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.

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
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM, FACP
KENNY KAN, CPA, CFA, MAAA
GREGORY POULSON, MBA
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD, MPH, MBA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
SCOTT SARRAN, MD

B&B Reporters
29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541

AGENDA PAGE

Supporting safety-net clinicians
- Geoff Gerhardt..3

Recess..73

Mandated Report: Evaluation of a prototype design for
a post-acute care prospective payment system
- Carol Carter, Kathryn Linehan.........................73

Lunch..121

Nursing facility staffing
- Kathryn Linehan, Lauren Stubbs, Carol Carter.......122

Recess...165

Mandated report: Study on the expansion of telehealth
- Ariel Winter, Ledia Tabor...........................165

Adjourn..246

1 P R O C E E D I N G S

2 [10:04 a.m.]

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

10 So Geoff, I am turning it over to you.

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

20 Our safety-net work started with a request from
21 the House Ways and Means Committee to examine access to
22 care for vulnerable beneficiaries. We explored a number of

1 ways of identifying beneficiaries who have difficulty
2 accessing care, including those who live in rural areas and
3 those with multiple chronic conditions. We chose to focus
4 on low-income beneficiaries because we found that
5 beneficiaries with lower income consistently use more
6 health services and have more challenges accessing care
7 compared to other Medicare beneficiaries.
8 While some providers have strong balance sheets
9 and are quite profitable, there have also been concerns
10 about the financial stability of providers who serve a high
11 number of low-income beneficiaries. However, supporting
12 safety-net providers through large across-the-board
13 increases in Medicare payments is not financially viable.
14 Therefore, we strived to develop a way to target safety-net
15 funding to providers serving low-income Medicare
16 beneficiaries.
17 Today's session will cover the following topics.
18 First, I'll review the conceptual framework developed last
19 cycle, and which appeared in the June 2022 Report to
20 Congress, that lays out how we identify safety-net
21 providers and helps guide decisions about whether new
22 funding to support those providers is warranted.

1 Second, I'll review the definition of low-income
2 beneficiaries that is used by the safety-net framework.
3 Third, we will look at how physicians and other
4 clinicians fit into the safety-net framework.
5 Next, I will present several policy options for
6 how Medicare payments could be increased to clinicians who
7 furnish care to low-income beneficiaries.
8 And finally, I will raise several policy and
9 operational issues about the policy options for
10 Commissioners to consider and discuss.
11 First, let's review MedPAC's safety-net framework
12 that appeared in the June 2022 Report to Congress.
13 The June report outlined a two-step process that
14 is based on the premise that safety-net providers should be
15 defined on the characteristics of their patients rather
16 than the type of facility they are, where they are located,
17 or some other criteria.
18 In the first step of the framework, our goal is
19 to identify safety-net providers. The second step is
20 deciding whether new Medicare funding is warranted to
21 support them.
22 The goal of having a two-step framework is to

1 allow us to broadly identify safety-net providers while
2 recognizing that new Medicare funding is not warranted in
3 all situations. This balances the desire to support
4 safety-net providers with the reality that Medicare has
5 limited financial resources.
6 We identify safety-net providers as those who
7 treat a disproportionate share of Medicare beneficiaries
8 who have low incomes and are less profitable than the
9 average beneficiary, or the uninsured, or those with public
10 insurance that is not materially profitable. The
11 underlying premise of defining safety-net providers this
12 way is that providers who treat a disproportionate share of
13 such patients could be financially challenged because their
14 patients cost more to treat or they receive lower revenues
15 for treating similar patients.
16 These financial challenges could lead to negative
17 outcomes for beneficiaries, such as having difficultly
18 accessing care if providers close or choose not to treat
19 certain types of patients.
20 Having identified safety-net providers, the
21 second step is deciding whether new Medicare funding is
22 warranted to support these safety-net providers. Medicare

1 should only spend additional funds to support safety-net
2 providers if three criteria are met.
3 First, there is a risk of negative effects on
4 beneficiaries without new funding, such as trouble
5 accessing care.
6 Second, Medicare is not a materially profitable
7 payer in the sector. If Medicare profit margins are
8 already high in a given sector, it suggests other solutions
9 beyond adding new Medicare funding are likely more
10 appropriate.
11 And third, new Medicare funding is only warranted
12 if current Medicare payment adjustments cannot be
13 redesigned to better support safety-net providers.
14 Since our framework is dependent on the income
15 level of beneficiaries, one of the key issues is how we
16 determine which beneficiaries are considered low income.
17 We define low-income beneficiaries as those who
18 receive full Medicaid benefits, partial Medicaid benefits -
19 - meaning Medicaid pays for their Medicare premiums or cost
20 sharing through one of the Medicare savings programs -- or
21 those eligible for the Part D low-income subsidy, or LIS.
22 The low-income subsidy provides assistance with

