.

So despite the fact that CMS is going to embark on this literature review, and they're basic it on historical studies that have a lot of limitations, and you know, we're not nationally scope. So I think we could get
greater insights into to what extent there is some relationship with quality of care.

I also like the fact that this is a much stronger measure than has been used in the past. So whether it's Nursing Home Compare, just greater transparency about actually what's going on, and particularly if it is intensity or acuity adjusted, I think that would be really critical.

You know, I'm particularly interested in better understanding how staffing levels vary by, say, the Medicaid mix of patients in a nursing facility or the percent private pay, to the extent that that's information that's available, as well as trying to understand the relationship between staffing levels and profit margins.

MS. KELLEY: Robert.

DR. CHERRY: Yes. I also want to thank the staff for the great work behind the report. I think it is very well done and the discussion has been great so far.

I think in terms of the staffing model in skilled nursing facilities I think a lot of this has to be really linked to two primary objectives. One is fairly obvious, is that staffing, as a measurement, is truly a quality and
safety tool for delivering care in our skilled nursing facilities. So it is something that I think we have to pay attention to. It can be linked to Medicare reimbursement and therefore again be potentially our business as well.

The other, which I don't think we've discussed too much because we've been focused on what do skilled nursing facilities need to take care of the residents that are actually there, but the other issue is also access to skilled nursing facilities. Because of the lack of staffing on weekend hours it is very difficult sometimes to place patients over the weekends, on Saturdays and Sundays, for example, which makes it very challenging for hospitals and health systems to be able to decompress and keep their throughput going, reduce length of stay, and also drive reduced costs within that population of patients as well.

So as we start to think about staffing, weekend hours are quite critical as well in order to make sure that throughput throughout our health care delivery is paid attention to as well.

Although we are primarily focused on nursing staffing issues, it is also, I think, important to pay attention to social services, case management resources.
that would allow for those patients to be able to be
successively managed throughout their stay within a skilled
nursing facility.

Otherwise, very well done, and I am looking
forward to additional discussion on this issue.

MS. KELLEY: Scott.

DR. SARRAN: As we think about how to use data
such as this to help us better understand correlates of
high-performing nursing facilities, I had two additional,
perhaps, lines of thought on other data with which to
integrate this, if it is available.

One is -- and this takes off a little bit on
Betty's earlier comments -- I wonder if we could look at
how this data matches up against Part B provider visits,
physician and nurse practitioners, in terms of helping us
understand what does a high-performing nursing facility
look like in terms of not just their own direct employed or
contracted staff but providers coming in the facility and
doing clinical care.

And the other is recognizing how limited the
penetration of institutional SNPs has been and still is. I
wonder if there is any data at all that would let us look
at staffing ratios as well as other sets of outcomes based on the penetration rate of institutional SNPs within a nursing facility, the underlying premise being that institutional SNPs, if executed, regulated, managed well, offer a significant lever for improved outcomes. And the question is are they actually getting those improved outcomes? If they are, what are the levers for those improved outcomes? Are they driving higher staffing because they are gain-sharing, for example, with facilities? There is a whole sort of body of inquiry I think that is appropriate to that as well.

MS. KELLEY: Okay. I have a short comment from Larry also, but first I'll see if anyone else has a Round 2 comment.

Okay. Larry wants to make sure that any study of staffing and quality account for the three different types of staff, which are very different from each other in ways that can contribute to quality.

So back to you, Mike.

DR. CHERNEW: Thank you, Larry.

So this has, on the plus side, opened up a lot of exciting opportunities, and I think what is clear from this
discussion is we are grappling with how to build it in the
spirit of what Cheryl said, understanding correlative
quality, which is slightly different than things that
causally related to quality. But nevertheless, the
relationship between staffing and outcomes I think
something that will be important. That doesn't imply that
we would then immediately decide, oh, staffing has to be
this.

I actually resonate a lot with what Greg said,
which is we do have to allow some flexibility for new care
modalities, new approaches in a range of ways. So we want
to both make sure that the beneficiaries get the care that
they need without being overly prescriptive about how that
is prescribed, particularly in situations where it turns
out that the facilities couldn't attract the people they
are told they have to attract in a bunch of ways.

I think one of the particularly interesting
things that we didn't dwell a lot on in this set of
discussions is the role of contract nurses. There are
several ways in which that plays out. It plays out in
terms of a source of labor, but it also plays out in terms
of a drain of labor within the nursing space. And I think
there is some material in here that talks about that briefly, and I think that is going to end up being important.

So I am excited that we have this data and excited that we will be able to track what is going on. It remains unclear to me exactly in what context we will use it for specific recommendations, but I think seeing it and knowing we have it is really an improvement over where we were. So as happened in the meeting before lunch in post-acute PPS, the more we can understand what's going on in these facilities, the more we can think about a whole range of things. This is just one window of that.

Anyway, so that's where I am on this. We are ahead of schedule, which is fine by the way, because the next topic we are about to switch over -- and I will wait. We might as well take a five-minute break if people want to take a five-minute break since we are ahead of schedule and then come back, and that will just give us time to do the technical transition. And we are going to come back and talk about telehealth.

Lauren and Kathryn, thank you so much. I hope you heard the enthusiasm and appreciation from around the
table for the stuff that you did. I hope you are half as excited at the Commissioners are. So great job.

[Recess.]

DR. CHERNEW: So, if I follow this, we are actually live. So welcome, everybody. We are now going to deal with an issue which I think will be a continual issue over the coming set of cycles, and we've been asked to study it explicitly. But, frankly, sometimes you're asked to do things you don't want to do. Sometimes you're asked to do things you do want to do. I'd put this in the category of asked to do something we do want to do.

So I'm going to turn it over to Ledia or Ariel.

Okay, Ledia.

MS. TABOR: Okay, great. Good afternoon.

The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand of the screen.

Before getting started, we would like to thank Corinna Cline for her assistance on this work.

During today's presentation, we will review the requirements of our mandated report on telehealth, Medicare's temporary expansion of telehealth during the
public health emergency, the Commission's policy option for covering telehealth after the PHE that was in our March 2021 report, and permanent changes to telehealth policy since the PHE began.

Next, I'll review our analytic plan for the mandated report. Ariel will then cover alternative approaches to paying for telehealth services under the physician fee schedule and by FQHCs and RHCs.

Following the presentation, we would like your feedback on this material.

In the Consolidated Appropriations Act, 2022, Congress mandated that MedPAC submit a report by June 2023, which should include five elements: first, the utilization of telehealth services; second, Medicare program expenditures on telehealth; third, Medicare payment policy for telehealth services and alternative approaches to such payment policy, including for FQHCs and RHCs; fourth, the implications of expanded Medicare coverage of telehealth services on beneficiary access to care and quality; and finally, other areas determined appropriate by the Commission.

Before the PHE, Medicare's coverage of telehealth
was flexible in Medicare Advantage, two-sided ACOs, and other payment systems. However, coverage of telehealth was limited by statute under the physician fee schedule because of concerns about its impact on spending and program integrity. Under the fee schedule, Medicare paid for a limited set of telehealth services provided to beneficiaries in rural areas in certain settings, such as physicians' offices and hospitals -- in certain settings such as physicians' offices and hospitals, with some exceptions; for example, telestroke.

As a result, use of telehealth was very low. It accounted for less than 1 percent of fee schedule spending in 2019. This low use was consistent with other payers.

To allow beneficiaries to maintain access to care and help limit community spread of COVID-19, Medicare temporarily expanded coverage of telehealth under the fee schedule.

This table lists the key policy changes that apply during the PHE. First, Medicare began paying for telehealth services provided to beneficiaries in both rural and urban areas in any setting, including patients' homes.

Second, Medicare expanded coverage to over 140
additional telehealth services and began paying for audio-only interactions for certain services.

Third, CMS began paying either the facility or non-facility rate for a telehealth service, depending on the clinician's location.

Before the PHE, Medicare always paid the facility rate, which is usually less than the non-facility rate.

In our March 2021 report to the Congress, we described a policy option for covering telehealth after the PHE. Under this option, Medicare would continue to cover certain telehealth expansions for a limited duration, such as one to two years, after the PHE ends.

These expansions would include paying for specified telehealth services provided to all beneficiaries regardless of their location; covering additional telehealth services if there is potential for clinical benefit; and covering certain telehealth services when they are provided through an audio-only interaction, if there is potential for clinical benefit.

Continuing these expansions for a limited period of time would allow policymakers to gather more evidence about the impact of telehealth, when combined with in-
person care, on access, quality, and cost. This evidence should inform any permanent changes to Medicare's telehealth policies.

Our policy option also calls for returning to some of Medicare's prior telehealth policies after the PHE, along with establishing some additional safeguards. First, Medicare should go back to paying the fee schedules facility rate for telehealth services. Second, providers should not be allowed to reduce or waive beneficiary cost sharing for telehealth services. Further, there should be additional safeguards to protect Medicare and beneficiaries from unnecessary spending and potential fraud related to telehealth. These include applying additional scrutiny to outlier clinicians, requiring clinicians to provide an in-person, face-to-face visits before ordering costly DME and lab tests, and prohibiting incident-to billing for telehealth services provided by any clinician who can bill Medicare directly.

Since the PHE began, Congress and CMS have made other changes to telehealth policies. Congress extended the Medicare telehealth flexibilities for five months after the PHE.
Another change is that Medicare permanently began covering tele-behavioral health services received at home. After the PHE ends, an in-person visit must be provided within six months prior to the initial telehealth service. For subsequent mental telehealth services, there is an annual in-person visit requirement. However, the policy does not apply if the practitioner and patient agree that the benefits of an in-person service are outweighed by the risks and burdens.

Also, CMS extended the time frame for covering services provided by telehealth until the end of 2023. These include services that likely have a clinical benefit when furnished via telehealth but for which there is not yet sufficient evidence available to consider the services as permanent additions to the allowable telehealth services list.

CMS has proposed requiring a claims modifier for audio-only services, which will allow policymakers to study the impact of audio-only telehealth services. The proposal of an audio-only modifier is consistent with the Commission's recent recommendation to the Secretary.

I'll now switch to our analysis plan for the
mandated report. Using Medicare claims data, we will examine volume and spending for telehealth services provided by clinicians, FQHCs, and RHCs. We will use data between 2019 and 2021, which is the most recent data available. The more specific analyses are listed here and described in your meeting materials.

Over the coming meeting cycle, we plan to analyze the implications of expanded Medicare coverage of telehealth services on beneficiary access to care and the quality of care they receive.

Our analysis is limited by several factors. First, before the PHE, coverage for telehealth in Medicare was limited to certain services and areas; for example, rural areas. So pre-pandemic literature and data are of limited use in understanding the impact of an expansion of telehealth.

Second, data from many months of the pandemic when people were avoiding in-person care might not be appropriate to use when analyzing the potential impact of telehealth policy outside of a pandemic.

Third, there are technical challenges we have in measuring quality of care in general. Medicare lacks
comprehensive data sources like lab results and patient reporting outcomes. We can use administrative claims data in our analysis. However, there is a significant time lag in the availability of that data.

We are interested in the broader implications of telehealth expansions on quality and access. We want to understand if beneficiaries having access to multiple modes of care -- in-person, audio and video, audio only -- has implications for quality outcomes, access, and cost.

We are working with a contractor to test the feasibility of using population-based measures, for example, ambulatory care sensitive hospitalizations and emergency department visits, to study the impact of telehealth expansions on Medicare beneficiaries' access to and quality of care. We are currently working with the contractor to develop the methods to perform this analysis, and we will provide more details in future meetings.

Outside of the claims analysis on volume, spending, and quality, we are going to use additional sources for our mandated report.

Our other analyses includes reviewing the literature on the impact of expanded telehealth coverage,
focus groups with beneficiaries and clinicians, and our annual survey of Medicare beneficiaries and privately insured individuals.

I'll now turn it over to our Ariel to discuss payment options.

Next, we're going to talk about an alternative approach to paying for telehealth services under the physician fee schedule.

The fee schedule pays separately for each telehealth service, and there are downsides to this approach. First, this creates an incentive for clinicians to bill for more telehealth services. Second, this increases the administrative burden on clinicians because they need to document and bill separately for each service. Third, it is difficult to price individual telehealth services because some of them represent brief interactions between patients and clinicians that are part of a broader episode of care.

One option to address this issue is to bundle certain telehealth services into a larger unit of payment instead of paying separately for each service. This approach would parallel how other Medicare payment systems
pay for telehealth.

For example, CMS pays hospitals a fixed payment for all services provided during an admission, including those delivered by telehealth.

In the next few slides, we explore the possibility of creating a set of expanded codes for evaluation and management office and outpatient visits, which would include related telehealth and in-person services provided during a given period of time; for example, 30 days.

There are precedents in the physician fee schedule for bundled payments that cover a series of related services provided during a fixed period of time. First, there is a monthly payment that covers most outpatient dialysis-related physician services for ESRD patients. For example, for patients managed in a dialysis center, the monthly payment varies based on the number of visits they receive during the month. In addition, the fee schedule uses a global payment policy to pay for most surgical procedures. The global payment covers the procedure itself and postoperative clinician visits that are provided up to 10 days or 90 days after the
procedure.

The payment rate for each code assumes that the clinician provides a certain number of postoperative visits during the period after the procedure. However, CMS has collected data that show that clinicians actually provide fewer visits than are assumed in the payment rates for many codes. Thus, many of these procedures appear to be overvalued. Despite this evidence, CMS has not yet changed how it pays for global surgical codes. This experience demonstrates the importance of monitoring changes in care delivery that could affect the accuracy of payment rates and adjusting rates if necessary.

Here, we illustrate what an expanded E&M code could look like. In this example, a clinician provides an E&M visit, either in-person or by telehealth, a virtual check-in in which a patient checks in briefly with a clinician by phone, and another E&M visit to the same patient during a 30-day period.

Currently, Medicare pays separately for each service. But, under an expanded E&M code, there could be a single payment rate that includes all three services, and the payment could be the same even if there is more than
one virtual check-in.

The period of time covered by the bundle could be increased to 60 days or 90 days.

Whether the same clinician provides all the services in the bundle or they are provided by different clinicians in the same practice, Medicare would make a single payment. This type of payment would counter the financial incentive for clinicians to provide more services than are necessary to deliver high-quality care, and it would reduce clinicians' administrative burden because they wouldn't have to bill Medicare for each discrete service.

If CMS decided to adopt expanded E&M visit codes, there would be several important design considerations, and here are some key ones.

First, which services should be included in expanded E&M codes? It probably makes sense to include E&M office and outpatient visits, both in-person and telehealth, as well as certain other telehealth services, such as virtual check-ins, remote evaluation of images or videos sent by the patient, and online digital evaluation services. But the code would not include the originating site fee for telehealth services because Medicare pays this
to a separate provider, and telehealth services that are not bundled would continue to be paid separately.

Second, what time period should be covered by the codes; for example, 30 or 60 days?

Third, how should CMS account for the variation in clinician time and resources during the time period defined by the policy?

Fourth, how would the payment rates be determined?

And lastly, how would CMS track changes in care delivery over time to make sure that the payment rates remain accurate?

Medicare's experience with global surgical codes reinforces the importance of monitoring these changes. If Commissioners are interested in exploring the concept of expanded E&M codes, we could use claims data to analyze patterns in the use of E&M visits and telehealth services during different time periods; for example, 30 days after an initial E&M visit.

Now I'm going to switch gears and talk about FQHCs and RHCs. In general, Medicare pays higher rates for services provided by FQHCs and RHCs than it pays clinicians.
under the physician fee schedule.

During the PHE, Medicare temporarily expanded coverage of telehealth services provided by FQHCs and RHCs, as shown in this table.

Before the PHE, FQHCs and RHCs could only bill as the originating site for a telehealth service. This is where the patient is located while receiving the service. They could not bill as the distant-site clinician; that is, the clinician who provides the telehealth service. But during the PHE, they can bill for telehealth services as the distant site, and they can provide telehealth to beneficiaries in any location, including at home. And they can bill for any telehealth service that is payable under the fee schedule.

During the PHE, Medicare's payment rate for FQHCs and RHCs for telehealth services is based on the physician fee schedule rate for comparable services. This is less than what Medicare pays FQHCs and RHCs for in-person services.

If telehealth services continue to be covered in FQHCs and RHCs after the PHE, CMS could decide to pay them their standard in-person payment rates for telehealth. CMS
has already decided to do this for tele-behavioral health services, which will be covered after the PHE.

But another approach would be to pay FQHCs and RHCs a rate that is based on the physician fee schedule rate for telehealth services, which would be about 50 percent less than their standard FQHC or RHC payment rates. This is how Medicare pays them for telehealth during the PHE. Continuing to pay a lower rate for telehealth services than for in-person services would reflect the lower facility costs of providing telehealth.

In addition, it would align payment rates for telehealth services across FQHCs, RHCs, and clinicians who bill under the fee schedule, thus, achieving payment parity across settings. It would also balance the dual goals of ensuring access to care for beneficiaries and prudent fiscal stewardship of the Medicare program.

This policy would likely require a change in statute.

For your discussion, we are interested in getting your feedback on our analytic plan for this mandated report, the alternative approach we outlined to paying for telehealth services billed under the fee schedule, and the
alternative approach to paying for telehealth billed by FQHCs and RHCs. Also, is there other material you would like us to include in this report.

I'll conclude with a reminder that this report will be a chapter in our June 2023 report. And now I'll turn it back over to Michael. 

DR. CHERNEW: Terrific. We're going to start Round 1. If I have that correct, it's Marge. 

MS. GINSBURG: I guess I just wanted to start first of all with a comment. Was that you, Mike, that said earlier this morning about how -- was it another Commissioner who said once you provide something, you'll never be able to take it back? I can't remember. 

DR. CHERNEW: That was David quoting Bill Scanlon. 

MS. GINSBURG: Okay. Well, anyway --

DR. CHERNEW: Bill, if you're listening, we love you. 

[Laughter.]

MS. GINSBURG: This one really shouts it out, and so I just want to make my own personal comment. We need to be extremely careful about going forward or I personally

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believe we're going to be facing a disaster financially and no good health care that comes out of it.

Okay. But I do have a question. We keep saying after the PHE. Have we actually determined when the PHE is ending? I mean, so far, I've seen no evidence that it is. I'm under the assumption that it's basically here to stay, but I think we need to somehow define when we imagine this is going to start. I know it's not up to MedPAC to decide when the public health emergency is over, but I would think this needs to be, in some way, part of our discussion here. Is that outside our domain? Anyway, that's my Round 1 question.

MS. TABOR: My thought would be it is a bit outside of our domain.

DR. CHERNEW: That's a yes.

MS. TABOR: Yes.

DR. CHERNEW: There will be people deciding when the PHE ends. It will not be us.

MS. KELLEY: Marge, do you have another question?

MS. GINSBURG: No.

MS. KELLEY: Okay. Greg. With a Round 1 question?
MR. POULSEN: Yeah. On the global surgical code example that you guys gave, which I thought was great, it was very illustrative, do you capture virtual check-ins today or is that in-person, when we said there weren't as many as had been anticipated?

MR. WINTER: The data were collected beginning in 2017, from clinicians in nine states. And so the virtual check-in code was not introduced, I think, until 2018 or 2019, so it was not even an issue then. And I think they were focused on post-operative visits as in like E&M visits. Virtual check-in is a much shorter interaction, a much lower payment rate. So that would not have been captured.

MR. POULSEN: Yeah, thank you.

MR. WINTER: The data was analyzed by RAND.

MR. POULSEN: Yeah, I think that's great. The reason I asked that is we may be seeing, and already have been seeing, virtual being inserted in place of face-to-face because it was convenient for the patient and the doc.

MS. KELLEY: Kenny.

MR. KAN: Great work. I am very enthusiastic about where this could be headed.
On Slide 18, a clarifying question. Are FQHCs and RHCs in rural and frontier areas also paid at 50 percent less than the standard rates for telehealth? Because I'm trying to think about the whole access and cost question.

MS. TABOR: So RHCs and FQHCs, regardless of the location, are currently, during the public health emergency, being paid at the physician fee schedule rate of about 97 percent.

MR. KAN: Okay.