1 Part D premiums and cost sharing to beneficiaries who are
2 eligible for full or partial Medicaid benefits or have
3 incomes below 150 percent of the federal poverty level and
4 have limited assets.
5 Because both full and partial dual-eligible beneficiaries
6 automatically receive the LIS, we collectively refer to our
7 entire low-income population as "LIS beneficiaries."
8 We will now look at how the framework applies to
9 clinicians.
10 In the June report we applied the safety-net
11 framework to acute care hospitals. Unlike hospitals,
12 physicians and other clinicians do not submit cost reports,
13 so information about their revenues, costs, and
14 profitability is limited. Therefore, we have to make
15 inferences about clinician profitability based on what we
16 know about revenues for low-income beneficiaries.
17 Clinicians are prohibited from collecting the 20
18 percent cost sharing from beneficiaries who are eligible
19 for full Medicaid benefits and those are dually enrolled in
20 Medicaid through the Qualified Medicare Beneficiary
21 program, known as QMB-ies.
22 We also know that 42 state Medicaid programs make

1 reduced cost-sharing payments or do not make any cost
2 sharing payments for services furnished to many LIS
3 beneficiaries. We estimate that the combination of these
4 two policies results in clinicians not collecting $3.6
5 billion in revenue that they would have otherwise received.
6 Finally, some clinicians are serving a
7 disproportionate number of low-income beneficiaries. For
8 example, 15 percent of clinicians had more than 50 percent
9 of their fee schedule claims associated with LIS
10 beneficiaries.
11 The framework's second step is to determine
12 whether clinicians should be given enhanced financial
13 support. Surveys indicate that low-income beneficiaries
14 have more difficulty accessing care from clinicians
15 compared to other beneficiaries. For instance, 12 percent
16 of fully dual-eligible beneficiates and 18 percent of
17 partial duals reported having trouble getting needed care,
18 compared to 6 percent of the non-LIS population.
19 While we cannot measure profitability directly,
20 treating low-income beneficiaries tends to generate less
21 revenue than other Medicare beneficiaries. Since there is
22 no reason to believe that the cost of caring for low-income

1 beneficiaries is less than treating other beneficiaries, we
2 infer that low-income beneficiaries are less profitable and
3 may present financial challenges to clinicians.
4 The final step in this process is to determine
5 whether Medicare already has policies that directly support
6 safety net. While the physician fee schedule does have some
7 add-on payments, such as the health professional shortage
8 area bonus, targeted financial support for safety-net
9 clinicians does not currently exist.
10 Since the safety-net framework indicates that
11 many clinicians are safety-net providers and additional
12 support from Medicare may be warranted, the next several
13 slides walk through options for implementing a safety-net
14 add-on payment for clinicians.
15 One potential approach to supporting safety-net
16 clinicians is to implement an add-on payment for services
17 that are furnished to LIS beneficiaries and paid under the
18 physician fee schedule. For each service furnished to an
19 LIS beneficiary, Medicare would calculate an add-on
20 adjustment based on a specified percentage of the full fee
21 schedule payment rate.
22 Instead of varying the adjustment percentage to

1 reflect a provider's share of low-income beneficiaries, a
2 uniform payment adjustment would apply to all clinicians.
3 The aggregate amount of the add-on payments for each
4 clinician would vary according to the volume and pay rate
5 of services he or she furnishes to LIS beneficiaries.
6 The envisioned add-on payments could vary on two
7 dimensions: the percent used to calculate the add-on
8 adjustment, and whether the add-on adjustment should be
9 based on a single percentage for all clinicians, or whether
10 they should be higher for primary care clinicians than non-
11 primary care.
12 Because the fee schedule does not have existing
13 bonuses or add-ons aimed at safety-net clinicians which
14 could be repurposed, the framework calls for the safety-net
15 add-on to be funded by new Medicare dollars and not
16 implemented in a budget neutral manner.
17 This slide provides some options for how a
18 clinician safety-net adjustment could vary across the two
19 dimensions that I just mentioned.
20 Under Option 1, fee schedule payments for
21 services furnished to LIS beneficiaries would be adjusted
22 by 5 percent, regardless of the clinician's specialty.

1 Option 2 has the same uniform approach to the payment
2 adjustment, but fee schedule payments for LIS beneficiaries
3 would be increased by 10 percent rather than 5 percent.
4 Options 3 and 4 use different adjustment percentages
5 depending on whether the clinician specializes in primary
6 care or another specialty.
7 Here we provide a numerical example of Option 2.
8 This assumes a clinician is furnishing a service to a fully
9 duel eligible beneficiary where the full fee schedule
10 payment rate is $100. Assuming that the beneficiary has
11 reached their Part B deductible, Medicare would pay $80 to
12 the clinician who billed the service, which is the payment
13 rate minus 20 percent cost-sharing.
14 In this example, the provider is prohibited from
15 collecting cost sharing from the beneficiary and the
16 state's Medicaid program will not make payment for any cost
17 sharing, so Medicaid's contribution is zero.
18 A 10 percent safety-net add-on means the
19 clinician would receive an additional $10 for this service,
20 bringing the total payment to $90. This is less than what
21 the $100 the clinician would have received if the service
22 had been furnished to a non-LIS beneficiary, but more than

1 what he or she would have been paid in the absence of the
2 safety-net add-on. Under a scenario where either the
3 beneficiary or Medicaid program paid the full cost-sharing
4 amount, the clinician would receive a total payment of
5 $110.
6 To give a sense of what impact these options
7 would have, we used fee schedule claims from 2019 to
8 estimate average add-on payments for different types of
9 clinicians and the total increase in payments for both
10 groups. This table just addresses the effect of making
11 add-on payments in fee-for-service. I'll talk about
12 applying the add-on in Medicare Advantage later in the
13 presentation.
14 As you can see, we estimate that total add-on
15 payments in Option 1 would increase revenue for primary
16 care clinicians by an average of $780 a year, and non-
17 primary care clinicians would receive an average of $1,040
18 annually. Total add-on payments for Option 1 would be
19 approximately $1.2 billion.
20 I won't walk through the financial impact for
21 each option, but I would point out that total add-on
22 payments for a given clinician would depends on how many

1 LIS beneficiaries they treat and what services they
2 provide. On average, clinicians receive about one-quarter
3 of their fee schedule revenue from services furnished to
4 LIS beneficiaries. Clinicians who receive a higher-than-
5 average share of their fee schedule revenue from treating
6 LIS beneficiaries would receive a proportionately larger
7 amount of add-on payments.
8 There are several policy and operational issues
9 raised by the proposed safety-net add-on. One issue is how
10 large the add-on adjustment should be. Because the 20
11 percent cost-sharing doesn't get paid for many low-income
12 beneficiaries, a 20 percent add-on seems like a natural
13 limit for the adjustment. A smaller adjustment would be
14 less costly, but may not be as effective in addressing
15 financial challenges faced by some clinicians.
16 Another issue is whether to apply a flat add-on
17 to all clinicians or to vary the add-on by specialty.
18 Average total compensation for primary care clinicians is
19 lower than most specialists and they tend to serve a higher
20 proportion of low-income beneficiaries. On the other hand,
21 some specialties have a relatively high portion of claims
22 from LIS beneficiaries and low-income beneficiaries can

1 have difficulty accessing specialty care.

2 Commissioners also need to think about whether

3 total payments, including the safety-net add-on, should be

4 permitted to exceed the fee schedule's full payment rate.

5 Given state and beneficiary-level variation in cost-sharing

6 policies, capping total payments could be administratively

7 complex.

8 Another issue for Commissioners to consider is

9 whether and how a safety-net clinician policy should be

10 applied to Medicare Advantage. Like their fee-for-service

11 counterparts, LIS beneficiaries enrolled in MA report

12 having more difficulty accessing clinician services than

13 non-LIS enrollees. CMS could use the same basic

14 methodology we have been talking about in fee-for-service

15 to make add-on payments to clinicians in MA, provided that

16 plans submit accurate encounter records for clinician

17 services.

18 To ensure that clinicians receive the full

19 benefit of any add-on, aggregate payments would be made

20 directly to providers instead of going to the MA plan. And

21 like the add-on payments in fee-for-service, we assume

22 safety-net payments in MA would not be included in Medicare

1 Advantage benchmarks.
2 That being said, it is not clear how treating MA
3 beneficiaries with lower incomes affects clinician revenue.
4 While we can assert that treating fee-for-service
5 beneficiaries who are low income generates less revenue for
6 clinicians because of restrictions on cost-sharing, we lack
7 reliable information about how MA plans deal with cost
8 sharing for dually eligible enrollees.
9 Before I turn things over to Mike, I want to put
10 a series of questions on the screen that we would like
11 commissioners to consider during today's discussion.
12 First, should staff continue to develop a
13 clinician safety-net policy along the lines of what I
14 presented today? If so, what is the appropriate magnitude
15 of a safety-net add-on adjustment for clinicians?
16 Should certain types of clinicians, like those
17 who specialize in primary care, receive a higher add-on
18 adjustment than clinicians in other specialties?
19 Should aggregate payments for a given service be
20 permitted to exceed the allowed payment rate under the
21 physician fee schedule?
22 And should a clinician safety-net add-on apply to