MS. TABOR: Regardless of location.

MR. KAN: Okay.

MS. KELLEY: Okay. Larry has a Round 1 question.

Larry's first question is, would the expanded E&M code apply to all visits, and if not, at what point would it be billed?

MR. WINTER: This is really a design question, but the concept is that it would include at least E&M visits provided during a certain period of time, and certain telehealth visits but not all telehealth visits. For example, a telehealth visit for behavioral health probably would not make sense to include, or a telehealth
visit for physical therapy, assuming that continues to be paid after the PHE.

And his other question is when would it be billed? So it probably makes sense for the clinician to bill this either at the end of the period defined by the code or towards the end of that period, because then they can determine what level to bill this at. For example, did they provide one E&M visit and that is it in the 30-day period? Did they provide four or more visits? That would influence the payment rate. So it would probably make sense for it to be billed towards the end or at the end of the period covered by the code.

MS. KELLEY: Okay. And his second question is, if I have an E&M visit for a patient with asthma and that patient comes in a week later with a sprained ankle, does the second visit get billed under a second expanded E&M code? I can see problems with that, but it doesn't make sense to have the ankle sprain included in the asthma expanded E&M claim.

MR. WINTER: Right. That is a good question. I think that is another design issue to think about is whether it would allow clinicians to bill for separate
expanded codes, for different conditions. And you could
make an argument that it makes sense to do that because the
kinds of services might be different, and to pay for two
very different conditions under one expanded code might not
reflect the resources used to treat two very different
conditions.

On the other hand, it would open the door to kind
of unbundling, and clinicians could find ways to bill for
multiple E&M codes for the same time period, for the same
patient, if they just code different conditions, code
different diagnosis codes. So there are pros and cons.
There are tradeoffs to either alternative.

MS. KELLEY: Okay. Larry has one more Round 1.
His question is, would all E&M visits be paid at an
expanded rate?

MR. WINTER: We were thinking of focusing on E&M
office and outpatient visits, not E&M inpatient or ED or
E&M visits in nursing homes. If the question is would you
pay all E&M office and outpatient visits under an expanded
code, I think it probably makes sense to do that. And if
the episode, let's say, includes only one E&M visit, well
then that would be probably the lowest level of the coding
system, of the coding levels. And so that is all you would
be paid. But if you did more things within that period
then you would get paid a higher-level code. That is how I
was thinking of this.

MS. KELLEY: Okay. I have David with a Round 1
question.

DR. MATHEWS: If I can just jump in -- another
way to interpret Larry's question would be do we envision
scenarios where a clinician is providing an E&M visit only
and does not anticipate billing or having any subsequent
telehealth interactions with the patient around that visit.
And in that case does the physician or the clinician have
no other option but to bill an E&M visit that does include
some degree of subsequent telehealth assumed in the rate.
Maybe Larry will respond via chat to see if I am
anticipating what his question is getting at.

DR. GRABOWSKI: In the meantime maybe I will ask
my question. So you had asked for feedback on the proposed
evaluation by the contractor, and I wanted to ask about
Slide 11. In the lower bullet there you said "Working with
a contractor to test feasibility of using population-based
measures." What do you mean? Just so I understand, what
are population-based measures?

MS. TABOR: Yeah. So it is the avoidable hospital use or ambulatory care-sensitive hospitalization and ED visits that we use in our payment adequacy work in the physician chapter. So it is kind of a measure of both accessing quality, because it is for those with chronic conditions and certain acute care, like pneumonia, for example, are patients going to the hospital, either hospitalized or going to the ED. And the idea is that if they had diabetic care that was appropriately monitored and get access to primary care and/or their specialist, they wouldn't need to be hospitalized.

DR. CHERNEW: I am going to follow up on David's question now, to make sure that I understand your clarification to his clarifying question. So that is a design where you would take -- this is truly a question. I am going to say it as a statement. You would take people that had telehealth visits and look at their, say, ambulatory-sensitive admissions and compare them to people without telehealth visits. And the population-based part of it is the ambulatory-sensitive admissions.

MS. TABOR: It would be -- actually, it is an
element of both. The measures themselves I think are population-based, but we were planning to look at markets with high telehealth intensity versus markets with low telehealth intensity, in doing that diverse and difference analysis. That would control for their risk factors, which we will be very excited to tell you all about in April once we have the results.

DR. CHERNEW: That was quite clarifying.

MS. KELLEY: The Round 1 queue is rapidly multiplying. I have Dana next.

DR. CHERNEW: Oh, there we go.

DR. SAFRAN: Yeah, the answer to the previous question may have answered my question, but my question is also about the analysis plan. I may have misunderstood but I thought from what you shared that you are planning to use methods that do not involve claims. But now you are planning to use methods that do involve claims.

MS. TABOR: Yes. We only are going to use claims, because we do not have access to clinical data.

DR. SAFRAN: Right. I thought you were saying that you were going to use focus groups and Medicare beneficiary survey and literature review.
MS. TABOR: So we are doing all of those things. I think in the mandate we even have to look at access and quality. So we are testing this proof of concept of can you use claims-based population-based outcome measures to compare the quality and care with telehealth access. So that is one that we are doing. And then we have also been talking to beneficiaries and clinicians about their experiences with telehealth, and we are continuously tracking the literature that is coming out.

DR. SAFRAN: Got it. Okay. You have answered my question.

MS. KELLEY: Lynn.

MS. BARR: Thanks. Great work, guys. I'm really excited about this, and I have some comments in Round 2. But getting back to Round 1, the thing that happened with global payments on surgery is kind of interesting to me because when we want to get physicians to do things, we pay them to do them and they do more of them. And so have you looked at the number of patients that had follow-up visits prior to global, and did it drop off? Because my concern would be that we're going to pay them and we are going to pay more and get less, not an equal
amount. Have you looked at that?

MR. WINTER: I do not think the data exist to look at that because from the beginnings of the resource-based relative value scale fee schedule, the fee schedule as we know it today, which began in the early '90s, at least for the work RVUs, they always had built-in the global surgical codes with 0-, 10-, or 90-day global periods.

Now I guess if there were codes that kind of switched from, let's say, 10 days to 90 days, then you could exploit that change and look at whether there was a change in the number of visits. The problem is that we have very limited data on the number of visits that are actually provided. It is not routinely reported. CMS began collecting this information in 2017, from clinicians in practices of 10 or more in only 9 states, for 299 procedures, and I don't know if that data are public, publicly available, and I don't know if they've continued to collect it or if it stopped. So I'm not sure the data exists for us to be able to answer that.

MS. BARR: Okay. Fair enough.

The next Round 1 question I have is, do you know
what the impact of telehealth in the PHE was on traditional telehealth? So we have been pushing that traditional telehealth rope forever and not really getting a lot of uptake. You know, the rural would be the originating site. Did that just go away or did it maintain at about the same level?

MR. WINTER: We can look into that, and if you look at 2020 claims data, and we talked about that last November, you still see telehealth being provided in rural areas. You still see originating site claims, although as a percentage of the total they've gone way down because most telehealth is provided at home now and there is no originating site to claim for that.

But when we look at 2021 data, as we are just starting to do, we will keep an eye. We will look at whether patterns of telehealth use in rural areas and originating site, where there is an originating site claim.

MS. BARR: That is interesting, because it seemed to me, when I observed that telehealth in rural areas it was more of a consult. You know, because the provider is almost always there, right, so that was a big problem. They were not getting paid for that, and that kept utilization
down. So if you have this, do you still need that other
system? It is just a question of whether one replaces the
other.

And how would you propose to deal with providers
-- 50 percent of rural providers refused to do telehealth
during the PHE, mostly, according to what I heard, because
of the payment rates. But how would you deal with
providers that say, "I don't want to do telehealth, and I'm
not going to do virtual check-ins." Are you going to pay
them this extra as well?

MR. WINTER: Is that a question regarding the
expanded E&M code?

MS. BARR: Yes. Now we are into the expanded E&M
code. I'm sorry.

MR. WINTER: Okay. The lowest level code could
be one that is only for an E&M visit. That does not
include virtual check-ins or other related telehealth
services. It would just be regular, in-person E&M visit,
and that's one level. You know, you bill one code for
that, that kind of service.

MS. BARR: Right.

MR. WINTER: But if you do provide, let's say,
some telehealth associated with that, that would be a
different code with a higher payment.

MS. BARR: So E&M with 30 days of telehealth
access, E&M with 90 days of telehealth access.

MR. WINTER: Right.

MS. BARR: Maybe those kinds of things. Great.

Thank you very much. Those are my Round 1 questions.

MS. KELLEY: Larry has a clarification that kind
of builds off what you were asking, I think, Lynn. He
wants to be clear on what the proposal to bundle would
actually mean. You can't tell whether there will be
subsequent telehealth visits. So either all visits would
need to be billed as expanded E&M at the time of service or
no visits would be billed as expanded E&M at the time of
service. This would mean that all visits would need to be
billed 30 days later as expanded or not, depending on what
happened in the meantime, which would be administratively
complex and also complex with regards to billing the
patient.

MR. WINTER: I think that is a fair point. And I
might argue in favor of a shorter time frame, like 30 days
instead of a longer one, like 90 days. But if a clinician
knows up front that I am just going to see this patient once, provide one E&M visit and no telehealth afterwards -- it could be, let's say, an acute visit for a one-time-only issue -- then they could go ahead and bill for that code or they could decide to wait.

There is also a process for submitting, for amending claims. So if the nature of that service changes you could submit an amended claim.

MS. BARR: Can I just follow up on that? So you are not proposing then that they would be able to bill for an E&M and then, oh gosh, I have to do telehealth so I'll bill for a telehealth visit on top of that? Is the proposal there that the telehealth codes go away?

MR. WINTER: I don't think so. So you would need like a triggering service to initiate this bundle or episode. So I think it makes sense for that triggering service to be an E&M visit. And then once you have that E&M visit, if you do, let's say, a virtual check-in, a remote evaluation of images or video, that then becomes bundled with the E&M visit. But if you only do a virtual check-in or some other kind of minor telehealth service, without an E&M code within a certain time frame, then you
just bill for that separately.

MS. BARR: Can I just ask one more --

DR. CHERNEW: Let me just stop for a second.

MS. BARR: Okay.

DR. CHERNEW: Here is what I think is going to end up happening. We are going to get a lot of clarifying questions to try and understand exactly what the proposal is, and you're going to be thinking, well, some of these are design issues. The proposal isn't as tight. So it's hard to ask a clarifying question about what do you mean because I think some of what you mean would depend on how the Round 2 questions go.

If that is accurate, what I want to do is I want to go into -- I think I have this right, that Cheryl, or I could be wrong, Cheryl had a Round 1 clarifying question. If it's not related to -- excuse me? Oh, Cheryl and Betty. And then I want to have our Round 2 questions, because I think our Round 2 questions are going to get to these comments about design.

MS. BARR: I have an unrelated Round 1.

DR. CHERNEW: Yeah, so that is fine. You can ask that. But I do want to make clear there are a lot of
design issues here, so I think it is hard to try and pin folks down on what the proposal is when the answer is we are going to develop the proposal or not, depending on how Round 2 goes. So I just didn't want to spend all of our time in Round 1 to circle.

Lynn has one more question, then Cheryl, then Betty, then Round 2.

MS. BARR: Okay. So my last question was because we're using this to pay for virtual check-in, what has been the adoption rate of virtual check-ins?

MR. WINTER: Yeah. So the code was introduced in 2018 or 2019, and it increased a lot between 2019 and 2020, which would have been related to the pandemic and all the people that were not going to the doctor's office anymore. And we will track it in 2021. We will come back to you with that information. But it did increase between 2019 and 2020.

MS. BARR: The only reason I bring that up is because most of the physicians we talk to about implementing virtual check-ins refuse to do it because the cost of billing was higher. So I would be nervous that we are pricing in a service that was only used during the PHE,
and I would welcome other clinicians to speak whether your organizations use that code to any extent.

MR. WINTER: And in 2020, CMS introduced a high-level virtual check-in for a longer phone call, that is paid more. So we will see what the utilization of that was like.

MS. KELLEY: Cheryl.

DR. DAMBERG: I think this is a quick question. My understanding is CMS is going to start tracking, as of January 1, 2023, the HCPCS claim modifiers saying whether it was audio only, right? But it seems as though, in your analytic plan, that you are going to look at patterns by type of service, whether it is telephone only or telehealth. So I was confused on how you're going to be able to do that in the time frame you're looking at.

MR. WINTER: Good question. So there are certain E&M telephone codes, where you do an E&M service only by phone. That has a separate CPT code or HCPCS code. And so we can identify that in a claim stream.

There are other telehealth services which you can provide either by audio-video or audio-only, but you bill the same HCPCS code or CPT code for that, regardless of the
modality you use. And we cannot tell in the claims was it audio-only or not. So for those we cannot tell if they were audio-only, until we get 2023 data with a modifier.

MS. BARR: Okay. So you're --

MR. WINTER: But there are certain codes we can already tell that were definitely performed by telephone.

MS. BARR: Yeah. So you'll get an initial look but then you'll be adding on with the 2023 data.

MR. WINTER: Correct. It will be a conservative estimate.

MS. BARR: Okay. Thanks.

DR. CHERNEW: Okay. Now, if I have followed -- and I'm not sure I have -- we are now transitioning to Round 2, and that's going to put us to Amol, if I -- got it.

DR. NAVATHE: Great. So, first off, really important work. Thanks, Ariel and Ledia, for the thoughtful nature of this chapter. I have sort of one big conceptual comment and then a couple of really specific suggestions on analyses that we can add to.

The big conceptual comment, I think some in part relates to many of the design questions that are happening
here, which is I'm concerned -- and I will say as somebody who supports the notion of bundling or episoding, generally speaking, as we have done with PPS and dialysis and a whole bunch of things, I'm concerned about the suitability of this with an episode or bundle-like structure, because, Ariel, you've pointed out already several of the features that we intend to look for. We looked for some sort of defining, triggering event for a clinically defined episode that ideally has a start and a stop. I think in this case it's unclear -- maybe the start is clear. It's perhaps unclear what the stopping point is.

I think there's -- ideally you want to create some kind of accountability structure that comes with any payment that's happening where there's a lot of degrees of freedom underneath what that -- what activities can actually be captured by that. In the general fee-for-service system, we don't have an accountability mechanism. I think we're inherently going to end up with some kind of cliff at some point. It's a 30-day bundle, it's a 90-, 60- whatever-day bundle, and then there's going to be a strong incentive to clump around that cliff. And I think that might be something that's concerning, again, from a
design perspective.

I really like the fact that you went through and gave us some examples in terms of the dialysis side and the general surgery, the sort of surgical professional services bundle. I think if we compared the two of them, this seems to me to look at lot more like the surgical professional services than the dialysis. It's not highly predictable if people aren't getting dialysis three times a week in the same way -- or if they do, whereas, here it's unclear exactly what the regular pattern is. And so this feels a little bit more like the surgical side, which I think should make us a little bit concerned, because there we see that some attending surgeons don't do their post-op visit because they don't get paid for it, but the NP or the PA or MA, whoever, somebody else does it and gets paid.

So I think we should be careful around these different dimensions and think about the suitability and whether -- I understand in some sense you're asking about what are design features. I'm worried that I'm not sure we can come up with a cohesive set of design features that are going to appropriately check the box, or check the different boxes that we would want for consistent with
Commission principles kind of design here. I think Larry in his questions and others have highlighted to the extent that you have levels of these codes that are influenced by the activities that happen in the episode, that also undermines the concept of having the episode where you're kind of bundling a set of activities, again, with some accountability.

So I don't want to belabor the point, but I'm concerned about that. I think it struck me that in the request, however, there was a request for a design, and so I understand that we're trying to come up with something. This is very raw and off the cuff. I wonder if it makes more sense potentially to think about something that is a telehealth-only bundle that is triggered, can be triggered with the first telehealth visit so we avoid some of the issues that some folks have had around every E&M code has some telehealth packaged in and maybe telehealth doesn't happen, so then we're paying without getting telehealth services. Here we could potentially at least guarantee that we'd have a telehealth service.

Again, it's going to have all the same problems that I mentioned, so I'm not sure it's a solution. I just
wanted to throw something out there because I know we're searching for something there. That's the kind of broad conceptual point. Now the specific tiny things.

So on page 10, there's a list of analyses in the paper. I think it would be helpful to understand also the dimension of by specialty, particularly primary care versus specialty, in terms of the various types of telehealth use.

On page 12, there's a list of dimensions that we're interested in. I think in part we're really concerned around appropriateness. We probably can't get at that specifically, but I wonder if there's a way to try to understand something about the substitutive versus additive element of how telehealth is being used. I know there are some estimates from the literature that suggest that 85 percent of telehealth visits during the pandemic seemed to be more additive except for the very acute phases where people are sort of sheltering at home, and so that should give us budgetary concerns, if you will.

I do agree, on page 12 you kind of outline what the orientation is here, that we're not trying to compare in-person versus telehealth, and I think that's totally
right. I think we're thinking about what this system would be in-person plus telehealth versus what the prevailing system is. So I just wanted to voice support for that perspective. I think that's really important.

And then I think the last small point I wanted to make is kind of in sync with this accountability piece. I think it would be nice somewhere in here, consistent with what we've said in previous telehealth chapters, that it would be nice to layer in flexibility aligned with APM participation, and that might be one way to think about aligning some of the design elements with a system that actually could work, even if there are some of these potentially volume-enhancing or number of episode-enhancing kind of design features.

So thank you very much. Interesting work. I think we have our work cut out for us to make a design recommendation.

MS. KELLEY: Okay. Larry is next, and he has a couple of points.

The first point -- and I will use the "I" word, so just pretend I'm Larry. I suggest that MedPAC give some attention to the question of whether organizations that
provide only telehealth services should be paid for these services at the same rate as telehealth services provided by bricks-and-mortar provider organizations that mainly provide in-person clinical services. I think there are three justifications for arguing that telehealth-only organizations should be paid at a lower rate.

First, telehealth-only organizations are likely to have lower costs of providing the service since they don't have to support the fixed cost of having bricks-and-mortar infrastructure, invoking the principle that Medicare should not pay a lot more for a service than it costs to provide the service.

Second, if telehealth services are paid at the same amount for telehealth-only and for bricks-and-mortar provide organizations, the latter may be quite harmed, but they are, of course, fundamental to providing care, so harming them may not be a good thing.

Third, arguably, the telehealth service provided by a bricks-and-mortar organization within its in-person service area is a very different service than the telehealth service provided by a telehealth-only organization. For example, the bricks-and-mortar providers
can easily order lab, imaging, and other ancillary services as well as make referrals for in-person visits for patients who need them. They are likely to be able to choose convenient, high-quality services, make referrals to the appropriate specialist, arrange for patients who need care very soon to receive it, et cetera.

I, Larry, also want to point out that Mike Chernew and colleagues just published an excellent, wide-ranging article on policy issues related to telehealth in The Milbank Quarterly. It's excellent and includes a nice discussion of the telehealth-only company issue, but it goes far beyond that and very nicely lays out a conceptual map for thinking about the many and diverse new things happening in telehealth. The paper made me realize that I'm thinking far too narrowly. I imagine that MedPAC staff are already thinking more broadly, but in any case, I suggest that this paper can help MedPAC think about how telehealth work might go over the next cycle or two. I think it would be terrific if some sense of the breadth and issues in Mike's paper could be alluded to in the upcoming report under the rubric of the congressional request for analysis by provider type and geographic area and Medicare
payment policy for telehealth services and alternative approaches to such payment.

This would be helpful even if the issues are not explored in depth in this report. I would like to see us explore at least some of them in depth going forward. It's extremely important and likely to move quickly.

And so our next Round 2 comment is from Lynn.