1 services furnished to LIS beneficiaries enrolled in
2 Medicare Advantage?
3 Thank you and I look forward to your discussion.
4 DR. CHERNEW: Great. That was terrific.
5 So we are going to start with Round 1. I am
6 going to let Dana run the queue. But I just want to
7 emphasize, Round 2 I anticipate will be a very rich
8 discussion. What that means is please treat Round 1 as
9 Round 1, so we can get to Round 2 with enough time.
10 So with that, Dana.
11 MS. KELLEY: Jonathan.
12 DR. JAFFERY: Thanks, Dana, and Geoff, this is
13 great, a great chapter, and a really great presentation.
14 It was concise and teed up a whole bunch of things for
15 discussion.
16 So my question is, you know, on Slide 16 and I
17 guess the table on page 27, Table 5 in the chapter, you
18 looked at the impact on the primary care and non-primary
19 care providers for different options. And I wondered if
20 you had any information on that that's a little more
21 granular.
22 In the chapter you had Table 3 on page 19, which

1 shows there is quite a bit of variability in terms of the
2 percent of LIS beneficiaries that are served by different
3 specialties. I think in the top 20 it ranged from
4 basically half for nephrologists down to 6 percent for
5 dermatology. So you could see where that average is really
6 quite variable. I don't know if that might inform some of
7 our thoughts about the four options. So I don't know if
8 you have any more granularity on that.
9 MR. GERHARDT: I mean, there certainly is a lot
10 of variation, and I think if you look at the table that
11 breaks down the specialties you can see the tremendous
12 amount of variation there. There was an earlier table in
13 the report, Figure 3, that shows that a relatively small
14 percentage of clinicians -- and this is overall -- a lot of
15 their claims are from LIS. There is a much larger
16 percentage that have very few claims from LIS
17 beneficiaries. So both when you look at on a specialty
18 basis or across all clinicians there is a ton of
19 variability, yes.
20 I think the way that this policy has been set up
21 is that the add-on payment would scale. I mean, it would
22 correspond with how much of your revenue, how much of your

1 allowed charges are for LIS beneficiaries. So those that
2 are on the top scale, top end, would get a lot of add-on
3 payments, where those that don't serve many or have very
4 little revenue from LIS beneficiaries would not get very
5 much. So there would be sort of this scaling that would
6 occur under the policy on its own merits.
7 DR. JAFFERY: Sort of self-adjusting that way.
8 MR. GERHARDT: Yes, because we are not scaling
9 the percentages themselves, you know, to how a given
10 provider's patients are LIS, or we are not having a cutoff
11 point. There is no cliff involved her.
12 DR. JAFFERY: Right. Maybe analogous to when we
13 think about boosting up payments for all E&M services,
14 thinking that people who have serving more of that E&M
15 base, cognitive work, even if they're specialists, are
16 adjusted.
17 MR. GERHARDT: Correct.
18 DR. JAFFERY: Okay. Thanks.
19 DR. CHERNEW: So I think we should read Larry's
20 question now because I think his question is exactly on a
21 variant of this point.
22 Larry had a Round 1 question.

1 [Off-microphone discussion.]
2 DR. CHERNEW: I understand. We will work through
3 the queue, but right now -- well, Larry's -- I'll read. So
4 Larry's question was, which I think very much relates to
5 this, could the staff provide us with an annual mean and an
6 amount per clinician by quintiles rather than the mean
7 amount?
8 I don't think we actually need to have an answer
9 to that question. I think the answer is yes. The staff
10 could.
11 MR. GERHARDT: Yes. I believe we can.
12 DR. CHERNEW: Right. And now I think we can go
13 to the queue, and I actually had Lynn -- yeah, Lynn does
14 have Round 1 questions, so --
15 MS. BARR: You missed me in the queue, but that's
16 okay. I got in last night.
17 [Laughter.]
18 MS. BARR: No, I'm just kidding.
19 At any rate, I have five questions. So, Geoff,
20 great work. I am really excited about this chapter.
21 We talked about the difference a little bit in
22 rural versus urban, right? And you're focused on the

1 physician fee schedule, right, and there was a
2 recommendation in the chapter that we didn't need to
3 consider rural health clinics and FQHCs because they're
4 paid more, right, you know, than the physician fee
5 schedule.
6 And so my question about that is, how are you
7 thinking about that? Because it's really still the same
8 copay issue, right? And so have you looked -- I mean, all
9 -- we're addressing that the physicians are not getting a
10 copay, and rural health clinics are cost-based reimbursed.
11 So I was wondering what are you -- you know, so they're not
12 getting their copay. So they're getting less than cost.
13 So what was the thinking behind that?
14 MR. GERHARDT: I think the thinking generally is
15 that on a per-service basis, like FQHCs get paid at
16 generally a higher rate than for an equivalent service
17 under the fee schedule, and so they weren't quite in as
18 much need as when, you know, the clinicians are being paid
19 piecemeal basis, where the payments are not connected to
20 cost in any way, and so, you know, the argument for
21 extending policy to FQHCs, RHCs. But we wanted to
22 initially focus on this, this tranche of physician fee

1 schedule services because they are not connected to cost in
2 any way. The payments tend to be lower on a per-service
3 basis, and there's just a lot more dollars sort of in the
4 system at stake there.
5 MS. BARR: Okay. I'll address that and then in
6 Round 2. Thank you.
7 And my next question is, as we look at -- how is
8 the data confounded by LIS enrollment? And so, you know,
9 when you're looking at the data, we've been told that half
10 of the patients that are eligible for LIS are not enrolled.
11 Do you see that evenly across the board? I'm wondering,
12 you know, because there was such a high number of disabled
13 patients, is it because if you're disabled, we make sure
14 you're in LIS? You know, whereas, maybe as a physician, if
15 you're in LIS -- and I don't -- you know, I might have to
16 give up a co-pay. I'm as less likely to enroll you. Are
17 MA plans more likely to enroll? So I was wondering, is
18 there anything to be seen in the data about those various
19 effects on the data of who's enrolled in MA versus not and
20 disabled versus not?
21 MR. GERHARDT: Are you talking about people who
22 are eligible to enroll in one of these programs but have

1 not for whatever reason?

2 MS. BARR: Right, right.

3 MR. GERHARDT: Yeah, I mean, I think that's

4 always, you know, a concern when you're talking about

5 Medicaid beneficiaries. There are certainly studies that

6 have been done that show people -- more people are eligible

7 for the program than actually are enrolled, and --

8 MS. BARR: Is there a difference in MA versus

9 fee-for-service?

10 MR. GERHARDT: I am not aware. I mean, we can

11 talk about --

12 MS. BARR: That was kind of one of -- I was

13 really wondering like, you know, is there -- as we think

14 about MA -- okay.

15 And my next question is related to the

16 beneficiaries themselves, and so the comments about 29

17 percent of LIS beneficiaries delayed care because of cost.

18 So there's nothing in this policy that really addresses the

19 problem for the beneficiary, and I was wondering, as you

20 look at these stark numbers of the disparities, you know,

21 of access to care and the impact on the beneficiaries, is

22 there something that we should be thinking about in this

1 policy that's specific for the beneficiaries?
2 MR. GERHARDT: I mean, this policy does not get
3 at beneficiary cost, per se. It's really more about the
4 fact that in a lot of these situations, the provider is not
5 receiving the cost sharing --
6 MS. BARR: Right.
7 MR. GERHARDT: -- because they're not allowed. I
8 mean, there's some evidence --
9 MS. BARR: They're not allowed, right.
10 MR. GERHARDT: -- that some do ask their
11 Medicaid beneficiaries for copayments.
12 MS. BARR: Right.
13 MR. GERHARDT: But under the law, they're not
14 supposed to, and the fact that all these states are out
15 there that have these lesser-of policies where they don't
16 themselves make the payments. And this policy is kind of
17 focused on the policies from a clinician perspective, not
18 necessarily a beneficiary perspective.
19 MS. BARR: I was just curious. Is the answer to
20 fix the payment for the physicians, or is the answer to
21 provide Med Supp for the patients? And then you solve -- I
22 don't know what the difference in the cost of that. You

1 know, could you consider -- is there -- you know, is there
2 a way to address both issues with a different mechanism
3 other than a payment update?
4 DR. CHERNEW: Just to level-set, we're trying to
5 understand how one feels about the four options to make
6 sure -- we just want to make sure that we were asking in
7 Round 1 that you understand what the four options are, and
8 in Round 2, you can give your opinion on the four options
9 or whatever else for that matter.
10 [Speaking off mic.]
11 MS. KELLEY: Amol.
12 DR. NAVATHE: Thanks.
13 I wanted to clarify one point based on what I
14 think Lynn's first question is. When we're defining low-
15 income benes here for the work, we're not requiring Part D
16 enrollment, however, right? We're talking about
17 eligibility for the LIS?
18 MR. GERHARDT: ██████████████[1]

---

[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

1 DR. NAVATHE: [redacted]

2 [redacted]

3 [redacted]

4 MR. GERHARDT: [redacted]

5 [redacted]

6 [redacted]

7 [redacted]

8 [redacted]

9 [redacted]

10 DR. NAVATHE: [redacted]

11 [redacted]

12 [redacted]

13 [redacted]

14 [redacted]

15 MR. GERHARDT: [redacted]

16 [redacted]

17 [redacted]

18 So my second question, I guess, is -- so, Geoff,

19 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.