MS. BARR: So I'd like to address the FQHC/RHC question. You know, as you saw in your data, there was limited uptake in rural communities and there were significant barriers. And a lot of it was the fact that the providers in rural health clinics -- and I am just going to talk about provider-based rural health clinics that are cost-based reimbursed -- it's a nightmare to carve out issues like this and try to make this work from a financial perspective. And so it's important for us to think about, you know, if our policy prevents access, that's a bad policy. And, you know, they're cost-based reimbursed, so all of their costs -- you know, I mean all of their costs are divided by the number of visits, right? And that's what we pay them. So why do we care, you know, whether or not we're paying them this and then we're going
to cost-based reimburse them on everything else if it creates such a barrier to care and it makes -- and it creates a big administrative burden? I don't understand why we would care, and then we have to have legislation to change it. So I am not a fan of cost-based reimbursed facilities having that type of situation.

Now, FQHCs are different because, although they have an all-inclusive rate, they're not cost-based reimbursed. So if they do more, they lose money, right? It doesn't scale. So I think that would be -- you know, I don't feel strongly about FQHCs as I do about cost-based reimbursed RHCs.

My other comment on design is if I was designing this, I would design something very similar to the chronic care management program where, if you want to have -- if you want telehealth services from your provider, you sign up for a monthly fee where you have a co-pay and you get telehealth services. This is sort of like -- this is somewhere between concierge medicine and, you know, where we are today. But you can pay -- say it's $50 a month, right? And so I have a $10 a month co-pay. We know from our experience with chronic care management services that
$10 co-pay is an incredible barrier for the beneficiaries to adopt. So they're not going to say, oh, I don't care, I've got supplemental insurance. They all had supplemental insurance. It's still a huge issue.

So we could use that as a potentially different mechanism. You still want to have it triggered by an E&M, and as the beneficiaries I think said in earlier work that you've done, they want telehealth from their provider. They don't want it from some -- they don't want to call Teledoc. They want this just as a convenient way for them to get care, and so they don't go to the emergency room.

And so I would be a big proponent of doing this, but perhaps in a way that doesn't allow as much gaming.

Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: Well, I was going to see if Dana would just read my comments because I think it would sound better.

[Laughter.]  

DR. DUSETZINA: So, guys, I think this work is fantastic, and I'm really -- I think the chapter is excellent, and it was really fun to think through where
this work could go, because I think it is super important, beneficiaries seem to really like it, but there is that whole problem of gaming and how do we pay for this and not overpay and not underpay.

I guess there were a couple of big-picture thoughts I had when reading the chapter, and one was that I don't think I fully understand how people use telehealth today. And I know that's part of what you can look at. Are people using this before going to a face-to-face encounter? You know, a lot of our Round 1 questions and the idea of bundling are you start face-to-face and then you have telehealth follow-up. But I often think about telehealth as I don't want to go to the doctor, and that's what we saw during the pandemic. I want the services, like medication orders or whatever. But can I avoid a face-to-face visit? And I think as we're thinking about bundling, should we be also thinking about from that other side of the coin of you get some sort of visit and then what if you trigger a face-to-face visit shortly thereafter? Then should you have paid the same amount for that telehealth visit that subsequently ended up in an encounter? So kind of maybe a reverse bundling or -- so that was one thing I
think would be helpful for context of just how are people accessing it.

I really like the analysis plan that was laid out and the use and spending measures that you specified. One of the things I wondered about, though, is being really intentional about looking at how service use has changed over time, even though we don't have a long time frame. But with the pandemic, we know that use was probably really different than it maybe is today. And I also wonder, you know, is there learning going on between beneficiaries and their clinicians where they understand what services really they can't do well by telehealth. So if you look at the most recent period, do you really get a good sense of what we should pay for or what we should encourage under telehealth?

One other thing that I was thinking about for the analysis plan is the avoidable hospital use I think is a good outcome to look at, but, again, I think that we might be missing an opportunity to think about avoidable face-to-face visits and how often did you have telehealth that did not result in a face-to-face visit, or the reverse of how often did you have telehealth and very soon thereafter come
in for a face-to-face visit, to maybe flag where we should be paying attention, like this is not an appropriate type of care for telehealth.

And then for the E&M code options, I think that in the bundling -- some of the conversation, I think Amol's comments in particular, like, oh, should we bundle it or should we not bundle it, I like the idea of it on its face, and I think in general I like the concept that you could have access to this additional care. I do worry a little bit about, like, would everybody just start to overpay, like, would everybody just bill assuming they'll get some telehealth visits? And then does that mean that beneficiaries have overpaid for services they don't ultimately receive?

If there is flexibility around that billing, so if you're able to do something that says, okay, well, you billed as though you were going to provide it and you didn't, or if you billed that you weren't and you did, we give you kind of like a combined rate later. I just don't know from, like, a payment perspective how much of that accounting can happen.

But I'm very excited to see this work moving
forward and think you guys did a great job with the
chapter.

MS. KELLEY: Jonathan.

DR. JAFFERY: Thanks, Dana. So, first, like
others have said, this is a great chapter, great work, and
there's so much that I think we're all excited about trying
to get to something here. It also feels like you're tasked
with -- you know, with all the moving parts, you're tasked
with sort of carving something out of a boulder while it's
rolling down a hill. So I think I really appreciate the
fact that this is challenging work.

And I also appreciate, you know, the plan you've
laid out for analyzing some of the changes, and, again, one
of the challenges is a lot of that analysis might be very
important for informing some of these other alternative
payment plans. So it's a little bit of a chicken-and-egg
thing.

All that said, like some others have said, I'm
very concerned about the alternative approach with this
bundle, and a lot of what Amol started off with were some
of the things I was thinking about. I'm not convinced that
the analogies in the chapter and the presentation work that
well. So like Amol was saying, hemodialysis is -- you
know, we're talking about bundling payments to physicians,
but that's got a clear-cut definition around clinical
encounters of, you know, a dozen a month, where there are
other clinicians or people providing care, you know, many
hours a day, several days a week. And the one example that
maybe speaks more to it is the global surgical one, and as
we've talked about, there are some issues with that.

I think Stacie's comments are really important
about, you know, what is the point of the telehealth
service? Are we saying that it is just an add-on to an in-
person visit? Sometimes that may make sense. Maybe it
makes sense that, you know, you have an in-person visit
every six or 12 months related to ongoing mental health
telehealth care. But for every service, I think the goal
here and the idea, the beauty of it is that it becomes much
more convenient and substitutable for an in-person visit,
and not every condition requires multiple visits.

So I think maybe channeling Dana from this
morning, like, what is the problem we're trying to solve?
And when I look at Slide 13 and you lay out some of the
problems with paying separately for each telehealth
service, incentives to bill more services, increased administrative burden, and even difficulty knowing what's the right price to pay, that doesn't strike me as problems for telehealth services. That strikes me as those are problems with fee-for-service.

And so at the end of the day, I feel like what we really want to get to still are these four -- the things we're talking about, our population-based payments. From the beginning, years ago, we started talking about could we use telehealth as something that folks in APMs are allowed to use with more freedom and flexibility? And I still think that's a good approach. And I just hate to decrease the availability of this for people based on all these other -- you know, patients, beneficiaries, providers, based on all these other potential barriers. I actually think a CCM-type approach where you've got somebody paying co-pays on a monthly basis is very problematic for a lot of beneficiaries and they just wouldn't -- I'd have a real concern about disparities being exacerbated with that.

I'd love to see this get to more of -- from a telehealth perspective, how do we think about putting it into population-based payments and then allowing health
systems and providers to innovate around delivering this
care in whatever combination makes the most sense for their
patient population and for their systems?

Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. So taking off on the points
already raised, particularly Jonathan's, I wonder if it
would be conceivable or feasible to pilot the idea of this
bundled with just three chronic diseases, two or three
chronic diseases. diabetes, heart failure, COPD, right?
The big three that drive the high volume of preventable
admissions, that have a lot of quality gaps, and where sort
of the round peg of fee-for-service payment does not fit
with the square hole of what people with serious chronic
diseases really need. And that might be a way of taking
off the table some of the concerns about waste and fraud
and overpayment and administrative complexity. If you
limited it to just beneficiaries with one of those three
chronic diseases, maybe do it as a zero-dollar copay. So
you take away any barriers because, really, we don't want
barriers for beneficiaries with those diseases to access
the ongoing chronic disease, the exact opposite of what we
So I don't know if that would need to be a CMI, you know, explicit pilot, but it seems to me that could be a way to get our foot in the door in the way that would be most likely to create new value.

MS. KELLEY: Great.

MR. POULSEN: Well, I'm grateful that we've heard what we've just heard. I'm glad for the good work on this. This is obviously an incredibly complex area, lots and lots of good information, thoughtful insights.

But amen to everything Jonathan said and that Scott just said. I agree with both those points as well, really for three reasons. One, telehealth, I think, has just unbelievable potential value. It's much less expensive when it's appropriate than is face-to-face care. It's often safer, not always but often. Even in the absence of COVID, we've seen just huge benefits there. Again, when appropriate, it's incredibly satisfying to patients and their families.

I think that we may underestimate the ability that telehealth leads -- can lead to entire system redesign. Thoughtful systems have been using telehealth
now for two to three decades of change, just dramatically.  
Now, the systems that have done that have all been prepaid. It seems to only work, as Jonathan said, in a prepaid world, but where that exists, it radically changes the fundamental organizational imperatives of the organization.

Those positives all said, however, I think that the fear of abuse is absolutely legitimate. It's so easy to -- it takes something -- I mean, abuse is real in the world as it is, and this just makes it just significantly easier to do.

So I think those are all -- you've called them out. I'd just reinforce that we've -- I think we've all seen it.

So I guess my thought would be to the extent that we have to fall short of the all-inclusive bundle -- the capitation, the pre-payment -- I still like the idea of looking, with a degree of skepticism, at some bundles. I was going to the same place Scott went where looking at some chronic diseases would be a place, because that most approximates capitation, and if you're really caring for a bundle of somebody with diabetes, you're caring for all of
the needs associated with it, and that makes sense to me.

And then my view would be that we'd be agnostic as to whether teleservices were the mechanism to do that. Instead what we would do would be to recommend that there's a bundle that takes care of the chronic disease, the person with the chronic disease, and oh, by the way, telehealth is certainly a tool that you have at your disposal. And you would not be penalized for using teleservices versus in-person services or vice versa.

And I guess my thought would be -- and this may or may not be helpful to you all. There are a number of prepaid organizations that have been doing this with a pretty long track record that may well be willing to share information that would help in your analytics that you may not have. We may not collectively have access to otherwise.

MS. GINSBURG: I have a quick follow-up question because I was going to ask that as well.

So I'm in an MA system that uses telehealth beautifully, very happy. What do we know about how MA programs are currently using it? Do we have access to that information at all and how that works? I would imagine we
have a lot to learn about that in terms of how to transition it if we're going to OM.

MR. WINTER: We know in the past that the MA encounter data are -- have problems with completeness and reliability and accuracy, particularly completeness. And so we're not planning to use those data for our -- for this report. Hopefully, in the future, the data will -- the quality of the data will improve and we'll be able to do analyses, use them for analyses of telehealth. But right now they're not in a state where we can use them for that purpose, unfortunately.

DR. CHERNEW: Marge? It's me. Hi. You might be talking about an MA organization that is integrated with a provider organization.

MS. GINSBURG: [Speaking off mic.]

DR. CHERNEW: Thanks, Marge.

[Laughter.]

DR. CHERNEW: And then difficult to think through whether that's a question about how providers are using it when there's an integrated incentive between the payment and the provider as opposed to MA organizations that might be more common. So there's another related question which
is how do MA organizations that are not integrated with the provider using payment to cover or not telehealth.

I don't know the answer to that. I do think it is worth -- that's a Round 1 question that we've inserted. So let's put that on the docket, but I think that's -- I mean, I do believe it is the case that if you integrate a provider organization with a payment model and then ask them how they're going to manage telehealth, they have a lot of flexibility, because they're effectively behaving like an ACO in an Elliott Fisher world, right? And when you separate out the payment from the provider of what they're doing, you run into the problems that have clearly bedeviled in large part -- can I use that word in public? -- this conversation.

Again, I have a few thoughts, but I think we should keep doing to Round 2Q, and we'll see where we are.

MS. KELLEY: All right. Robert?

DR. CHERRY: Thank you. Great discussion, and I think it feels very early in the discussion, believe it or not, because I think there's a lot more that has to be fleshed out when you think about what's involved.

Putting a clinical hat on here, it's difficult to
figure out how to implement and operationalize some of this. So you think, for example, palliative care. Palliative care is a great use case for telehealth. They've been able to use it across multiple disciplines and one visit, even meet with different family members across the country in order to arrive at decisions in the best interest of the patient. It may or may not follow cleanly with a first visit, for example.

There's dermatology, which I think has a great use case for telehealth, and it's not just necessarily a first visit in 30 days. It's a first visit, and it could be 90 days, six months later, nine months later, because following lesions that are clinically low suspicion, there's some value perhaps in following lesions for a longer period of time.

For a diabetes case, the same thing. It could be one visit plus maybe three virtual visits over 90 days. The end marker for that may not necessarily be avoidable ED visits or hospital days because the point of controlling diabetes is to reduce long-term incidence of stroke and heart attacks, and you may not necessarily have the data for this right now.
Every situation is a little bit different, and because of that, it may not be cookie-cutter, and because it does feel like it would take a long time to land a plane, you may want to think about perhaps a phased rollout. The same way we found value in mental health, maybe there's a use case for, let's say, primary care home models, for example, and that could be a great use for telehealth before moving on to the next thing.

So maybe instead of thinking broadly about what universally E&M codes should be like, to think about particular conditions or population health models as an initial phase, and then build on the learning experience from there.

DR. CHERNEW: I have a few Round 1 questions that I loosely want to ask. They're not really quite Round 1 questions, but I want to ask in the middle because I think I don't want to get to the end -- you'll see why in a minute -- and then raise this point.

So, first, I interpreted -- and I think Jim can chime in -- loosely interpreted some of the questions we were being asked by folks on the Hill was essentially how would you pay for telehealth in broadly a fee-for-service
world. So they didn't say that explicitly, but my understanding is a lot of the questions we're getting from the Hill or otherwise have that sort of flavor, and so that is a different response than where I think a lot of the conversations is going, as well if we could bundle this in particular places, which I think we would agree with that. It's just not clear we're responding to a particular thing.

There has been, as an aside, of course, they have limited and then expanded, but there's this question about the scope of what services, which is slightly different than what type of patients. So you could have a patient with diabetes and then think could they use telehealth for whatever, but the point is -- so one thing on the question is we could go -- I'm trying -- I'm sensing some concern with the sort of extended E&M bundle version, and I'm sensing a lot of comments around the table around ways we might do something that's not quite that. And those comments, sort of Scott had one and we've gone back and forth, involved some version of, well, this could work if we paid in a fundamental different way, which is kind of an APM world -- I agree -- or, well, maybe we should roll out in a narrower sense, people with chronic conditions.
That's also quite reasonable. I'm not sure how much of that is responsive to what they want in a particular way. So that another approach -- and again, I'm not sure it's right. In fact, the article that Ariel and Ledia is referring to could have been subtitled "Fee-for-Services Well Suited for Telehealth." Right? Which is frustrating when you're asked then how should you pay for telehealth with fee-for-service. Right? You get that point. But one easy way to sort of transition -- "easy" might be the wrong word. In fact, I take that back. One way that is simpler is you could do some combination of just lower facility fee. Keep it as -- it's still fee-for-service. It doesn't have the bundling complexity. You don't have the issue with the patient are qualified or not qualified. You don't have to get confused in how it fits into your APMs, and you just start with the world in which you change the facility fee, and in primary care, which might be central to some of the chronic conditions, you could deal with that in other mechanisms, like you could then just bump that into a, say, partial cap primary care fee. There's a whole bunch of other stuff that's gone on
in primary care, e-messages. There's a lot of other stuff that's happenings in primary care that is, I think, really problematic for physicians that they don't get compensated for and aren't well suited to fee-for-service for both patient monitoring. There's a bunch of these things that are just not -- technology has sort of outgrown the fee-for-service system in these ways.

So what I'm -- the reason I stopped in the middle is what's going to happen is, obviously, we're going to come back to this, and what we need to get out of this session is some sort of direction. What I'm hearing is concern about bundling. So I'm thinking, well, what's the alternative? The alternative could be APM-ish, but that's sort of in a little different place, and we're not going to force every physician or everyone else into their types of APMs.

So another alternative is just let's spend our time on questions like the facility fee component or other aspects of it and then keep the tone that we've had in the past with -- and be cautious about what services you let in because of all these other concerns.

In fact, to Larry, who I'll just look up to
Larry, you could conceptually have a different facility fee. I'm not saying we should. I'm just saying you could conceptually have a different facility fee for tele-only versus brick-and-mortar providers.

Again, I wasn't advocating that.

[Laughter.]

DR. CHERNEW: We'll chat later, but I'm saying you could think about how to manage this in a way that's much more consistent with fee-for-service as opposed to trying to move it into an awkward -- I didn't mean awkward -- a more complex episode-y kind of way, which is where we were going. And I just want to get folks' sense because we don't want to come back again and say, well, you could do it this way and have people get -- so, anyway, I made my point.

I think we should go around the -- keep going around the queue.

MR. POULSEN: Before you do that, though, I suspect Kenny has the same question I have which is, to what extent is it within our appropriate role to say essentially what you just said regarding your paper, which is we don't think this is well suited in a fee-for-service
world, and we think we ought to contemplate mechanisms that are departures from that?

[Laughter.]

DR. CHERNEW: It seems to be getting late.

I'm not sure I have a great answer to that. I think it depends on how some of the remainder of this discussion goes. I don't know if Ariel or Ledia have a sense of that.

I think that we certainly can describe in some detail the complexity of trying to shoehorn telehealth into fee-for-service. So that, I think, is a tonal thing in the chapter, which I think we should and will do.

The question then is if we say, therefore, we're not -- I'm not quite comfortable with that, although I think, depending on how this discussion goes, I could become more or less comfortable with that. That's a charge issue, which is what you asked me.

MR. KAN: I think for me, it would be helpful to know like could we as a Commission type in the scope and narrow the scope of what we're trying to focus on because -- I mean, the permutations involved in the design of this are mind-numbing, frankly. So, to the extent we know what
we're trying to shoot for, that helps.

DR. CHERNEW: Yeah. I'm watching Jim's finger to see how close it gets to the button.

[Laughter.]

DR. CHERNEW: The answer is we can obviously do whatever we want to do at some level, but realize we are trying to be responsive to people that asked us a reasonable question. So while we can narrow or manage the scope, we are, in fact, trying to give advice to policymakers who have a legitimate concern that is -- very much came around the table.

And I think, Greg, you said it spot on. When used appropriately, this is an unbelievably valuable service, and no one wants to be the one to tell people that they can't access a service that can improve the quality of life, that can get them assess to needed care, do it in a way that's much more convenient. We don't want to be that group. We don't want to say that.

On the other hand, we have had this long history of being concerned that when you open up the door to that, there's a bunch of unintended consequences that we worry a ton about, and we have, therefore, struggled.
I think I will again speak for me, but I think at least some subset of you believe this. In different payment models, you have just a completely different worry about this whole set of things, but the world isn't all in those different payment models, and we have been asked for a broad set of policy things. What should we do sort of outside of that space?

So, if the narrowing question, Kenny, was, well, let's think about what to do in the context of an ACO, that's a fine thing to say. I don't think that's particularly responsive to what we've being asked, and I don't think they want the response, you know, "See our ACO chapter." So I think we are struggling.

What I was trying to do with what I said before is come up with -- again, I used the word "simple." I didn't mean it, but come up with a less -- an option, if you will, that's less complicated than many of the things that Ariel laid out and Larry's comment went through in some detail about how you know when it's triggered. Then you go back. You know, it's a game, as Stacie said. A lot of people have gone through with sort of issues where the bundling in with E&M is problematic. So what would you do
if you weren't going to bundle in with E&M? I think the easiest thing to do that gets at the consistence of where we are is, well, let's -- the work part is the same, presumably, in the televisit. So then it's just let's look at the practice expense part and see if we could stay in a fee-for-service world, we can say we don't like, but we can say if you're going to stay in a fee-for-service world, you're going to have to do something on the practice expense and on the monitoring side to make sure that this works.

DR. MATHEWS: Just to add to those comments, I can't go into too much detail without betraying some inside information, but going to the point about once you give something, it is hard to take it back, given the changes to telehealth payment that were implemented during the public health emergency, as you can imagine, stakeholders got used to those higher levels of payments. And with the end of the public health emergency on the horizon and payment policy in line to revert back to prior payment, the appetite for ideas about what the appropriate level and the appropriate mechanism for paying for telehealth is tremendous, and if we were to say, "Well, you know, it's
not suited for fee-for-service. It's a population-based thing," that sort of sidesteps the issue because even in, say, an ACO environment, all of the transactions are still being conducted on a fee-for-service basis.

And the question of the day is when that claim for a telehealth service comes in, whether it's from an ACO physician or not, how much should Medicare pay for that service? That's the thing that the folks that we respond to on the Hill are dealing with.

So I'd like, if we can, to be able to help them on point. It's not to diminish any of the discussion thus far about concerns with the bundling approach that we put on the table or the lack of appropriateness for telehealth in a fee-for-service environment, but if we can do something constructive with respect to this specific question, it would be tremendously well received.

DR. CHERNEW: So, if I have this right, we're going to go to --

MS. KELLEY: Dana is next.

DR. CHERNEW: I have Dana -- for the next three, I have Dana, Jaewon, and Kenny --

MS. KELLEY: Yes.
DR. CHERNEW: -- are my next three.

MS. KELLEY: And then?

DR. CHERNEW: And then I have Betty and Cheryl.

MS. KELLEY: Correct.

DR. CHERNEW: And Lynn at some point. So Lynn after that. But in the interim, we have half an hour, which is good, but this is a long sort of digression, Ledia and Ariel, and you haven't really had a chance to -- I have been trying to read your faces but I am old guy. Do you have anything you want to add, or should we just go around the queue?

MR. WINTER: No, this is really helpful to get this guidance, so thank you.

DR. CHERNEW: Okay, then Dana.

DR. SAFRAN: All right. Well thanks. And, you know, joining others in my appreciation that we're having this conversation and my view that this has very far-reaching implications. I think, you know, the challenge that we're all grappling with is the challenge of threading a needle. How do we sustain access to the value of telehealth without driving up cost? And one of the things that strikes me is
kind of the elephant in the room that none of have named so far, is name one other industry where you make a service more efficient and don't lower the price. And that's our problem, is we have figured out how to be freed from the tyranny of the office visit, but we are not willing to reduce the prices of services, even though the cost of delivering them will be lower.

So that is why, for me personally, I'm glad, actually, that we can't narrow the paper, because I think part of what the paper needs to get across is how a fee-for-service model of payment together with telehealth can potentially bust the budget, and that it is just one more reason to really move aggressively toward alternative payment models.

And I will also say I have never been a fan of bundles, but I kind of like Scott having raised -- and I didn't like the bundled concept that you proposed, but I could get comfortable with the bundled concept that Scott proposed and that Greg and others have voiced appreciation for, for a couple of reasons.

One is, you know -- and Amol will back me up on the literature here -- but I'm pretty sure it's the case
that chronic condition bundles have not shown any evidence
of saving money, that some procedural bundles have but that
chronic illness bundles, for the most part, have not. And
I think that this potentially could change that, and it
gives us the opportunity to do the kind of evaluation of
impact that we aren't going to be able to do with the
available data that you have. So one of the reasons I kind
of like the idea of the chronic condition bundles is that
it does give the opportunity to very systematically plan
and execute some evaluation of the impact of this on
access, on quality, on outcomes, and very importantly, on
equity. Because it could be one of the important values of
telehealth is equity through lowering barriers to access.

Let me see if there was anything else I wanted to
mention. Nope. I don't think so. That's it. Thank you.

MS. KELLEY: Jaewon.

DR. RYU: Yes. So just a few points. I agree
with a lot of the comments that have already been raised.
I think my difficulty with this is that telemedicine has
been used in so many different ways. There is a lot -- and
we use this word a lot -- "heterogeneity," and I think the
reality is there are a lot of babies but also a lot of
bathwater in this space. And I think the trick is trying
to figure out which one is which.

So one of the things that I'm hoping we see in
the contractor work, Ledia, that you referenced, is some
understanding of where are the situations? What are the
scenarios where it is more likely to be replacement versus
where are the situations where it is more likely to be
duplicative or demand inducing, whatever term you want to
use. So I am hoping we can at least get some lens into
that.

In the meantime I think as far as the
recommendations I think on Slide 7, I agree with all of
those, whether it is reverting back to the physician fee
schedule facility rate, the copays, making sure those are
in place, and the other safeguards that were described. I
think that makes sense.

As far as the bundled proposal, I just don't
think it naturally lends itself to that. But if we were to
do like a targeted chronic disease sort of approach, I do
think that starts making more sense. But I think even that
would require a lot of work to try to ensure that it's
value-add as opposed to extra utilization.
MR. KAN: This is great work. In theory, I initially like the bundled payment and extended E&M visit to help lower costs and streamline the administrative burden. In practice, I struggle and share many of Larry's, Amol's, and Stacie's concerns. I really think it is actually very hard to predict when the next visit is, for most docs anyway.

I am also concerned about the administrative burden, both to docs and payers, to reprocess the claims. And then gaming, I don't know how frequently this happens, but I really need some kind of access to care on Day 59, and there is a 60-day limit, so what happens if I contact my doc and they say, "Oh, you're not covered." Well, you know, it's possible that they may say, "Oh, I cannot see you on Day 59. I can only see you on Day 61." That probably doesn't happen a lot, but I'm just curious about some of the gaming concerns that Stacie indicated earlier.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. This has been a fascinating conversation and fascinating work. Thank you.

I have to admit that when I was reading this
chapter my first thought was is there a way to deploy the popularity of telehealth as a way to incentivize risk-bearing and move away from fee-for-service, but not that helpful, I guess.

But really paralleling Jon's comments, I really appreciated Scott's thought about a trial, Robert's about a rollout, and Greg's comment that it shouldn't be specific to this one in the office, this on telehealth, or whatever. And I would also add provider agnostic. And the reason I say that is particular with chronic condition management. It might really be a social worker or a diabetes educator or something. And so instead of thinking this day, this day, this day, we have this condition and here is what we are going to have, and how do we get reimbursed for it?

So I rather liked the bundling idea, and I guess, you know, respectfully, I'm sure it's very difficult. I see Larry talking about the people with the broken ankles that come in. But I do think with certain kinds of conditions we have some sense of what it is going to take.

So that's where I'm at. I'm interested to hear more about what you develop. I support the principles on
page 7 and also, I'm pretty positive about the population-based measures that you talked about. So thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you. I too share concerns about the potential for overuse and overpayment in this space. It's a tricky landscape. In a perfect world we'd run an experiment here or have access to these population-based data to try to understand where telehealth has been used effectively and efficiently.

I also share Dana's concern about this is an opportunity subtly to enhance the delivery of care to certain subpopulations that may have had access problems or a different modality that could be more effective. But how is it that the Medicare program can recoup those gains in efficiencies? And I feel like we really haven't been able to fully consider how best to do that.

I think in terms of -- and I'm not going to go into this notion of an episode payment piece, but when I was listening to you describe it I was wondering, do you know what fraction of visits are kind of one-and-done versus they have multiple follow-on events? Because I don't know whether we're talking about 20 percent of all
visits tend to have follow-on activity. So I think it
would be helpful to have some context there.

I do think that it's going to be important to
monitor what is going on in this space, whether it is
potential for inappropriate use. You know, certainly we
can look at low-value care delivery, but I think we suffer
from the lack of measures or imperfect measures to be able
to measure inappropriate care in this space. And so I
think it would be helpful to give some more thought on
where the hunting should be, if we're going to try to flag
what is inappropriate use.

I also wonder what the potential is for
misdiagnosis, and is it higher in this environment than,
say, an in-person visit? I'm not sure how to measure that.
I know the patient safety community has been trying to
think of that, how to measure misdiagnosis and how often it
happens. I do not know if there is anything we can learn
from that community that could be applied here.

MS. KELLEY: Lynn.

MS. BARR: I just, You know, I want to echo that
I don't think the bundle approach is going to be the right
approach if the question is what is the fee-for-service
approach.

Jonathan, I do appreciate your comments about chronic care management and the issues with that, but it did allow us to move forward, as messed up as it is. And my personal feeling is that all APMs should be able to waive copays on chronic care management. If you're in an APM, you're responsible for the cost, so you've got the built-in incentive. And we need to build incentives for providers to enter into APMs. There are very weak signals that drive providers into incentives, into APMs today. And having the ability to do telehealth would be an incentive, and to be able to do it without copays.

So I do think that there is a way to structure this more. I'm not a big fan of just cutting the facility fees because I don't think that ends up like solving the problem. And I think we're going to overpay and there's going to be lots of fraud. And so the beneficiary protects us with the copay, and the ACO protects us if there is no copay, and that's a way that we can get at this and give broad access to people, but then at a provider level make a decision on whether or not they would have to pay that copay. Does that make sense?
DR. CHERNEW: Let me think. Let's go back to the facility fee part. There's an issue about cost-sharing, which we haven't discussed very much today, which actually requires, I think, a lot more attention, because the logistics of collecting cost-sharing on telehealth visits is complicated in a range of ways, and we haven't had that discussion. So I'm not even sure I know how we're going to work through that part.

The APM stuff is fine, but there are a lot of places outside of the APM world now that we are really talking about.

So the question in my mind for what makes sense is not -- I'll be super clear where I am -- I would never have thought that anything on the facility fee solves our problem. I think the solutions are bigger than in some ways what we have been asked, per Jim's comment.

So the question that I didn't understand from your comment is are you saying -- I'm going to ask you a very narrow question. In a world in which moving forward we are paying for telehealth under fee-for-service, would you have (a) the facility fees but what they are in the public health emergency, which it depends on the site you
go to, (b) have the facility fees at the non-facility rate
regardless of where you are, which I think is where the
MedPAC recommendation has historically been, or have © a
third, possibly lower facility fee to at least do some
balancing of things?

MS. BARR: I would bill them a monthly fee, like
chronic care management, that gives them access to
telehealth. There is no facility fee.

DR. CHERNEW: I'm not sure what billing them
means. I'm sorry.

MS. BARR: So in chronic care management you pay
$40, $50 a month.

DR. CHERNEW: Yeah, but what do you do for a
specialist who is providing telehealth services for
something?

MS. BARR: You pay for it on a monthly basis.
You say, "I want telehealth services with you. I'm willing
to pay the copay." Or you say to me, "You need telehealth
services. I know you can't afford it. We can waive your
copay."

DR. CHERNEW: So I am just trying to -- this is
like a Round 1 question. I
MS. BARR: -- your CCM framework.

DR. CHERNEW: I'm checking the clock.

MS. BARR: Right.

DR. CHERNEW: We are going to have to finish this probably offline, but let me just say, if I understand correctly that is a beneficiary signs up for telehealth service and is charged a copay for doing that. That is different than how the provider gets paid in that context.

MS. BARR: With a provider. I signed up with you.

DR. CHERNEW: Yeah, I understand. You're a patient. I'm a cardiologist. You sign up for me.

MS. BARR: Just like CCM.

DR. CHERNEW: That's right. I know that you would be charged under your model. I'm not sure what that means about how I would get paid for it.

MS. BARR: So you get the fee every month. Just like CCM, you get the $50 a month. I pay the copay.

DR. CHERNEW: Okay. So we are not going to have the time. This is neither the time nor the venue to sort all the details of that, but I do think it's important to at least get a version of that on the record in the public
meeting. So in that sense thank you. Dana, I think that was the end of the queue. Are we right. So I'm going to pause for a second to see if anyone else --

[No response.]

DR. CHERNEW: Okay. So this is the type of conversation that is why you sign up to be on MedPAC. So this could have just been a recruiting session for those of you that are like, boy, I wish I was in the room. It's a remarkably challenging conceptual problem. It's an increasingly important problem, in a range of ways. I think the work in the chapter that you guys did, Ariel and Ledia, was outstanding. The judge is how good the conservation is after the fact, and the conversation was exceptional.

So for the public, please, if you do want to chime in, although you couldn't be here, send comments to meetingcomments@medpac.gov, or go on the website. There's a place where you can give us comments.

This is obviously not the last time we are going to focus on this issue. I just want to say one last thing. It didn't come up, that if I would've had a Round 2 comment

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this would've been my Round 2 comment.

In whatever we do, I think we have to be really
cognizant of the administrative costs of doing all of this.
I think that for a lot of the health care system the
documentation and the coding and the administrative stuff
is crushing for what people do, and this is an area where -
- I very much want to avoid an outcome where we define some
codes, and they have to be policed, and you are eligible
for this service if you meet these three clinical criteria
and are certified by this person, and it is more than 15
minutes, and you didn't have, within the past 45 days, a
visit to an E&M doctor for a related condition, even though
you may have had a visit for three things and one of them
was --

The regulatory burden of how you do this in a
fee-for-service world is crushing, and I think too often we
forget the administrative burden that we place on the
system that is already administratively complicated. And
although Larry is not here, I will try and channel one of
Larry's comments, which I think is completely spot-on.
However, we deal with some of the payment for physicians,
which is obviously important, I think one of the
frustrations that I think people in the medical community face, of all types, is just the administrative hassles of just doing their job in a range of ways.

And so I just want to say whatever we do here I want to at least try and make sure we don't make that substantially worse. I don't know how to do that, which is why I'm going to say thanks, everybody, and thank you all at home. Send us comments, and we'll keep working on it.

So with that we are going to adjourn for the night, and we are going to show up again tomorrow at 9 a.m. We're going to be talking about inpatient psych and Part D data and drug rebates and discounts, two also very important topics.

So again, thank you all. Have a safe evening, and come join us tomorrow.

[Whereas, at 4:45 p.m., the Commission adjourned, to reconvene at 9:00 a.m. on Friday, September 30, 2022.]
MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

and

Via GoToWebinar

Friday, September 30, 2022
9:01 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
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AGENDA

Congressional request: Medicare and inpatient psychiatric facility care
- Betty Fout, Ledia Tabor

Recess

Analysis of Part D data on drug rebates and discounts
- Shinobu Suzuki, Tara Hayes, Rachel Schmidt

Adjourn
[9:01 a.m.]

DR. CHERNEW: Hi, everybody, and welcome to our Friday morning MedPAC session. We have two great topics today -- inpatient psych and Part D drugs. We're going to start with inpatient psych, and I am going to turn it over to Betty and Ledia.

DR. FOUT: Great. Thank you.

Just as a reminder, there's a PDF of the slide available from the webinar's control panel on the right side of your screen.

And before I start, I just wanted to thank our colleagues, Jamila Torain, who is not here, and Corinna Cline, for their excellent work and contributions to this work.

In this presentation, as part of a response to a congressional request, we discuss inpatient psychiatric facility services under Medicare.

In January 2022, the Chairman of the Committee on Ways and Means requested that the Commission conduct an analysis of mental health services in the Medicare program.

The request has three components.
First is to update the Commission’s prior work on trends and issues in inpatient psychiatric care for beneficiaries. This includes examining access to care, quality of care, Medicare payments and provider costs, and information on beneficiaries reaching the 190-day lifetime limit on care received from freestanding psychiatric hospitals.

Second is to describe the utilization of outpatient mental health services, including tele-mental health services, and the characteristics of beneficiaries using them.

And, third, to the extent possible, is to describe the use of mental health services by beneficiaries enrolled in Medicare Advantage.

In this presentation, we address the first and third component as it relates to inpatient psychiatric services, and we anticipate the findings will result in an informational chapter in the June 2023 report to Congress. The Commission will not be making recommendations on payment updates for psychiatric hospitals during this cycle.

Beneficiaries experiencing an urgent, acute
mental health, or substance use crisis may be treated in inpatient psychiatric facilities, or IPFs. These facilities can be standalone psychiatric hospitals, or what we are calling "freestanding IPFs," or distinct part units of an acute care hospital, or what we call "hospital-based IPFs."

To be admitted to an IPF, patients generally must be considered a risk to themselves or to others. IPFs provide 24-hour care in a structured, intensive, and secure setting. Among other treatments, patients may receive individual and group therapy, psychosocial rehabilitation, drug therapy in the form of psychotropic medications, and electroconvulsive therapy.

The goal of IPF care is to stabilize the individual's condition and enable safe return to the community.

As is the case for general acute care hospitals, IPF stays are covered under Medicare Part A. Services from physicians and other clinicians received during the stay are covered by Part B.

Medicare reimburses IPFs for the inpatient care they provide to fee-for-service beneficiaries through the
IPF prospective payment system, or PPS, which was first implemented in 2005. To determine the payment for an IPF stay, a base per diem rate is set and updated annually. The per diem base rate is then adjusted for geographic, patient, and facility factors. Geographic factors includes the wage index, cost of living adjustments for certain states, and rural location of the IPF if it applies. Patient factors include age, principal diagnosis, presence of certain comorbidities, use of electroconvulsive therapy, and length of stay, with the per diem for each additional day decreasing with longer stays. Facility adjustors include teaching status and presence of an emergency department.

There is an outlier policy for stays that have extraordinarily high costs, drawn from 2 percent of total payments. Medicare makes an outlier payment when the total cost for a stay exceeds the total payment plus the fixed-loss amount, adjusted by facility factors.

In 2019, there were 1,542 IPFs for which a Medicare fee-for-service beneficiary had at least one stay. Over 230,000 beneficiaries had nearly 350,000 stays, and the Medicare program spent $3.9 billion on these stays.
The volume of IPF services and Medicare program sending was substantially lower in 2020 due to the COVID-19 public health emergency.

To the extent possible, analyses in this presentation include 2020 data as it is the most recently available data. However, we recognize that 2020 is an anomalous year, and for some analyses, like those for Medicare margins, we use only 2019 data for now but plan to include data through 2021 when available.

In the next few slides, we review the characteristics of beneficiaries admitted to an IPF using data from 2020, but we know that the patterns were similar in prior years.

Medicare beneficiaries admitted to IPFs are among the most vulnerable and costly.

In these charts, the top green bars represent Medicare fee-for-service beneficiaries with at least one IPF stay in the year. The bottom red bars represent all other Medicare fee-for-services beneficiaries.

The chart on the left shows that beneficiaries admitted to IPFs are much more likely to be low income or be disabled compared to other beneficiaries.
On the right, we show that Medicare Part A and B spending per beneficiary for those with an IPF stay was nearly four times higher than all other beneficiaries. Medicare Part D prescription drug spending for those who had an IPF stay was twice as much as other beneficiaries. In addition, beneficiaries with IPF stays also had higher risk scores, greater prevalence of certain chronic conditions, were younger, and were more likely to be Black compared to other fee-for-service beneficiaries.

Beneficiaries admitted to IPFs are assigned to 1 of 17 psychiatric Medicare-severity diagnostic related groups, or MS-DRGs, which are based on the principal diagnosis of the stay. The MS-DRG system does not differentiate well among Medicare beneficiaries using IPFs.

As shown in the upper right blue wedges of this pie, nearly 75 percent of stays were assigned to the psychosis MS-DRG in 2020. The psychosis MS-DRG is a broad category that is split between patients with a principal diagnoses of mood disorders, such as bipolar disorder and major depression, and non-mood psychotic disorders, such as schizophrenia.
The remaining stays composed only 26 percent of the total, as shown in the lower left green wedge. The MS-DRGs for these stays are grouped and listed on the slide. The most common were organic disturbances which were 7 percent of stays and alcohol or drug dependency at 6 percent of stays.

While there are 17 psychiatric MS-DRGs, some are very rarely used. The top seven MS-DRGs accounted for 96 percent of all IPF stays.

We update the Commission's prior analyses on IPFs related to access to care, quality of care, and Medicare payments and provider costs. We examine access to care by looking at supply and capacity of IPFs and the volume of services used by Medicare beneficiaries.

Next, we discussed quality of care measures available through the IPF quality reporting program.

Then, lastly, we examine Medicare payments under the IPF PPS and IPFs' costs of providing care to Medicare fee-for-service beneficiaries. This includes presenting aggregate Medicare margins for IPF PPS services and discussing issues related to payment accuracy.