1 - and this is from the paper, reading materials -- the
2 specialist billing, I was curious how does that vary by
3 facility versus not facility, basically setting, you know,
4 using a place-of-service code or something like that. And
5 I'll talk maybe a little bit more about it in Round 2 as to
6 why I'm asking, but have we done any of that
7 stratification? Do you have a sense of that?
8 MR. GERHARDT: We haven't done it per se for
9 this. I mean, we can take a look at that breakdown. I
10 think, typically, somewhere around a quarter of fee
11 schedule payments go to hospital-based, you know, services,
12 either inpatient or emergency room. So I don't know
13 whether that would extend to this. We'd have to look at
14 it.
15 DR. NAVATHE: Got it. And that might just -- to
16 clarify, that might vary by specialty as well?
17 MR. GERHARDT: Yes, absolutely.
18 DR. NAVATHE: When we look at the table
19 proportional by specialty, that would be another dimension
20 that would affect what Jonathan was asking.
21 MR. GERHARDT: Yes.
22 DR. NAVATHE: Okay, great. Thanks.

1 MS. KELLEY: Stacie.
2 DR. DUSETZINA: Thanks.
3 So just one quick -- well, two quick questions.
4 One is for states. I know you mentioned that many states
5 have the lesser-of policies, and I just wondered, like,
6 when you say "many," is it almost all of them?
7 MR. GERHARDT: Well, we know -- so 42 states have
8 some version of a lesser-of policy. It varies. I mean,
9 states are allowed to set this on their own. So the
10 policies themselves tend to vary a little bit, but also,
11 the payment rate for a given service under these lesser-of
12 policies, some of them are far below what the Medicare
13 payment rate and some are the same or maybe even more. So
14 it does vary.
15 We're taking those 42 states. We're taking
16 averages of what their payment rates are compared to the
17 Medicare fee schedule rates, and that's what we're using to
18 sort of generate our estimated, you know, foregone cost-
19 sharing payments, if you will.
20 DR. DUSETZINA: Okay. And the other question I
21 had was thinking about the Inflation Reduction Act's
22 expansion of the LIS up to 150 percent of poverty. My

1 assumption is that that will bring in a bunch of people. I
2 know there's been an estimate of like only 34 percent of
3 people who are eligible enroll in when they're not
4 automatically enrolled. So can we somehow bring that
5 information in when we're thinking about like how much --
6 how many people would be affected? Are you able to do
7 that, or is it just sort of a this will be more complicated
8 and more people over time?
9 MR. GERHARDT: So I am not the Part D expert
10 here. So I'd have to talk to my colleagues about what we
11 might be able to do in terms of thinking about how that
12 policy change would change our study population.
13 Obviously, all this work was done prior to that expansion,
14 but we can give some thought to how the law change might
15 affect our group.
16 DR. DUSETZINA: Great. Thanks.
17 MS. KELLEY: Marge?
18 MS. GINSBURG: Two comments/questions. So, in my
19 mind, there are two sets of issues we're looking at. We've
20 got patients who are at the LIS level who need a lot more
21 care and attention than the fee schedule allows and what
22 they're getting paid, and then on the other hand, there are

1 the states who aren't paying what I call their "fair share"
2 of the missing 20 percent. And we're combining these two
3 issues together. I just want to make sure we're clear.
4 One has to do with the states that aren't paying enough,
5 and the other has to do with the certain clientele that
6 needs more action.
7 It worries me a little bit that if we augment
8 payments to physicians, that states will be even less
9 attentive to paying their fair share if they feel that
10 Medicare is going to step in and pick up the gap.
11 Okay. That was a Question 1 too.
12 And the other is just a comment on pages 12 and
13 14. We use very tentative language about we believe it is
14 reasonable to infer that LIS beneficiaries are less
15 profitable than non, and page 14, there's also that same
16 tentative language. And I was just curious why we're so
17 tentative when it's sort of shouting out to us that they
18 are less profitable.
19 Thank you.
20 MR. GERHARDT: I think the reason that we are
21 tentative, as you say, is because unlike hospitals and a
22 lot of the other facilities where we have cost reports that