This chart depicts the number of IPFs serving...
Medicare fee-for-service beneficiaries from 2016 to 2020 by IPF type and ownership.

As shown in the left-most bars, the most common type of IPFs are hospital-based nonprofit IPFs. Though this number has been declining, they remain about 40 percent of the total.

In contrast, the number of freestanding for-profit IPFs are increasing, as shown with the white circle, and now represent about 20 percent of the total.

Freestanding government IPFs, shown in the right-most bars, were the predominant form of psychiatric hospitals in the 1960s and '70s but now are a small share of the total at about 10 percent.

There was an overall annual decline in the number of IPFs from 2016 to 2020 of about 1 percent. However, because freestanding IPFs tend to be large, the overall number of inpatient psychiatric beds actually slightly increased over the same time period.

This table shows the annual changes between 2016 and 2019 and then between 2019 and 2020. There was a steep decline in utilization due to the start of COVID-19. The number of IPF stays decreased by 16.2 percent between 2019
and 2020. However, the decline, to a lesser extent at 5.1 percent, was already occurring prior to 2020.

We found that average length of stays have increased during this time, possibly indicating a change in the mix of Medicare beneficiaries who are using IPFs. The increase in length of stay likely contributed to the increase in Medicare payment per stay, observed in the last row of the table.

Although the total number of IPF beds have been stable in recent years and overall utilization of IPFs has declined, there have been reports of shortages and wait-lists for IPF beds. This has been exacerbated by COVID-19.

We did find high occupancy rates among freestanding government IPFs, as shown in the top green line on this chart. These IPFs frequently function as providers of last resort, serving patients with severe mental illness who are difficult to place in other facilities. The high occupancy rate for these hospitals suggests that access to inpatient psychiatric services for some of the sickest beneficiaries may be inadequate in some areas.

The occupancy rate across all other psychiatric
hospitals was 71 percent in 2019 and 72 percent in 2020, both lower than the occupancy rates from 2016 to 2018, indicating some capacity available. However, as a point of comparison, the occupancy rates across short-term acute care hospitals was 65 percent in 2019.

The Commission has previously reported on the incompleteness of the Medicare Advantage encounter data, though there have been improvements over time. In this analysis, we combined the MA encounter data with claims data to identify MA enrollees admitted to IPFs in 2019, which is the most recent year of available encounter data. We believe that the combined data are sufficient for broadly comparing the MA and fee-for-service beneficiaries receiving IPF services.

We identified approximately 120,000 MA enrollees admitted to IPFs in 2019. This represented 0.5 percent of the MA population. In comparison, we found 0.7 percent of the fee-for-service population were admitted to IPFs.

The demographic characteristics of MA enrollees using IPF services were generally similar to those of fee-for-service beneficiaries admitted to IPFs, with any differences mirroring the differences between the two
When comparing the principal diagnosis for the IPF stay, we found that MA enrollees admitted to IPFs had a higher percentage of mood disorders and a lower percentage of schizophrenia compared to fee-for-service beneficiaries admitted to IPFs.

Under Medicare, coverage of treatment in freestanding psychiatric hospitals is subject to a lifetime limit of 190 days, after which beneficiaries are responsible for all costs.

This provision was enacted in 1965 with the implementation of Medicare when a majority of inpatient psychiatric care was provided by government freestanding facilities.

The 190-day limit does not apply to hospital-based units, which compose 60 percent of IPF stays, and may therefore affect the type of facilities from which some beneficiaries seek care and possibly disrupt patient care when beneficiaries reach the limit during a stay.

For the cohort of beneficiaries with Medicare fee-for-service sometime during 2019, we examined admissions to IPFs from the time of their initial Medicare
enrollment through July 2022, and we found that 722,000 of
these beneficiaries had used at least one day in a
freestanding IPF, and 35,000 had exhausted all 190 days.
We found an additional 9,000 beneficiaries were within 15
days of reaching the limit. In future work, we plan to do
additional analyses to examine the characteristics of
beneficiaries reaching or close to reaching the limit.
I'll now switch to quality of care.
In summary, we found that data on the quality of
care provided by IPFs are limited.
The Medicare program currently has an IPF pay-
for-reporting quality program that includes 14 measures, of
which the vast majority are process measures.
Providers report results in aggregate for each
IPF, meaning they report numerator and denominator values
based on their own administrative and clinical data.
As IPFs begin to report patient-level quality
results beginning in 2023, CMS and others will be able to
better assess the quality of care provided by IPFs.
The program does include one claims-based outcome
measure, a 30-day, all-cause, unplanned readmission
following psychiatric hospitalization, which measures the
impact an IPF has on care during the stay and at discharge to prevent patients returning to a hospital. The national mean for the measure is about 20 percent.

We calculated Medicare margins for IPF services by comparing payments made under the IPF PPS to providers' costs for their Medicare fee-for-service patients.

Overall, IPFs' margins have decreased over time. In 2019, the Medicare margin among all non-government IPFs was negative 2 percent, down from 0.9 percent in 2016, but we do note that these numbers are preliminary and may change.

As shown in the chart on the right, IPF Medicare margin varied widely by the type of IPF. In 2019, the aggregate Medicare margin among freestanding for-profit IPFs was 25 percent, as shown in the top solid white line, compared with negative 23 percent among hospital-based nonprofit IPFs, as shown in the bottom red dotted line. The high positive margin among freestanding for-profit IPFs was driven by low costs among these facilities.

In the next few slides, we discuss gaps in available information that affect payment accuracy or the ability of the payment system to accurately capture costs and classify patients.
First, administrative data may not be sufficient to capture the variation in per diem costs related to differences in patient severity. As shown earlier, nearly three-quarters of IPF patients fall within the same psychiatric MS-DRG, demonstrating the difficulty in using MS-DRGs to differentiate the costs of IPF patients.

Earlier studies have found that activities of daily living deficits, serious danger to self or others, and involuntary admission to be important cost drivers, but they are not available on administrative data. Including these and other elements that significantly affect IPF routine nursing and staff time could improve the accuracy of Medicare payments, but doing so would require IPFs to submit additional information about their patients.

Second, we found gaps in the reporting of a portion of IPFs' costs. IPFs' costs for caring for Medicare beneficiaries consist of routine and ancillary costs, which are reported to CMS.

Daily routine costs include costs for staffing and room and board, which are typically provided to all patients, and the reporting of these costs generally do not vary across patients admitted to an IPF.
In contrast, ancillary costs are for specific services, such as prescription drugs and laboratory services, which are the most commonly used, and can vary for each beneficiary and stay. Charges for ancillary services are recorded on the claim and provide a source of cost information that varies by the patient.

Hospitals must apportion costs for Medicare patients to each ancillary department unless they have an all-inclusive rate or no-cost structure. For all-inclusive rate IPFs, ancillary services are not reported separately. An all-inclusive rate designation is common among government IPFs.

For IPFs that do not have an all-inclusive rate, CMS requires the submission of costs for ancillary services and actually began to specifically enforce this in 2017 and 2018 by rejecting cost reports without this information.

However, we have observed poor reporting of ancillary services by some IPFs. First, we found a growing number of IPFs designating themselves as all-inclusive-rate providers that do not report ancillary services separately. The growth was concentrated among freestanding for-profit IPFs. As
shown in the figure on the right, from 2016 to 2019, the
current of these IPFs designating as all-inclusive-rate
hospitals grew from 21 to 64 percent. We did not observe
similar changes in designation among other types of IPFs.

Second, charges for ancillary services were
missing among some IPFs that are required to report them.
Most notably, 43 percent of stays at non-all-inclusive-rate
freestanding for-profit IPFs did not include any reported
prescription drug charges. In contrast, nearly all stays
at hospital-based IPFs reported prescription drug charges.

Overall, we found that 32 percent of stays in
2019 did not have any associated prescription drug
ancillary charges. Any updates to IPF PPS adjustments,
which have not been done since implementation, will need to
address the lacking ancillary services, though how they
would be addressed would differ depending on the reason for
why they are lacking; that is, whether the data are missing
or truly zeros.

In summary, we found the supply of IPFs to have
remained relatively steady over time while utilization
decreased. Occupancy rates were high for freestanding
government IPFs but showed some spare capacity for other
types of IPFs. We found some concerning trends and identified gaps where additional information is needed to assess the quality of IPF care and accuracy of Medicare payments. We emphasize the need for urgency in filling these informational gaps, given that Medicare beneficiaries using IPFs are among the most vulnerable and high risk.

As next steps, we plan to update these analyses using data through 2021 in the coming months. We also plan to conduct telephone interviews with IPFs in the fall. A future presentation will cover analyses of outpatient behavioral health care under Medicare.

We anticipate this work will form a chapter in the June 2023 report to the Congress.

And for discussion today, we would like Commissioners to comment on whether any clarifications or further investigations needed for this particular paper and whether there is any additional guidance for us to consider in putting together the June 2023 chapter.

Thank you.

DR. CHERNEW: Needless to say, issues related to behavioral and mental health are increasingly important
across the board, and I don't know anyone involved in the health care sector that's not spending a lot of time worrying about a range of psychiatric issues. And so I'm really happy that we're looking into this. I'll probably say something a little bit more when we transition from Round 1 to Round 2, but now we'll just start with Round 1. So, Dana?

MS. KELLEY: Jonathan.

DR. JAFFERY: Great. Thanks. So thank you. It's a fabulous chapter and a presentation. Amen to Mike's comments. You know, it's just pretty sobering to think about how little I actually understand about some of these issues five years into MedPAC, and so I'm really excited we're looking at this, and I'll have some thoughts in Round 2 as well.

Just two questions for now. Can you say a little bit more about the 190-day policy limit? I get that that happened in 1965, but it's been a long time. Is there a rationale now? Is there anything analogous to that? Do we do anything like that anywhere else in Medicare? That's my first question. I have one other after that.

DR. FOUT: I will just mention that there is the
60-day reserve days for all inpatient care hospital. But that is very different from this, and there have been definitely calls to change this policy, but it was enacted at the time when it applied to all psychiatric hospitals evenly. But, I mean, it's a common theme in the literature and articles about -- yeah.

DR. MATHEWS: Jonathan, one thing to add to that, in addition to the lifetime reserve days that Betty just mentioned, there is a limit on Medicare-covered inpatient days during a spell of illness as well. So there is an analogue there.

DR. JAFFERY: Gotcha. But there's no limit on numbers of spells of illness?

DR. MATHEWS: Pardon?

DR. JAFFERY: There's not a -- you can have multiple spells of illness.

DR. MATHEWS: Correct. Correct.

DR. JAFFERY: If you have your eighth heart attack, nobody says, "Sorry."

Okay. Second question, and I'll come back to some of my thoughts on that in Round 2. But if you go to Slide 7 for a second, I don't know if you have any
information about this, and, again, this might be something in Round 2 I'll suggest. But were you able to or have you looked at repeat stays for individuals for the same MS-DRG? And I'm not just thinking about a 30-day readmission, because these are longstanding problems for people, right? So did somebody -- were they admitted for, you know, a mood disorder and then had another admission -- it could be any period of time, but seeing if people are having repeated stays for that?

   DR. FOUT: That's a good question. We haven't looked within MS-DRG, but we could.

   DR. JAFFERY: That's it for now. Thanks.

   MS. KELLEY: Lynn.

   MS. BARR: Great chapter. I'm really excited we're digging into this, and, you know, I have a lot of compassion for the beneficiaries that are in these institutions.

   A question about the data so I'm trying to understand. Is utilization declining, you know, for organic reasons, or is this tied to the economy? And because you were starting in 2016 where the economy is booming and, you know, you would think that that might have
a dampening effect on mental illness, is it -- do you have
data going back to 2000? Can you give us a better picture
of, you know, are we going to need more beds as the
recession increases, et cetera?

DR. FOUT: We have looked back to like 2011 and
maybe even prior to the beginning of the PPS, 2004. It has
been declining kind of consistently.

MS. BARR: It is a consistent decline?

DR. FOUT: Yeah.

MS. BARR: Any thoughts about why?

DR. FOUT: It's a great question.

MS. BARR: It's really interesting, because
certainly mental illness is not a flat thing.

DR. FOUT: Right.

MS. BARR: So I'm very curious about that. I'm
curious, too, about the profitability of the for-profit
IPFs. That seems a little concerning and possibly looks
like, you know, somebody's getting very creative and
entrepreneurial out there. And I was wondering who owns
these IPFs, you know, and is there -- do they have a
different patient profile? I'm particularly concerned
about how they're converting to, you know, an all-inclusive
rate and at that time their profitability is going up and
the drugs being reported are going down? And I'm, like,
what is going on there? So what are your thoughts there?

DR. FOUT: Yeah, all those are very similar
questions we had. There is a table in the chapter that
shows beneficiary characteristics by IPF type and
ownership, so you can see there are some differences in the
types of patients served by these different IPFs.

MS. BARR: Did that change in the last -- I was
wondering if you could look at just the for-profit IPF. Is
there something -- like, I mean, because there could be an
opportunity for us to create policy to block whatever the
heck is going on there -- right? -- if we understood it
really well. So if we could dig in more on what's
happening in that space.

DR. CHERNEW: So, yeah, I mean, some could be --
I agree, some could be a case-mix issue; some could be a
care delivery pattern issue, right, which --

MS. BARR: Right, but it's not happening to
everybody else, and so like they --

DR. CHERNEW: No; I understand.

MS. BARR: They've clearly identified an
opportunity.

DR. CHERNEW: I'll take that as [off microphone.]

I think that summarizes, Betty, where you are.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks. Really an excellent chapter, I think. I think you did a very systematic job of covering a lot of the different dimensions here. I have three questions. Hopefully it will be fairly short.

The first one, I promise I'm not trying to be cheeky here. I'm actually earnestly curious. We talk about the occupancy rates, and in some sense, I was kind of wondering what is a healthy occupancy rate. Like, what would we think is good? Because we cite on Slide 11 71 percent or so is low, 84 percent is high. Then we talk about the short-term acute-care hospitals, and they're even lower. And so just because we're using these adjectives of low and high, I was curious, do we have some kind of internal barometer of what we should be seeing in this sector? And how do we determine that?

DR. FOUT: That's a good question, Amol. That's why we put the occupancy rates from acute-care hospitals on there as kind of comparator. Whether we have a barometer,
I mean, I'm not sure. I can definitely look into that.

But, yeah, I think some of those highs and lows are somewhat subjective. And, remember, they're aggregates, too, so it does not mean that it's that at every single IPF.


The second question I had is on page 17 of the reading materials, in a couple of paragraphs you sort of describe the distribution across the different sectors, like for-profit, nonprofit, government freestanding, which is hospital, and then also just the total beds. And I think the general trend on the total beds, for example, was slight increase but generally stable. And what I was curious there is do we have a sense of what's happening across markets? I mean, you just mentioned, for example, that occupancy rates are going to vary by different facilities, which totally makes sense.

When we look at it at the market level or the geographic area level, do we see that there's some places where there's greater for-profit, freestanding entry and so the number of beds there is going up; whereas, in other
markets maybe we don't see that, and there's some closures, and we're actually seeing it going down? Is there a lot of geographic variation? I'm most interested in the total beds, but also curious about the composition.

DR. FOUT: Like just between urban and rural, I think the patterns are pretty similar. They're trending in the same direction for urban versus rural. We haven't looked in specific markets.

DR. NAVATHE: Okay. Thank you. And then the third question -- and I apologize if this was in the reading materials and I missed it. I did try to look for it. But can you just clarify for us how an IPF designates the all-inclusive conversion and whether there's requirements associated with that or what that process looks like?

DR. FOUT: So our understanding is that -- I mean, the all-inclusive rate designation, a lot of the hospitals have them, the government ones, had them for a very long time. And our understanding is that you aren't really supposed to switch from an all-inclusive rate -- sorry, from having a non-all-inclusive rate, meaning you have all the structure and the accounting structure to
allocate your costs to the different departments to an all-inclusive rate meaning you don't anymore. But we're seeing it on the cost reports, and that is a question that we've had, and we know that others have seen this and are looking into that as well with the processes for designating that.

But, I mean, I will note that we're looking at the cost reports -- kind of a checkmark on the cost report designating its all-inclusive rate. It might all this happened later and they changed, so we're going to continue to look at that. But we have the same question: What is the process for this?

DR. NAVATHE: Okay. So I guess the related follow-up question there is the reading material implied that there are facilities that are switching from non-inclusive to all-inclusive, so it does look like there's -- you kind of mentioned in your first part of your response that in some sense it may have been kind of a legacy designation and not necessarily intended from there to be switching across that. But that being said, there is switching going across that. Is that something that we have a sense of the quantification? And if not, is that something that we can do?
DR. FOUT: You mean the quantification of how many have switched or --

DR. NAVATHE: Yeah, over time --

DR. FOUT: Yes, and some of that is in the paper. It has increased in 2017 and 2018, which also coincided with when CMS really issued some transmittals and edits to the cost reports where they were going to reject it if they did not contain ancillary charges. So that happened about the same time.

DR. NAVATHE: Great. Thanks.

MS. KELLEY: Greg.

MR. POULSEN: This is an incredibly specific question, and I apologize if we don't know the answer to it. On the 190 days, I understand the difference between inpatient hospital-based facilities and others. What I didn't understand either in the reading or this -- and I couldn't find a quick answer to it -- is do days in a hospital-based IPF contribute to the 190?

DR. FOUT: They do not.

MR. POULSEN: They do not. So if you had 180 days in an inpatient -- or, sorry, a hospital-based inpatient facility, that would still not contribute; you'd
still have 190 days to count.

DR. FOUT: That's right.

MR. POULSEN: Thanks. That's, like I said, very specific, but interesting.

MS. KELLEY: Marge.

MS. GINSBURG: Interesting work, and we have a lot more to go, but that's very exciting.

On Slide 13, you mentioned that 35,000 beneficiaries have exhausted their 190 days. I was curious if we knew anything more about what happens to them. Do they stay there and get billed privately? Do they stay there and the facility eats it? Do they get transferred to a government facility? What happens to those that reach their limit? Do we know anything at all about that?

DR. FOUT: Yeah, that's a good question, and I think it will be part of our future analyses, looking at that. We got that data very recently, so we haven't really been able to dig in. But those are things that are on the top of our mind, too.

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks. This is really super work. I wanted to ask about Slide 14. It reads,
"Quality of care: Data provided by IPFs is limited." I feel like this is like an evergreen heading for MedPAC.

"Quality of care: Data provided by [blank] is limited," and insert your provider there. Ledia, I think you've used this template before.

[Laughter.]

DR. GRABOWSKI: I wanted to ask specifically about how do we improve the measure set, and my reading of the chapter was that we have these chart-based measures, and they're provider-reported, and we don't sort of trust those. And then there's these outcomes-based measures like hospitalizations, mortality is coming in terms of new measures. Are these -- the third bullet there, "providers must report patient-level results," is that the chart? And if not, like, where do we go, Ledia, to kind of get better measures here?

MS. TABOR: I think it's two things. One is I think the -- so the beginning of next summer -- it was voluntary this summer -- IPFs will have to report basically the chart information below the numerators and denominators that they've been report now. So I think it's going to add some validity to what's being reported. So I think that's
going to be a huge step.

And then I think there are opportunities to develop more outcomes measures, which CMS has said in the proposed rulemaking that they're working on, like the mortality measures, I think there are some patient-reported outcome measures, which are important. I know many Commissioners have supported it in the past. I think there's also patient experience measures.

I've heard from an IPF that we did a site visit with over the past years that they used HCAHPS. So I think it's not uncommon for IPFs to already be doing some kind of patient experience, but to have it be required and reported so that could be publicly reported I think would be valuable.

DR. GRABOWSKI: Just as a quick follow-on, I really like potentially the patient-reported outcomes, experience, maybe family -- there are a lot of possible measures there. And I don't know if this is a fair question or not, but are hospitalizations and mortality good -- do we know that they're good measures for this population? Like, how do we think about them? I know they're sort of the go-to's here, but are those the first
measures I would want to look at with an IPF?

MS. TABOR: I think readmissions has value, and, I mean, I don't -- I think we see differentiation across facilities on it, and the readmission rates are higher than they are for acute-care hospitals, for example, so I think it shows there's definitely opportunities for improvement. I guess as CMS continues to develop the measures on mortality, it could be that there's no variation, it's not reliable, you know, kind of all those things. But I can't kind of say without looking at the data results. But I think conceptually it's interesting.

DR. CHERNEW: Yeah, I just want to jump in and say one point on this which is relevant. This whole discussion is very facility-focused, what's happening in IPFs. It's not very patient-focused, and as was pointed out, these patients may go to other types of hospitals and get other types of care. So there's a version of quality measure what's happening in the IPF, but there's also a version of quality of care what's happening to people, and I hear across several of these clarifying questions that basic concern, which is sort of -- we're concerned about the people, and we're now in a conversation about one type
of facility that deals with them. So I think that's a theme that will come back, but certainly in the quality measure set issue, it's particularly relevant because -- for a range of other things.

I'm sorry. I didn't mean to jump in. Were you done, David?

DR. GRABOWSKI: Yes.

DR. CHERNEW: Okay. Dana.

MS. KELLEY: Scott.

DR. SARRAN: Yeah, somewhat expanding off of David and Mike's comments, I'm just so struck by the discordance between, on one hand, all the sort of troubling hints and reasons we would want to know more -- right? -- the whole for-profit freestanding piece, you know, which I think generates a lot of immediate concerns, the vulnerability of the population, the impacts on quality of life, and the obvious -- and people have known this for umpteen years -- need to think long term about outcomes. This is not seeing whether somebody's hip replacement was successful 30 days out. This is what's happening in their lives 180 and 360 days out. So we've got all that on the one hand; then on the other hand, all the things you report
that suggest CMS has not taken, at least until very
recently, the need for reasonable diligence with outcomes
very seriously. And, in fact, they may be backing off by
allowing these hospitals to go, you know, the route of all-
inclusive and, therefore, having less robust granular data.

So my question is: Do we have any insights into
why CMS has not been more rigorous in this space about
looking at outcomes? It just feels like something -- like
they've decided for some reason not to pursue it seriously.

MS. TABOR: I can say for the quality piece -- a
very hard question. I think we're challenged across the
Medicare program to look at outcomes because of things that
we talked about yesterday, like data limitations and how do
you track a patient kind of outside of the data that we
have. I don't know if anybody has something to add.

DR. CHERNEW: [Off microphone.]

MS. KELLEY: Mic.

DR. CHERNEW: Here's my interpretation of that
answer, Ledia. Tell me if I'm right. It's a very hard
thing to do, and we don't know exactly why they've decided
to put more or less resources into doing it. That might
not be that clarifying, and that might lead to a Round 2
comment, but at least in the clarifying sense, the answer is it's hard for us to say something about the motivations of CMS in what is an admittedly difficult area. Is that --

MS. TABOR: That's perfect. Thank you, Mike.

DR. CHERNEW: I'm sorry.

MS. TABOR: No, that was good.

DR. CHERNEW: I'm looking to see where Scott is in Round 2.

[Laughter.]

DR. CHERNEW: I can see he has a Round 2 face.

It's a face I'm learning to recognize.

[Laughter.]

MS. KELLEY: Cheryl.

DR. DAMBERG: I'm going to pile onto the measure conversation. I wholeheartedly agree with everything David pointed out. I think I'm sort of struggling with two things. So I recognize there's sort of a shortage of the types of measures we might want related to outcomes, but I always sort of feel like there's kind of a lack of precision when we sort of throw out the term "outcomes" without sort of saying what exactly we would sort of want to signal to Congress or CMS that they should be focused on
measuring. So I don't know whether there's any work we can
do to, you know, add a little bit more precision in that
space.

But I wondered, because I think you have sort of
this near-term charge of being able to try to assess
quality and quality differences, are there other claims-
based measures that you could be looking at? I don't think
I saw ED utilization on there because to me that would
maybe signal that something's going awry. And I did see
that there was, you know, medication continuation within
the 30-day period, but I'm assuming that these patients are
on longer-term medications, and whether we want to look
out, you know, 90 days, six months, really understand what
that profile looks like, you know, to try to manage their
conditions in an ambulatory space or in the home space.
And then, you know, potentially looking at whether there's
sort of excess ambulatory care utilization sort of in some
time period.

MS. TABOR: Those are good ideas. We can take it
back.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, I had two questions, one of them
also on the 190-day phenomenon. So we talked a little bit about what happens to the beneficiary. What happens to the facility? So if someone needs to be admitted, they have already exhausted the 190 lifetime limit. Does that just become uncompensated care then for the facility that admits them?

DR. FOUT: That's our understanding from conversations we've had.

DR. RYU: Okay. And there are no alternate kind of sources of funding, whether it is state or other?

DR. FOUT: I mean, that is possible. I don't know about that.

DR. RYU: And then the other question was around ER use. I think it is a significant setting where a decent amount of this care gets delivered. Is that envisioned to be part of the later meeting outpatient chapter or is that going to be covered in this hospital chapter?

DR. FOUT: It wouldn't be covered in this chapter, but you mean going to the ER?

DR. RYU: Just to understand it more.

DR. FOUT: Yeah, about ER use?

DR. RYU: Yeah.
DR. FOUT: Yeah. That's a good point. It could be in this chapter, yeah.

MS. KELLEY: Kenny.

MR. KAN: This is great work, very rich data.

On page 10, Slide 10, I'm really surprised by the fact that the unique beneficiaries, that's just a big jump of 18 percent, and then the Medicare spend, you know, only went down by 13 percent, suggesting that could be an acuity issue possibly. So I know that this report will be refreshed with 2020 and 2021 data, so a couple of things is I'd be very curious to see what is the impact of COVID over time, as we learn more about this.

And also, I'm wondering, on page 10, can we show how this varies between for-profit, nonprofit, and government, the statistics here? That would be very helpful. Thank you.

MS. KELLEY: Wayne.

DR. RILEY: Thank you, Betty and Ledia, for this very sobering analysis of a very tough issue that continues to perplex a lot of us in terms of psychiatric resources for Medicare beneficiaries.

Going back to Slide 6, you point out that the
beneficiaries who tend to be the most affected, vis-à-vis the IPFs, are Black beneficiaries. Can we assume by inference then that they are a significant portion of that 30-plus percent who have exceeded the cap? Do we have any specific data on that because I would flag it as another dimension of health disparity.

DR. FOUT: That's a great point and we will look into that when we dig into the 190-day limit.

DR. CHERNEW: That is the end of Round 1.

MS. KELLEY: No, I have two more actually. Lynn, go ahead.

MS. BARR: Just continuing on the quality recommendations, following on Cheryl. I'd be interested in seeing whether or not they actually saw a therapist, you know, got some ambulatory care, so it's not about overuse of inappropriate ambulatory care but actually that would be a good clean space measure.

And it seems to me like the outcomes that we're really looking for is that people can live a reasonable life. So do they have a home? I mean, so there are ways of looking at that as well. Thank you.

MS. KELLEY: Okay. And I have two round 1
questions from Larry. The first is, can you say a bit more about the advantages and disadvantages of moving to all-inclusive status and about the advantages and disadvantages of not reporting ancillary costs, even when the hospital is not all-inclusive?

DR. FOUT: Those are good questions and I think we're going to get some better answers for those when we do interviews with IPFs in the fall.

MS. KELLEY: Okay. And his other question is, can an IPF refuse to admit a patient, assuming the IPF doesn't have its own ED?

DR. FOUT: Yes. If they don't have an ED, they can refuse a patient.

DR. NAVATHE: Because EMTALA doesn't apply then.

MS. KELLEY: Okay. That's the end of Round 1.

DR. CHERNEW: Okay. That was a pretty comprehensive Round 1, and I have a reasonable sense, I think, of where people are going. I'm going to summarize it. We have a bunch of Round 2 so I'll summarize it quickly.

There is a ton of enthusiasm and there are a lot of issues. So just a little stage setting. I'm going to
1 turn to Jim in a second to make sure that I get my stage
2 setting right.

3 We have been asked to do an information chapter,
4 and we will do an informational chapter. There are a lot
5 of issues that the information that is reported in that
6 chapter will raise, and one of the questions that we have
7 to address is how much further to push down. So as you saw
8 in the mailing, we are not going to do a vote. There is a
9 lot of this that feels, for the new Commissioners, a lot of
10 this feels like a December discussion and it just doesn't
11 get us to a December point. In fact, in many cases there
12 are more issues than typically an update chapter would
13 have. There are issues of a cap, like on cap that came up,
14 a bunch of these things.

15 So as we go through Round 2, understand that one
16 of the things I'm trying to sort -- and again, almost I'm
17 warning Jim -- is how far down that path we want to go,
18 just saying, as my earlier comment indicated, this issue of
19 care for patients with psychiatric illnesses is very
20 important and growing in importance.

21 And so I'm pretty sympathetic to pushing along
22 those lines, but we have to figure out where we get into
doing that. Right now the chapter that we're going to present is likely going to be an informational chapter, but we certainly are open to sort of figuring more and which directions, depending on how the conversation is about to go.

Jim?

DR. MATHEWS: I would agree with that. Given the very expansive nature of what we've been asked to do here, it is going to be a full-time job for Betty and Ledia, and Ledia has many full-time jobs at this point, simply to comply with the terms of the request. And in the course of this work we no doubt will identify policy issues that warrant some attention, and we can take those into consideration for future work if there is interest among the Commissioners in doing so.

But I think the drill for this cycle is going to be report out what we have been asked to do, and to the extent things warrant further analysis it is going to be a next cycle kind of thing.


DR. JAFFERY: Great. Thanks, and I appreciate, Mike and Jim, that set-up. This has been great to dig into
this conversation. Clearly, as Mike said, there's a lot of enthusiasm. We all acknowledge and understand the growing recognition of the need for paying attention to mental illness, that the fact that we all had questions about this 190-day limit policy that seems kind of crazy right now but in 1965 probably made a lot of sense to people. I think it really speaks to the fact that we have come a long way, but we have a lot to go.

And so I'll try and focus some comments about things that I think could push us down towards work that we could do this cycle that might address the mandated report but also speak to maybe things we could do in subsequent cycles. And I don't approach this thinking about it like a December discussion at all.

I'm really glad that part of the plan for this cycle is to look at some of the use for outpatient behavioral health services because as you know and as people have already commented on, this is not just an acute episode issue for people who are coming in with a need and being taken care of in X number of days in an inpatient facility.

This is really about a spectrum of care that
spans inpatient and outpatient therapy, and many of these conditions that are treated actually, in fact, have that spectrum of inpatient hospitalization to intensive outpatient, and then individualized outpatient. So understanding those patterns of use for beneficiaries is going to be extremely important for us to understand, are people getting needs met.

As we think about the capacity issue, it is very difficult to think about what the right goals are in some senses, and I think about are our treatment regimens even adequate. So, you know, there are evidence-based approaches to certain things. For example, a substance use disorder, we know that 90 days treatment -- and again, this is not an inpatient treatment. It is a spectrum of inpatient and intensive outpatient and whatnot, depending on individualized needs -- has much better outcomes than shorter treatment regimens. And yet a lot of coverage for people in the commercial and in other worlds limits things to 28 days.

And so understanding what people are actually getting and then what the outcomes are, and as Scott mentioned, this is not a 30-day, are people ambulating
after a hip surgery. This is, are people at 6 months, in
12 months, and even 18 and 24 months, are they living
independently, have they been readmitted for their whatever
MS-DRG they had or are they resuming use of a substance.
So I think that's going to be really important
for us to think about, and it is going to stretch us to
think about it in ways that we haven't necessarily had to
in other areas.

But again, thinking even in terms of this
capacity, I guess thinking more about are we looking at the
same metrics that we look at in other sectors. And there
is a very different kind of supply and demand dynamic going
on here.

With that I'll just finish up with a couple of
ideas for the analysis, and I'm probably just being
redundant here, but again, thinking about this in terms of
a spectrum, and maybe it's almost an episode of care that
includes that outpatient. And I'm not thinking about a
payment model here yet in a bundle. I'm thinking about
understanding what happens in the course of treatment for
somebody.

I had talked about repeat stays. Marge had
mentioned what happens after the 190-day limit. That is going to be a really important thing for us to understand. Thirty-five or 45,000 people who are at that or exceed it or are close to it, are they coming back in? And that's obviously a huge cost and quality issue.

So I'll leave it at that, but I'm very excited about this. I think it's long overdue, clearly, and I appreciate you guys putting all this effort into it. Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thanks very much. I will echo Jonathan's comments. I think this is a great and sobering chapter, and I'm glad we're looking into it. I appreciate Mike and Jim's comments too about scope and thinking about what it is we've been asked to do and what we could do.

Although I think that everyone has very nicely raised the days limit and how old that policy is and how much things have changed, I think the report already starts to highlight that. I think it will do even more than that in the next iterations.

And it might be nice if we could make a strong statement of some kind, even if it's not a recommendation,
that this needs to probably be revisited if that's where the data lead us.

But thank you so much for this work. I think it's absolutely incredible and very important.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. I really do appreciate the team digging into this analysis. It's really a very worthwhile discussion, very important work, and thanks to Mike and Jim for kind of level-setting what the objectives are here, that this is really informational and hopefully will set the stage for future work in future cycles.

I had two broad-based comments. One is I guess a recurring theme about sort of the lack of data. And I would say that for this particular space it is rather disappointing that we don't have the data capture that is really necessary.

I would argue that just simply reporting out numerator-denominator information is insufficient and rudimentary from a quality perspective. You know, during my day job I would say that one of the things that I'm challenged with, and I think others are as well, with
regards to improving the quality of care within inpatient psychiatric facilities, is the need for risk adjustment models. And so just the numerator-denominator question doesn't really get to it because you really want to understand adjusted length of stay, adjustments with regards to readmissions, and it's very difficult to do that without the risk adjustment models.

So I would say in the informational report I would strongly encourage that that is a need, that the data capture is very important here. Certainly for acute care hospitals there's enough data, enough risk adjustment models that despite the challenge with data capture we've been able to move quality and safety efforts along. I think within mental health that there is a great deal of opportunity to improve the measurement sets here, even for things like the use of restraints. You know, there are certain diagnostic categories where restraints are utilized at a higher rate than others, and it's helpful to understand the differences.

I would also say that the DRG model is sort of insufficient for risk adjustment models because there are many different types of diagnostic categories within that.
So having 74 percent of the patients just lumped into a single DRG, that doesn't present the granularity that is necessary for risk adjustment models. So I would strongly really advocate for that.

The second thing, I think many of us found the 190-day lifetime limit and the 35,000 beneficiaries that have exceeded that limit to be a rather interesting measure. I think for me personally it triggered the fact that we're very much focused on psychiatric facilities and we're not thinking, I think, enough about preventative services as well.

Looking back at the ask by the House Ways and Means Committee it appears that they also want us to look at other outpatient services as well. And I really hate to add onto the work, because I know this is an enormous undertaking in terms of the informational report. But I do think that it's important in order to understand psychiatric facilities that we understand the entirety of the mental health delivery system that exists.

And by that the report really doesn't mention residential treatment centers. Some specialize in adults. Some specialize in pediatrics. Some specialize in eating disorders.
disorders. Some specialize in addiction services. But understanding county by county whether inpatient psychiatric facilities exist and what are the resources available in terms of residential treatment facilities could be important in understanding how to transition individuals back into the community successfully without readmissions and other impacts.

The same is also true for partial hospitalization programs, where they get the intensive resources of daytime hospital services but allowed to go home or even back to some sort of community group setting during the overnight hours.

Intensive outpatient treatment services is also not mentioned in the report, and this could be very helpful for individuals that have dual diagnosis outside of mental health in order to keep them within the community.

And some counties do have mobile crisis units as well so that they can present with a few crisis at the scene, help with the escalation procedures, decide appropriate triage of the individuals.

And so I think understanding all of these different models that exist within a community can help us
understand how those that are suffering from mental health
are actually expertly managed within their communities.

And so another important sort of quality measure
is disposition. So if they don't have the breadth of
services, like the ones that I mentioned, then you are
going to have an increase in readmissions, ED visits, and
unfortunately, suicide attempts or actual suicides.

And so I think that we have to look at the whole
model holistically and not just tease out the inpatient
facilities.

Otherwise, this has really been just a great
attempt to take a very difficult issue and try to wrap your
mind around, and I'm looking forward to future iterations
of the work.

MS. KELLEY: Greg.

MR. POULSEN: I would add to the compliments
regarding the great work. This is worthy of the hard work
that's gone into it.

I agree with everything that Robert said, which
is going to seem awkward when I'm about to do something you
said none, and don't just look at numerators and
denominators.
But in this case some work that we did a few years ago, I think it was 2015 and 2016, we looked at people who had gone to an emergency room, about a million people, was the group that we looked at, that had gone to an emergency room for a mental health condition, an acute mental health condition, and had subsequently been admitted to one of these type of hospitals.

So I think -- I was trying to remember this, but I think it was for hospital-based IPFs. Those would all be not, not for profit, nine freestanding IPFs that were for-profit and one freestanding IPF that was not for profit.

And then we looked at the 180-day, within 180-day time, the number who would have then gone back to an ER for an acute mental health need or been readmitted, one of the two, either of the two.

And what we saw was, I think, deeply troubling. It impacted what we did with our panels, but what we saw was more than a 3:1 variation between -- based on which facility they had gone to, whether they were likely to be readmitted or to end up in an ED with an acute episode again. And, you know, 3 or almost 4:1 difference in outcomes for a different type of condition, a readmission
for, you know, fill in the blank. And I think we'd be
stunned by that, but sadly, we weren't stunned by it when
it was those mental health numbers.

And I think that what you all found, looking at
the -- at least what appears to be a lack of interventions
and ancillary services and drug use and other things within
those admissions, within the admission structure, I think
may be indicative of that.

So my thought would simply be to say we should
not underestimate the magnitude of the quality differences
that exist, and it is well worth looking into that more
deeply because more than 3:1 if, in fact, our experience is
representative of the country is a remarkable variation,
and yet we're spending very similar amounts between those
places but potentially getting a wildly different value for
it, so thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much for this fabulous
and sobering work, and I really appreciate the comments of
the staff as well as the Commissioners.

I just want to make a few points. My major
comments were actually addressed largely in Round 1 with
the issues of the quality reporting that's summarized on page 41 that David, Scott, Cheryl, Lynn, Greg, and others have talked about.

I certainly support the exploration of the whole continuum that's been brought up by Robert and Jon, particularly, but I wanted to understand something that Kenny said sort of in passing in Round 1 is the differences between the different types.

I mean, the magnitude of the profitability in one's group versus the other really brings to me questions about what are the staffing ratios, what's the turnover, what's the skill mix. So just like in our previous conversations, I think it's really important, to the extent that it's possible without being too laborious, think about what's happening within that facility, you know, at the working service.

The other thing I just wanted to comment, something that David said very briefly, I do think some measures that are used in other settings are applicable here, but others -- for example, the family experience, I think, is profoundly important in this particular setting, and how that can be captured would be very valuable.
Thank you so much for this fabulous work, and I look forward to our continuing efforts.

MS. KELLEY: Scott.

DR. SARRAN: So, in terms of the context, Mike and Jim, that you set up, I wonder if what we should do is just call out that, as we tried to put together an informational chapter, we have some glaring holes in that. I've thought about my short list of what I would -- my suggestion what we'd prioritize and include in that. First, that we need more granular data, and I would prioritize among that that we are seriously concerned by the all-inclusive hospitals and the way that that makes some of the data, the key data opaque and embrace that as a concern.

And then the lumping of the mood and non-mood psychosis just clinically strikes me as that's just dumping two things that may be completely different into one bucket, and that's at a minimum worth some exploration.

Then the second overall thing I'd suggest we raise is that we need to think about this in a much more patient-centric, beneficiary-centric fashion, and that's come up in the comments. And the ways I would
operationalize that would be that risk adjustment. This is a space that cries out for risk adjustment, inclusive of it, at a minimum social determinants of health and at a minimum dual diagnoses, and those would be my top priority stuff for risk adjustment.

And then that we need to capture over time a much more lengthy time period, the full range of inpatient and outpatient services. That would be my short list of what we tee up in the -- "Hey, we tried to do a good job of this, but we're missing some stuff that we need."