1 we can look at and we can quantify what their costs are,
2 what their revenues are, what their, you know, share of
3 Medicare and non-Medicare is, we don't have that basis of
4 information for clinicians. Our information about
5 clinicians is much more limited than those sectors where
6 cost reports exist.
7 So we kind of have to use these other datapoints,
8 particularly the revenue, as you point out, where states
9 are not paying the cost sharing, to sort of work our way
10 into statements about profitability. We make some
11 assumptions about costs being the same or higher maybe.
12 But, again, some of that is based on data. Some
13 of that is based on assumptions. So, yeah, it's just not
14 as strong as some of those other sectors where we can make
15 more definitive pronouncements about profitability.
16 MS. KELLEY: Dana?
17 DR. SAFRAN: I'm laughing because Margie used the
18 phrase "shouting out" at us and --
19 [Laughter.]
20 DR. SAFRAN: It certainly is shouting out at us.
21 So, yeah, I just had one Round 1 question, which
22 is, you know, you spoke early on and you had in that

1 chapter that overall I think your number was 3.6 million
2 not collected, and it's hard to get my mind around this
3 proposed set of policy options without understanding what
4 that impact looks like at the clinician level.
5 I know, you know, it's highly variable, but can
6 you give us any sense of for an average clinician, whatever
7 that means? What percentage of revenue are they missing
8 out on because of this, or can you put a dollar amount on
9 that? Does it relate somehow to the dollar amounts you're
10 showing us in the policy options? Just can you give us
11 some sense of impact for an individual?
12 MR. GERHARDT: Yeah. I mean, it's highly
13 variable, as you know. The total allowed charges under the
14 fee schedule are in the high-90-billion range, about a
15 million clinicians that charge. You know, that's 100 grand
16 each. So the thousand, 2,000, you know, it's a couple of
17 percentage points in additional revenue, but your milage is
18 going to vary a lot, depending on, you know, what kind of
19 specialty you are, what services you furnish, what
20 percentage of your patient panel are Medicare
21 beneficiaries. So we're trying to present these averages,
22 but you're right. At the clinician level, it's really

1 going to vary.

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

3 probably.

4 MR. GERHARDT: Yeah. I mean, the impact table

5 shows the per-clinician average, and so I think you're

6 asking how that stacks up to, you know, their total

7 Medicare payments. It's a couple of -- you know, it's a

8 percent or two, give or take.

9 DR. SAFRAN: Thank you.

10 MR. POULSEN: All right. I happened to run

11 through this for a whole bunch. We had a couple thousand

12 clinicians that we looked at on this, and I just asked our

13 data team to take a quick look at it. What we found is the

14 highest in our group was 6 percent, and that's in a state

15 that does not have cost sharing.

16 MS. KELLEY: Cheryl.

17 DR. DAMBERG: Thanks. I'll keep this very brief.

18 I recognize we're trying to consider how this

19 plays out in Medicare Advantage, and one thing I didn't see

20 any reference to -- and I'm trying to sort out whether it

21 belongs in this chapter and in our discussion -- is the

22 fact that Medicare provides additional payments to the dual

1 SNP plans, you know, to care for these patients who are
2 more complex, and I'm trying to figure out -- so we would
3 be adding payments on top of already additional payments,
4 if I'm understanding that correctly. So I think it would
5 be helpful to kind of clarify what's going on in that
6 space.
7 MR. GERHARDT: Yeah. We can do a little bit more
8 digging in terms of the D-SNP plans and what would happen
9 there. I think we just don't have a lot of visibility into
10 what each plan's policies are regarding clinician payments
11 and cost sharing and whether this would -- you know, how
12 much of an issue is this really in MA, we don't really have
13 a great idea, or how much foregone cost sharing is
14 happening is hard to estimate.
15 DR. DAMBERG: Yeah. I mean, I agree. I think
16 it's complex to figure out how much of those payments would
17 trickle down to physicians and where they're seeing gaps in
18 terms of their payment rates, but I think it would be
19 helpful to maybe have something in the discussion about
20 that.
21 MR. GERHARDT: And like I said, I think our
22 working assumption is that if the policy were to extend to

1 MA, the payments would go directly to the clinicians rather
2 than making their way to the plans to disburse how they see
3 fit. So we do recognize that there is the possibility if
4 you give it to the plans, it won't trickle down to the
5 clinician. So we would envision making that payment
6 directly.
7 MS. GINSBURG: A quick question about that. Have
8 we ever done that before? Not just we, but is there any
9 other policy that allows Medicare to pay MA physicians
10 directly rather than through the plan?
11 MR. GERHARDT: I do not know. Maybe Jim does.
12 DR. MATHEWS: Marge, we don't have a direct
13 physician analog to the extent that I'm aware of it, but
14 there is an analog on Part A where Medicare makes payments
15 -- or indirect medical education payments directly to
16 teaching hospitals that reflect the volume of MA patient
17 days that a teaching hospital serves.
18 MS. KELLEY: I think that is the end of Round 1.
19 DR. CHERNEW: Yes. That's the end of Round 1.
20 So now we're going to get into Round 2, and my general
21 sense is we have four options on the table. The most
22 important -- you can say whatever you want, but the most