MS. KELLEY: Jaewon.

DR. RYU: Yeah, a few points. And I agree with Scott's framing. I think that's about right, and I agree with a lot of Robert's comments. That's where I struggle as well. I think this is an area that's tough to confine because it spills over into so many other areas.

And I think the interplay between some of these settings is important to at least note, if not dig into the extent feasible. The categories I thought were, yes, inpatient, but also how it interplays with the outpatient availability of services. And I think you're going to get to that in the future meetings section, but I think there
is a correlation. Subpar access on the outpatient side,
I'm pretty sure that's got a spillover effect on increasing
inpatient need and demand.

But I think we should also make sure we don't
lose sight of the emergency room because I think most ERs
across the country, a good portion of psychiatric care is
actually delivered there, and it doesn't really show up as
an actual admission. Admission rights may be south of 10
percent, but an awful lot of folks may even be boarding for
multiple days, where functionally it resembles an
admission. So I think it's important to understand that.

The other is I think this impacts the work that
we had yesterday with safety net and LIS. If you look at
your Slide 6 -- I think it was Slide 6 -- on this deck, it
had LIS significantly more likely to be admitted inpatient
for psychiatric disorders, and I think there is a
connection point there that might be worth calling out.

A couple other points. On Slide 11, the
occupancy rates do suggest that there's some availability.
It would be helpful to understand that because, again, if
you go to most ERs across the country, you'll see handfuls
of patients boarding in the ER waiting for placement for an
inpatient psych bed, and those two things seem to be a disconnect that I can't reconcile.

And then the last point is around digging in on why the for-profits have higher Medicare margins. I just don't understand exactly what that might be due to even within a given category. So, within the freestanding, their margins are significantly higher. It would just be helpful to understand why we believe that's true.

MS. KELLEY: Cheryl.

DR. DAMBERG: This is excellent work, and I applaud the staff for all of your effort in this regard. Very illuminating.

It's clear from the comments of the Commissioners that there's, you know, more that we want to know and try to unpack, and I recognize we probably won't be able to get it all done in this particular chapter. And so I think it would be good to spotlight the areas where we'd like to see more work done.

You know, I'm in total agreement with Scott's framing, and I think sort of the real challenge that others have spotlighted is, you know, this isn't just about the inpatient admission. This is about comprehensive care
over, say, course of a year in trying to understand sort of the trajectories that these patients are on and how they get managed in trying to get to what I would call a much better integrated delivery system for managing mental health care.

I guess in terms of some of the things, as data permits, I would add to the list of unpacking. I do think it would be helpful to try to break down any of these statistics, particularly on the quality measurement side, by, say, duals, non-duals, race and ethnicity, and so on, again, to the extent that you can do that.

And I am also interested in trying to understand the relationship between these profit margins and quality performance, and I think it starts to channel some of what Betty's signaling in terms of staffing and other things that may be going on that could affect quality of care.

MS. KELLEY: David?

DR. GRABOWSKI: Great. Thanks again for this really important work.

Scott, I also appreciated your framing of kind of identifying those glaring holes. I would point to three. The first, I just want to double down on Jonathan's comment
around the 190-day limit and just that being outdated, and we need to really rethink that and given sort of the context today.

The second is Robert's point about IPFs being kind of part of a bigger continuum, and that's so important. And I'm glad you raised that, Robert, and I think it's hard to view this chapter in this broader context.

The third comment is really one a lot of us touched on, and that's quality. And I think we could really double-down here in the chapter of suggesting better data, better measures, better risk adjustment, as it came up with Robert and others.

This idea of a patient experience, family experience measures, once again, I think are so central here.

I think there's an opportunity here to signal to CMS and to the Congress kind of what sets of measures would really work for this population.

Thanks again for this great work.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Ledia and Betty.
So, obviously, a super important population and great work that you're doing here.

Largely speaking, I'll keep my comments pretty quick and high level because I think they're largely echoing what other folks have already said.

I think one point, the Round 1 question I'd ask, it would be helpful to understand something about the geographic variation in these trends. I suspect it could vary, but maybe it doesn't.

I think, as many have pointed out, it would be helpful to understand the type of care, the case mix, the types of patients, et cetera, scope of service at the for-profit and the freestanding.

I agree with Jonathan, David, Scott, Robert, and so the whole group about quality, about the 190-day piece. I think one thing that's helpful to think about, I think, as a framing in some sense around the system of care and the fact that there is an outpatient system that's related to inpatient is almost thinking a little bit conceptually about what is the analogy here to an ambulatory care-sensitive condition type of admission, because I think that's kind of the spirit of where we want to get in terms
of thinking about what the outpatient sector should look like and how that relationship is.

In part, understanding that we have -- being with constraints, I'm not forcefully suggesting this, but I wonder if we look at the commercial sector and/or the Medicaid-only sector, if that would help us understand a little bit more of what's happening here in terms of some of the interface and some of the dynamics.

But thank you very much for the work, and I agree really wholeheartedly with the other Commissioners'

MS. KELLEY: Okay. I have a Round 2 comments from Larry.

Two points. First, for clinicians in ambulatory care, getting timely and useful psychiatric help for Medicare patients with serious psychiatric problems seems almost hopeless.

Second, Robert is right. For the seriously mentally ill, various types of care in the community apart from direct clinical care from a mental health professional are incredibly important. So we can't really address the problem without understanding these, which as Robert said
are quite different from and go way beyond 1:1 clinical care. But I recognize that getting into these other services would be an enormously difficult task, but at least we should flag this area significantly in the report.

There isn't a great deal an ambulatory mental health clinician can do for a homeless person with interacting medical and social needs. And he also adds it will be particularly important to get a sense of the extent of cherry-picking that's going on in the for-profits.

And, lastly, I have Lynn with a Round 2 comment.

MS. BARR: Thank you. I really support this work, and you guys got a tremendous start to it.

I think that as we think about -- I've got to find my note here -- about the capacity issue, I think there is something here. I hear it all the time: "I can't find beds." And if we look at the profitability of the nonprofit hospitals -- we're shocked by the profitability of the for-profit IPFs. We should be equally shocked at the negative 20 percent margin of the nonprofit hospitals. Those are safety-net hospitals that have set up these facilities because there's no place else for these patients to go. So they're taking it -- I mean, basically, a 20

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percent hit on behalf of this population.
And I wonder when we talk about available beds,
are we talking about staffed beds, or are we just talking
about beds? So we have a number of beds in a cost report,
but we don’t know how many nurses there are, right? And
with staffing, the issue it is, you know, I could see how
for-profit hospitals are going to be more inclined to admit
patients that require less staffing, right, and that’s
going to increase the burden on our nonprofit.

So I think it’s really important for us to
understand the true capacity issues. We’re pretty high on
bed utilization there, and it would seem obvious to me that
that 20 percent is not actually available, and so I’d like
to see a little bit more understanding of that.

I don’t know how much we can do on this, but
maybe this is several years of work for the Commission.

Thank you.

DR. CHERNEW: Several years of important work.

Sometimes when we have these sessions, Jim and I
go back to debrief, and we’re trying to balance different
Commissioner views on things and figure out how we’re going
to thread the needle, and I think you could see some of
that in certain things yesterday. This is actually not one of those cases.

We had a really rich discussion of unbelievable agreement, both in terms of the enthusiasm and I think the substance.

So I think that, Betty, you did a terrific job. Ledia, great job. There's obviously a lot of nodding heads here, and so I look forward to where we go with this. We will figure that out. There's obviously a lot of places, and there's constraints of what we can do, but I think we should just go with "thank you." I think all those themes that you've heard resonated quite well, so we're good.

We have -- [speaking off mic].

We're going to take a five-minute break. My camera might even still be off. I apologize for those of you -- no one actually ever cares about seeing me, so that's fine.

[Laughter.]

DR. CHERNEW: I was, in fact, here for all of those of you that were wondering why my camera was off. But we are going to take a five-minute break, which I think is good, and we'll transition -- that just
makes is smoother, and we'll transition to Part D drug stuff.

And, again, thanks a lot.

[Recess.]

DR. CHERNEW: Hi, everybody. We are back.

Thanks for joining us. We are going to jump into the issue of Part D drugs and rebates. I am not going to take much more time for the intro. I am going to turn it over to Tara, Shinobu, and Rachel, and, Tara, I think you're starting. Go ahead.

MS. HAYES: Thank you.

Good morning. In this session, we will describe our team's continued work looking at proprietary pricing data on Part D drug rebates and discounts that Congress recently made available to the Commission. This follows presentations we made in October 2021 and this past April, and this work may become part of a chapter in the Commission's June 2023 report to the Congress.

Before we get started, we'd like to thank Corinna Cline for her help with this work. As a reminder to the audience, you can download a PDF version of these slides in the handouts section of the control panel at the right-hand
In 2020, the sum of all Part D spending at the pharmacy -- what we refer to as "gross spending" -- was nearly $200 billion. However, drug manufacturers and pharmacies provided mandated and negotiated price concessions, and net spending was about one-third lower.

The light green part of the bar in this chart is the amount that Part D requires brand manufacturers to provide for prescriptions in the coverage-gap phase of the benefit (about 6 percent of gross spending). The last portion (other DIR) is mostly fees paid by pharmacies to plans after the point of sale.

But the data we're focusing on now are the rebates negotiated between plan sponsors' PBMs and drug manufacturers, which represent 22 percent of gross spending, as of 2020, and reduce plans' costs of providing pharmacy benefits.

You've seen this slide of a simple pharmacy transaction before. When a beneficiary fills a prescription, she pays the pharmacy her cost sharing and the pharmacy bills her plan sponsor and its PBM for an amount they've agreed upon ahead of time.
After the prescription has been filled, if the plan sponsor has a rebate contract with the drug's manufacturer, the sponsor's PBM collects a rebate. The sponsor and PBM may also pay or collect a fee from network pharmacies based on contingent payment agreements, referred to as "pharmacy DIR." (Though, as of 2023, CMS is putting in place a rule that may lead to less pharmacy DIR.)

The thing to note here is that the price of a prescription at the point of sale does not reflect final costs to a plan because there are rebates and fees that take place after the transaction.

There are some inherent tradeoffs to bear in mind about how plan sponsors use DIR. First, note that because there are price concessions against the cost of providing Part D benefits, CMS keeps a portion of DIR to reflect the fact that Medicare pays a lot in reinsurance -- 80 percent of the cost of prescriptions filled in the catastrophic phase. Plan sponsors typically use the remaining DIR to keep their premiums lower than they would be otherwise. Lower premiums benefit every enrollee in the plan, as well as Medicare because the program subsidizes enrollee premiums.
However, there are tradeoffs. Part D plans charge coinsurance for prescriptions in certain phases of the benefit and for specialty-tier drugs. Because that coinsurance is a percentage of the price at the pharmacy before rebates, it's a higher amount of cost sharing that the beneficiary has to pay, or that Medicare pays on behalf of low-income enrollees. Sometimes that amount can be greater than plans' net cost for the drug. Further, higher cost sharing moves beneficiaries more quickly into the catastrophic phase of the benefit where Medicare pays 80 percent of the costs.

MS. SUZUKI: Factors that explain the rapid growth in DIR include certain features of Part D that provide incentives for plan sponsors to maximize rebates. Competition for enrollees has turned plans' focus on keeping premiums low. Changes in law and patterns of drug use have reduced sponsors' share of financial risk. The figure on the right shows that in 2007, plans were at risk for 75 percent of the basic benefit costs. By 2020, that share had declined to 37 percent. The flip side of that is that Medicare and, therefore, taxpayers are at risk for over 60 percent of the benefit costs.
Not all drugs receive rebates, and rebates aren't uniform across drug classes. To get a better understanding of circumstances around the use of rebates, we examined three drug classes as case studies: asthma and COPD medications, insulin, and TNF inhibitors for autoimmune conditions. Later in this presentation, Tara will discuss one of the case studies in more detail.

At a high level, for all three classes we found a high degree of competition among brands, but little or no generic entry. Gross prices at the pharmacy grew, and competition played out through rebates on somewhat different trajectories. Asthma drugs and insulin had larger rebates in percentage terms than TNF inhibitors, which may be due to their larger patient populations, a lower price point, or greater number of competing products than TNF inhibitors.

At the same time, consolidation among plan sponsors and vertical integration of the largest sponsors with PBMs have given those organizations bargaining leverage to negotiate more DIR.

In our analysis of the 2020 DIR data, we examined 30 brand name drugs selected from 10 categories of drugs
with a varying degree of competition among brand name products shown on the slide.

These categories were selected from drug classes with very different rebates. Average rebate ranged from less than 10 percent for antineoplastics to more than 50 percent for diabetic therapies.

Because rebates are not attached to specific claims, our analysis used the average dollar amount per standardized prescription calculated for each product for each plan.

Rebates can vary due to many factors, but we wanted to quickly go over how differences in organizational structure could affect variation we observe in the DIR data. For example, large sponsors use their own PBMs while many smaller sponsors use PBMs owned by large sponsors.

In this hypothetical setting, we have one large plan sponsor (sponsor A) that operates its own plans and serves as the PBM for other plan sponsors through its PBM XYZ.

In this example, PBM XYZ administers multiple formularies -- one for sponsor A and two each for the other two smaller sponsors.
A PBM could leverage their market share and negotiate across all of their Part D clients. For some products, the PBM may customize their rebate negotiation for each sponsor. Alternatively, because formularies are key to rebate negotiations, there may be a separate negotiation for each formulary.

But plan sponsors must report DIR at the individual plan level, which requires sponsors to allocate the DIR across their individual plans. So, at the most granular level, we looked at how rebates varied across plans. But in addition, we tried to organize the data analysis at levels of aggregation that were more likely to be reflective of the actual rebate negotiation.

First, and maybe not surprisingly, we found that rebates received for the same product can vary widely.

Among the six largest plan sponsors, the median rebate for one product differed by as much as two and a half times.

We also found that rebates for a given product can vary widely even among plans operated by the same sponsor.

Large sponsors tend to use multiple formularies,
often to distinguish between basic and enhanced benefits,
or to tailor benefits to specific populations, such as LIS enrollees.

In general, manufacturers pay larger rebates for a formulary position that gives them advantage over their competition in winning market share.

Given the importance of formularies in rebate negotiations, the use of different formularies could explain why rebates sometimes vary widely even among same sponsor's plans.

When we compared rebates for a given product among plans that used the same formulary, we found that plans using the same formulary tended to receive similar rebates, but we also found instances where large differences remained.

The extent of the variation differed across plan sponsors, individual formularies, and by product.

This means that, in some cases, the net-of-rebate cost of a given product may vary widely even among plans using the same formulary. And this also has implications for cost sharing paid by beneficiaries and Medicare on behalf of LIS enrollees, which we'll discuss next.
For products with relatively high rebates, cost sharing can be a much higher share of the plans' costs than the amount suggested by the benefit design. For the six largest plan sponsors, average cost sharing for some products often exceeded 50 percent of plans' costs after accounting for rebates, or net costs.

In some cases, cost sharing exceeded plans' total net costs, meaning that, in those instances: plans did not incur any benefit costs for these prescriptions, and beneficiaries and Medicare's low-income subsidy paid more than the total cost of the drug.

In many instances, the highest cost sharing involved LIS enrollees, where Medicare paid most of the cost sharing.

MS. HAYES: Now we will focus on some of our findings related to asthma products, a class in which rebates are estimated to have grown substantially, from roughly 30 percent in 2016 to between 40 and 49 percent in 2020.

The findings presented here provide a snapshot of some of the variation Shinobu discussed.

First, some background. While inhalers have been
widely available for decades, brand name products continue
to dominate the market. Over the past 70 years, many new
types of inhalers have been introduced, and there are now
hundreds of drug-device combinations to treat respiratory
diseases. In six of the ten subclasses of asthma products,
however, brand name products accounted for 75 percent or
more of Part D claims in that class in 2020.

There are two key regulatory hurdles that have
slowed generic entry in the asthma market. First, inhalers
are drug-device combination products which makes it more
difficult for generics to gain approval since both the drug
and delivery mechanism must undergo regulatory approval.

Further, manufacturers of combination products
can patent both the drug and device, increasing
opportunities to extend their market exclusivities.

A study found that among the 62 inhalers approved
between 1986 and 2020, there was a median of more than 8
patents per inhaler, and 53 of these 62 products were brand
name rather than generic.

The lack of generic competition in the market has
significant cost implications for the Medicare program and
beneficiaries. Let's consider one subclass: SMART
therapies (or single maintenance and reliever therapies), which is arguably the most competitive. SMART therapies combine a quick-acting inhaled corticosteroid with a long-acting beta agonist. This chart shows products from this class in 2020, plotting each product's price relative to its share of total claims. Three of the top four asthma medicines in Part D by gross sales were SMART therapies. Each of these products had gross sales over $1 billion that year and had been on the market between 7 and 20 years. Generics have only recently come to market, and all but one of these generics are authorized generics.

Notice that the generics, grouped in the bottom left, have much lower costs but very little market share. Despite this direct competition, gross spending per claim for each branded product has increased at an average annual growth rate of roughly 8 percent over the past decade. This growth in prices indicates list prices are not the basis for competition among these products. It appears, instead, the competition has taken the form of post-sale rebates, which are now some of the largest among all drug classes in Part D.

Formulary coverage decisions by plan sponsors
also suggest rebates are driving competition. An outside study examining coverage and costs for inhaler products across seven subclasses in Part D found nearly all plans in 2015 covered at least one product in all classes, though the product with the lowest total point-of-sale cost did not always have the highest rate of coverage, as shown here. In the chart, the bars show the average monthly cost at the pharmacy for various asthma products in different subclasses, with the gray portion showing beneficiary out-of-pocket costs and the blue, the cost to insurers. The lines mark the share of plans covering each product on their formulary. Notice that plans were much more likely to cover Proair, with 92 percent of plans covering, than Ventolin, which just 56 percent covered, despite Proair costing insurers twice as much as Ventolin on average, before rebates.

The same was true among inhaled corticosteroids: QVAR had the highest coverage rate despite the other four products in that class having lower point-of-sale costs for the insurer.

While we cannot know for sure why a plan sponsor would be more likely to cover a product with a higher cost
to them, one plausible explanation is that such products
are providing insurers with post-sale rebates to offset the
additional cost.

As Shinobu noted earlier, when plan sponsors
prefer products with high rebates, cost sharing can make up
a larger share of the drug's net costs.

This graph shows, for the six largest plan
sponsors, enrollee cost sharing for a SMART therapy product
as a share of plans' costs net of manufacturer rebates.
Plan sponsors A through F are arrayed in no particular
order. Each vertical line reflects the distribution of
cost sharing across all plans offered by each sponsor.
For example, median cost sharing across plans
operated by sponsor A was 32 percent (denoted by the orange
square) that is 32 percent of net costs, compared with 48
percent for enrollees in a plan at the 90th percentile of
the distribution.

For every other case shown here, median cost
sharing was greater than 50 percent of the plan's net
costs. The yellow dotted line shows where costs sharing
exceeds 100 percent. As you can see, many sponsors had
some plans with cost sharing above the yellow line. For
example, plan sponsor B had plans with cost sharing that was 168 percent of its net cost of the drug.

As Shinobu noted earlier, in these instances, plans would bear no cost for that product and may even earn a profit when it is purchased. We found similar patterns for other products.

Our initial analysis of the DIR data found wide variation in manufacturer rebates obtained by plans, including among plans using the same formulary.

For highly rebated drugs, beneficiary cost sharing can exceed plans' net costs.

Our case studies illustrate that what contributes to large rebates may vary widely across drug classes and products and likely evolves over time. Because of differences in how plan sponsors are organized and differences in the market dynamics of specific drug classes, it is hard to predict what we might expect each plan sponsor to receive in rebates.

We would be remiss, however, to not acknowledge the fact that the landscape is changing and the drug pricing environment will be very different in a few years given the recent passage of the Inflation Reduction Act.
This law included a redesign of the Part D benefit that will cap beneficiary out-of-pocket costs, increase insurer liability, reduce Medicare reinsurance, and change the amount owed by drug manufacturers in mandatory discounts.

The law also included inflation penalties which will require drug manufacturers to pay rebates to the Medicare program for any growth in prices faster than the rate of inflation.

Additionally, the law provides new authority for the Secretary of Health and Human Services to negotiate prices for some drugs.

Each of these changes are likely to affect manufacturers' pricing decisions which will impact the availability and size of rebates. Our DIR analysis will provide a baseline for evaluating how these major policy changes affect rebates.

For our next presentation, we plan to analyze data from other years to better understand the relationship between rebates and changes in the competitive dynamics of a product class. We also plan to examine rebates for drugs affected by specific policies such as protected classes or specialty-tier drugs. In all of our work, we will continue
to focus on understanding the potential implications for beneficiaries and Medicare program spending. In your discussion, aside from any questions, of course, we would like to hear other ideas for analysis of the DIR data.

And now we'll turn it back over to Mike.

DR. CHERNEW: Great. Before we do Round 1, I think Jim wants to say something.

DR. MATHEWS: Yes. Just to clarify for the audience who's tuning in to this presentation, Slide 14 presents some product-specific information on rebates, and I just want to say out loud that here we are citing an external health services research study. We are not reporting out this information on the basis of the DIR data that we have where we are subject to very, very stringent limitations on the degree to which we can report out drug manufacturer specific rebate arrangements. So I just need to say that out loud to avoid a lot of phone calls after this meeting.

[Laughter.]

DR. CHERNEW: Perfect. So, Dana, I'll save my comments, so let's start with the queue.
MS. KELLEY: All right. I have Kenny.

MR. KAN: I am enthusiastic about the fantastic chapter, which is based on very rich and powerful data, as I know that many of such data are highly proprietary.

As a new Commissioner, one of my biggest pleasant surprises is the high quality of the staff and analysis on very complex topics. So regarding this very complex Part D DIR topic, thank you for highlight, on page 17 of the deck, and page 20 of the reading material, that the Inflation Reduction Act could change a lot of this, or may change.

I, for one, believe that the Inflation Reduction Act would likely substantially mitigate many of the member cost-sharing and potentially reduced member access implications of the study. For example, when you cap a member out-of-pocket at $2,000, when you basically remove the beneficiary cost-sharing in the catastrophic phase I believe this would substantially mitigate some of the findings. So I would be very curious if that could be highlighted.

DR. CHERNEW: Let me emphasize one thing that came up, just as we go through. We are in a little bit of an awkward situation in the following sense, which is we...
wanted data like this for a long time, we have data like this for a long time. I think it's pretty clear when you look at this data that there were some things going on that we would rather have not been going on. Anyway, and then there's been a policy response, which was highlighted on whatever, Slide 17, the Inflation Reduction Act's policy response.

So as was said, we are not going to go forward and try and figure out what policy response should be imposed given the data that we have looked at because there has been a response. So we will be able to continue to monitor this to see what happens, to see how things are working. And there are a bunch of other things we will do.

That's just a little bit of a level-setting type thing. So I'm not looking for -- to be clear -- this is our next big Part D thing. And I might add, and I wasn't part of the Commission so I can say this sort of a little bit, some of the things you saw in the Inflation Reduction Act did have some connection to some of the things that MedPAC has been talking about for a long time. So I will just leave that there.

Anyway, Kenny, thank you. But yes, I agree. To
your basic point about this is data and now we're going to be changing some things, yes.

MR. KAN: Mike, great point, and I understand that we are in a little bit of an awkward situation here, But, you know, some very useful career advice I got early on is don't bury the punchline. You know, I'm reading and there's a lot of great data, very rich, and then it's at the end, and then I find out later there's been a policy response, and I'm trying to figure out how I should think about that.

MS. KELLEY: I have a Round 1 question from Larry. What is the rationale for rebates? Why not just have competition on prices?

[Laughter.]

DR. SCHMIDT: Thanks a lot, Larry. I think rebates are kind of a mechanism of price discrimination. So it's the way in which manufacturers are able to kind of figure out the exact willingness to pay of individual payers, individual plan sponsors based on the tools they have for managing and the number of enrollees they have and how they've organized themselves. And it's not the only market that uses price discrimination, but it is very
apparent in this one. 

DR. CHERNEW: There is a considerable amount of, 
I think, work and interest academically in trying to sort 
through some of the aspects of this. Because that is 
certainly true. It is a mechanism of price discrimination. 
But there are other aspects of things that are going on 
institutionally in the drug market that contribute to why 
you would want to do things through a rebate. So for 
example, some prices, for example, are tied to sort of the 
gross, and so you might not want to change your gross 
because of other things that are going on, and go through 
rebates, and there's a bunch of other things. I don't 
think we want to go through that particularly now. 

I think, Dana, Larry was the last Round 1 
question, which, of course, is interesting because if 
there's any area where we need clarification, this would be 
the topic. But I think that's fine. We should probably 
move on to Round 2. 

MS. KELLEY: Okay. Kenny, did you have a Round 2 
comment? 

MR. KAN: Yes. So there is a material 
difference, I believe, between a standalone Part D plan 

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and MAPD. So I don't know if the data that the staff looked at would be able to tease this out.

A standalone Part D plan would apply formulary and rebate strategies to optimize financial growth and quality outcomes. That may differ from an MAPD plan who are increasingly much more focused on medication adherence and multiple medication synchronization to optimize members' whole health, you know, that will result from less costly and unnecessary future health events, mitigate disparities, and improve star scores.

So perhaps for future phases of this work can the staff look into correlation between Part D star scores and medication adherence and DIR economics?

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you for a fantastic chapter and presentation. I'm going to start with a couple of just minor comments on the report and then I have an idea for kind of additional analyses that I think would be really helpful.

One is just on page 7 in the report. I think there is a little bit of a mixing two concepts, because you talk about the high price of specialty drugs and the gross-
to-net price growth. And as you all know there is a lot of variability within the specialty drug space where some don't get rebates. I think teasing those two things apart a little bit more would be really helpful in the chapter.

I love that you did with the within and across formulary analysis. As soon as I started reading into it, I was like, oh, could you look at it within formularies or standardizing of the formularies, and then you did. I always love when you anticipate all of my data needs, and it was great.

One of the things I did wonder, though, is whether the variation in rebates by the same plan sponsor could be differences in sales volume and getting to some sort of target volume-related discount. So I didn't know if you had the ability to look at like the size of the plan or something like that to get at maybe whether volume was the other piece that was missing when you saw those differences within a plan sponsor.

The last kind of broader comment I think is really related to, I don't think you buried the lead with the Inflation Reduction Act, and I don't think it's going to solve all of the problems here. I think it will solve
some of the gross-to-net price issue with the prices being limited, the list prices being limited to rate of inflation over time. But we don't know yet whether plans will use copays or co-insurance for that long initial coverage phase. So we know it solves the coverage gap problem.

So one of the things that I think would be really helpful, and I think in general would be helpful for this type of information, is how often do plans use copays in these circumstances for drugs that have these large rebates? So especially we see this like egregious data that show that patients are dramatically overpaying relative to their stated cost share, but it would be helpful to know, in the initial coverage phase, what percent, in those cases, use copays. My assumption is many use copays in those phases, which makes this problem less concerning, because we want plans to pick the drug with the biggest rebate and the lowest net price. We just don't want that to harm the beneficiaries.

So I think that contextually would help and maybe would help to kind of give us a little bit more information about like do we think that plan sponsors will still have really strong incentives to offer those drugs that copays
under the new benefit design in 2025. I certainly hope so, but we just don't know for sure.

I think that, going to Kenny's point about the MA versus PDP, that would also be a nice breakdown for those. So are we seeing different behaviors in the offering of high-rebated drugs with copays in the initial phase for MA plans versus PDPs.

And I think, in general, if it's possible, especially when looking at these, I always kind of do the same thing. I liked your case studies. I always give insulin as the case study to teach students about rebates and what that means from the consumer's out-of-pocket cost space. But then I follow it up with this is an extreme example because many, many drugs aren't in this high of a rebate category. And I wonder if it's possible to show what percent of brand-name products have rebates that are high enough that patients would be paying more than the plans.

So just as a kind of high-level, like how often does this problem happen I think would be nice context for the chapter, so that people don't walk away thinking that this is really representative of all of the behavior of
plans and the drugs that they cover.

I'm a huge fan of all of you and this work. I'm really excited to see where it's going.

MS. KELLEY: Scott.

DR. SARRAN: Yeah, excellent and important work.

For many years I've been struck by the perverse at least potential of rebates as well as the opacity of them, and I've had the same question in my head for many years that Larry raised, about would the world be better without rebates. But understanding that's not going to be an immediate option I focus in my mind on the other concern which is the opacity of rebates as they exist, and understanding how pharma and PBMs and plans want to maintain that opaque nature under the umbrella of needed proprietary protections so that their idea of the free market works well.

You know, I'm just so struck by how the opaque nature, both on one hand inhibits our understanding of how well the market is or isn't working to serve their consumer and the taxpayer, and it's antithetical to the principle of transparency that I think we all believe is important and pretty widespread in its application to understanding how
taxpayer money is being spent and how beneficiaries' money is being spent.

So I just think there should be some exploration, at least, of the pros and cons of making all rebate data public. I understand it's not simple, but I think it should at least be discussed.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks. Fantastic work. I think obviously this is very interesting and sometimes provocative data, and I think you've done a very nice job of leading us through it in a systematic form since we received the data.

A couple of comments, really a comment and a question in a sense. First off, I like Stacie's comments a lot. I think to some extent there are these very eye-catching pieces of the analysis where we see that there could be net profits to a plan sponsor if a beneficiary uses a particular drug.

I think to the extent that it is possible, if we could match it with Part D claims to get a sense of how often this is happening, I think contextualizing this would be really helpful for us to interpret. I think eye-
catching is different in some sense than expansive problem, and I think we should try to do our best to understand, understanding that it is obviously the prevailing historic system and some of that might change. But at least in the context that would be very helpful.

The second point somewhat relates to Scott's point, which is I think certainly the market economists amongst us would say we want a really well-functioning market here and price transparency, in some sense, is often a feature of a well-functioning market, but it depends on where that price transparency is and how it's influencing choice. And I think there are a number of layers of dynamics here that are somewhat complicated.

And so what I am curious about is, in some sense we also have this trend towards this notion of real-time benefit checks where through EHRs we can get access to what the benefit design is and therefore we can then understand what the transparent cost is to the patient at the point of care, or at least at the point of sale.

And so this is just an open question, Round 1, Round 2, Round 3 style, which is, from your expertise and your sense, given that the rebates are sitting behind this,
is that level of transparency ultimately giving the
beneficiary the information that they need, and to some
extent the price transparency that Scott is talking about
is behind the curtain. It's not transparent. It's behind
the curtain. But ultimately the beneficiary may get what
they want if we implement this real-time benefit check.
And I am just curious if you can comment on that in the
context of the dynamics around price transparency.

DR. SCHMIDT: So they're not, obviously, not
seeing the rebate piece of it, but I wouldn't say that it's
not beneficial at all, in the sense that if they are using
copays, for example, at least they could be made aware of
that. And it gets the bene to the point of being able to
say, hopefully with the prescriber right there, you know,
"What are my options, at least in terms of my copay?"
So I think that's still a beneficial thing. It's
not necessarily getting to what is the absolute lowest
cost, of course, as you are pointing out.

MS. SUZUKI: So one thing we have highlighted in
the paper is that manufacturers are giving rebates for a
better placement, and that typically means you're on the
preferred tier which has copays as Rachel mentioned. And
so I think there is some benefit to allowing beneficiaries to see in real time the copay amount rather than the co-insurance amount, which can be much higher than the copay that the plans set for preferred tier.

MS. KELLEY: Stacie, did you want to weigh in on this question of transparency?

DR. DUSETZINA: Yeah. I just wanted to mention that in the prior report on this we're trying to get a little bit at some of the economic arguments against price transparency that have been brought up forever, which include that some organizations are getting very large and generous rebates that lower the net spending on the program and others are not. And so there is this concern that if you have full price transparency everyone will regress to the mean, or the ones that are getting a good deal will not get a good deal.

So some of the initial work that the group did is trying to look at variability in average rebates by plan sponsor and size and things like that, to try and see if we see those types of signals, that there really are very large differences in the negotiations. Because there is so much consolidation over time in the plan sponsors and PBMs
there is a big question in my mind of is that actually true
or is everybody getting roughly the same deal, in which
case transparency would not harm or we would actually have
low prices and everybody is getting the same low prices.
Just they're not being transparent about it.

So I think that was part of what was reflected in
the prior set of work, that was in March or June. So I
think we're trying to get at some of those longstanding
economic arguments against transparency because every
effort that has been made for that at all it results in a
lot of lawsuits. So there is a lot of fierce arguing
against it.

DR. CHERNEW: So let me just add, the economics
behind this is complicated in a range of ways, and there
are both efficiency and equity issues that are playing out
here. So very broadly, almost unrelated -- not unrelated
but not directly specific to this, price discrimination
inherently is not a bad outcome in particular types of
markets. And what we're trying to do is we have a market
in which manufacturers have exclusivity, and we could
debate a whole bunch of things around that.

And so the PBMs are a source of competition
promoting it, and the process we have allows that to play out, at least in theory. But as is pointed out in the chapter, there are a ton of places where that goes awry that's just frustrating, including what I think we see your examples is the most egregious is where people are actually paying more out of pocket for a drug than the actual net cost of the drug is.

And part of what is happening is because of the nature of competition premiums are going down some, and it is being financed in part by targeted beneficiaries that are being charged more in ways that they might have a hard time of sorting out, and there are an enormous number of other, I would argue, administratively complex things -- real-time benefit adjudication things, copay card issues, although Medicare can't do copay card issues -- but there are a slew of other things that are happen morning broadly in the prescription drug market that make this complex, to make the economics.

But I think our main concern here is to have the data and understand sort of what is going on, and then we'll be able to track this going forward. I think the issue of copays versus co-insurance is a particularly
interesting one because of the difficulties in how people shop and how it gives rise to a lot of the underlying problems.

We are not in a stage now where I think we are prepared to make particular recommendations about what we will do, in part because we have a law that we just passed and we are going to have to see how that plays out, as Kenney said before. But I think tracking particularly what is happening to individuals and how competition is working in this market is going to be important.

And so we get sort of some insight with all of this data, but it's very hard to make normative judgments when you see disparities across things, right, because you have market power on the -- not only do you have market power at every point on that chart. At every point on that chart there is some market power, and then there are vertical connections between all of them. If Bruce Pyenson were here, he would point out that the organizational connections between these groups are very complicated, in both the PDP and the MA market.

So I think now we are, again, like in the last session, in sort of a reporting what's going on phase, and
will, over time, I think, begin to develop if something more needs to be done. I am sort of where Stacie is, that the Inflation Reduction Act will surely not solve all the problems we think might need to be solved in this space but we are going to have to figure out how that plays, in a bunch of other ways. So for example, we are going to have to see how that plays on innovation of drugs, which has been another sort of topic that we worry about. So there are a lot of puts-and-takes.

Sorry. That was longer than I intended it to be.

MS. KELLEY: Amol had something on this point?

DR. NAVATHE: Yeah. I was simply going to point out, in some sense, that I think what we mean by price transparency may not be interpreted by everybody the same way, and to your point, Mike, I think there is a lot of layers here. And so, if we mean price transparency to the beneficiary, this real-time benefit check kind of tool essentially sort of accomplishes that.

And I think it's unclear about advocating in either direction that, given the system that we have and what Stacie was pointing out, that there may be puts and takes in terms of thinking about what across-the-board
rebate and price transparency would look like if it were up to the entire system. And it's unclear to me, at least, that beneficiaries, if they know what the rebate is, if that's really going to influence their choice if they're relative to knowing what the price they're going to pay is in a copay setting.

So I think it's a nuanced thing, and I think when say price transparency, I think it means very different things to different people, and we should just be aware of that.

MS. KELLEY: Cheryl.

DR. DAMBERG: I just want to say thank you for this great work. It's just so exciting these data are available and we can start to get greater insights into this space. So that's incredibly welcome.

So, Mike, you stole my thunder over there.

I just was like -- was reading through this. I just kept going, how come we're not talking about consolidation and sort of all the perverse kind of market incentives that are in play here? And that we really -- like this market is not functioning in a way that is delivering value, and so I would hope at some point that
the Commission would try to spotlight that more. I don't know whether this -- it's in this particular chapter or a future chapter and what the implications are and what, if anything, policy can do to sort of affect a lot of those perverse incentives that are in this market.

DR. CHERNEW: If I'm correct, Dana, Cheryl was the last in the Round 2 queue, and so let me just say a few things, and then I'll try and watch the chat. We'll close up.

So I agree with all of that. This is a complicated area because so many of these things are happening outside of MedPAC in the broad environment, and so the sort of ways in which we kind of engage in Part D space, for example, a lot of stuff on the Medicare benefit design issue. In Part B space, you're going to see a lot of stuff on promoting competition. We'll have a whole bunch of Part B work. Some of that could deal with Part D as well. You'll see some of those things, like alternative kind of work, for example, in ASP+6.

So there's going to be ways in which we engage. How many of the bigger-picture issues that are dealt with and how the prescription drug market works in this country
are kind of beyond where we will really get to, although
your point, which I take as reasonable, it is useful to
point that out in the context of what's going on here,
certainly the consolidation between these different
sectors. It is relevant, and so, as Ken said, it has
ramifications for MA and certainly for the Part D stuff.
So, again, I think here's what I take from this
discussion. It's really great that we have this data. We
will be able to do things that heretofore we had not been
able to do. We have a particular concern with how the
beneficiaries are experiencing access to the medications,
and I think we would broadly agree that making sure that
beneficiaries have access to medications is a sort of core
goal to promote quality, I think, in most of the important
chronic conditions and areas like cancer and, you know, a
bunch of places. The innovations in the drugs that people
have access to is crucially important, and making sur that
we can maintain that in a fiscally sensible way, I think,
is sort of a core goal.
So, going forward, I think we're going to
continue to monitor this. There's obviously a lot of
changes in the market, but changes aren't going to really
bite in the near term. It's going to take a while for the new law to really work through to see what's happening. So we will continue to find places where I think -- I've said things like this in the past -- where there's issues particularly in the nooks and crannies of execution on the distribution of things, where we can find a policy way and to improve it, without trying to totally reform how we deal with drug pricing and distribution in this country is probably where our sweet spot is going to be, because there's a lot of things in this space that get talked about. We could use the rest of our time having Stacie go through them.

[Laughter.]

DR. CHERNEW: That are outside, they're outside. I mean, we're not -- just to be clear, we're not going to talk about a bunch of broad price index regulation. We're not going to talk about a bunch of reimportation things. We're not going to talk -- I mean, there's a bunch of broad issues here that we're not going to get into.

We're going to find the places that are particularly Medicare-oriented and try and make sure that we can do the best for the beneficiaries and the program.
within that kind of lane.

So I hope you all continue to be as excited about having the data as we are to see it, and I'm just looking to see. So it looks like I'm going to pause for a second to see if anyone wants to say anything else.

[Pause.]

DR. CHERNEW: So, for those of you at home, as always, we want to hear your comments on this topic, and you can reach us at MeetingComments@MedPAC.gov or go on to the website and leave us comments, reach out to the staff, to the Commissioners. Again, thank you for a wonderful end of September to bookend the wonderful beginning of September, and again, I think I will thank the staff for all of the work that they did.

And, as an aside -- and I was mentioning this to Jim before the meeting -- it may not always be clear how hard it is to run this sort of logistics of all that we have to do in the world that we live in, and actually, I am really amazed at how well -- this is our real -- it's the third meeting we've had in person since I've been chair, public meeting we've had in person since I've been chair, and the logistics of how it's worked have really been
really done well. So a special shout out to all the folks
that make that part happen, because it seems seamless, but
it is not. So, again--

[Applause.]

DR. CHERNEW: So, with that, broad thanks in a
complicated world, everybody, travel safe, and we'll see
you in a month. It will seem like two weeks.

[Whereupon, at 11:20 a.m., the Commission was
adjourned.]