1 important thing for us to take away from this is how you
2 feel -- which do you prefer, if any, you know, why. When
3 we leave, that's what we want to get. So if you have
4 strong reactions or preferences and rationales, I want to
5 get that out.
6 So now let's go to Round 2.
7 MS. KELLEY: Lynn.
8 MS. BARR: Thank you. I am wildly enthusiastic,
9 to quote Stacie, about this chapter and about doing
10 something about this work. And I do support Option 3 of
11 the options that are presented. That's the one that makes
12 the most sense to me and I think is the best way to address
13 the issues that you discuss.
14 I believe that, you know, this is very -- I've
15 had lots of conversations with lots of clinicians about the
16 issue of not getting co-pays and how it impacts them
17 financially. And I think it's really, really important
18 that we acknowledge this and do that. But this also
19 applies to rural health clinics because rural health
20 clinics are cost-based reimbursed, and they get 20 percent
21 less for that patient, and nobody pays them for that. They
22 can't add that to the cost report. So it's very important

1 that we also address this.

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

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

18 Thank you.

19 MS. KELLEY: Jonathan.

20 MS. GINSBURG: Can I --

21 MS. KELLEY: Go ahead, Marge.

22 MS. GINSBURG: My question links to Lynn's

1 statement that suddenly occurred to me. So we're assuming
2 most LIS patients -- we have that broad category -- have
3 their co-pays paid by, you know, supplemental, Medicaid or
4 whatever. But the cost-sharing part that isn't is the co-
5 pays they have for their meds. So when we show in the
6 chart that 13 percent of LIS patients have a problem, is it
7 the co-pays for their meds that they're talking about?
8 Because they shouldn't have any co-pays for the services
9 they get. It's all medications. Co-pays are relatively
10 low, usually, but they could still be a problem.
11 MR. GERHARDT: This policy doesn't contemplate
12 something like that. I mean, we -- it's focused on trying
13 to kind of make the clinician whole rather than the cost
14 sharing for medications. As you say, it's just -- we're
15 just looking at the services, physician fee schedule
16 services, so I think that would be sort of a new branch of
17 thinking about the cost sharing on the bene side for
18 medications -- if I understand what you're saying
19 correctly.
20 MS. GINSBURG: Yeah, I get them confused then,
21 because the chart shows that, you know, 13 percent or
22 whatever still have a problem with cost sharing. So I'm

1 just trying to find out what cost-sharing category they're
2 struggling with, because I just suddenly realized it wasn't
3 logical to me for it to be anything other than meds.
4 MR. GERHARDT: I don't think that the survey data
5 digs down to that level. It just sort of asks that broad-
6 ish question. And, you know, there might be other costs
7 that are associated with seeing the doctor that they have
8 to outlay, that their sort of thinking is a payment for the
9 service. It's difficult to know.
10 DR. CHERNEW: Let me just jump in and try and put
11 some balance on where we are here, because there's a lot of
12 issues, right? So, again, let me say we have three options
13 trying to address a specific question related to explicitly
14 physician payment. There's a portion of that, as pointed
15 out, a motivation for that, as pointed out, relates to
16 money not collected because of some of the policies that
17 were discussed.
18 However, our goal now is not to solve the broader
19 issue of beneficiary cost sharing or, for that matter,
20 rural health clinics or other things. We can have a
21 broader discussion. Right now this is just in the context
22 of this somewhat narrower view, and my concern is if we

1 expand -- we've already gone through hospital safety net.
2 We can think about other provider types. So I want to keep
3 this within the bounds of safety-net clinicians, and we can
4 continue to think about how we deal with that as we get on
5 to both the problem of beneficiary out-of-pocket cost
6 sharing and other provider types.
7 Did you want to add anything, Jim?
8 DR. MATHEWS: Very consistent with what Mike
9 said. Please keep in mind that the rationale for our
10 framework as we developed it over the course of the
11 previous cycle was to try and mitigate financial
12 vulnerabilities at the provider level that were imposed on
13 the providers as a function of their patient panels payer
14 mix. So we're trying to ensure that providers who serve
15 vulnerable populations can continue to exist in order to
16 serve as points of access for these populations.
17 I would think the question of beneficiary's
18 ability to afford their care and whether Medicare should be
19 doing more to address that question is a legitimate but
20 completely separate issue that is going to involve an
21 equally broad set of work above and beyond what we've
22 contemplated here aimed at supporting providers.

1 MS. BARR: Coming in on that point, I understand
2 and I agree, but I do not agree that rural health clinics
3 have any reason to be excluded from this. They have the
4 same exact issues of underpayment for these types of
5 patients. And if we're going to address it for all
6 providers, I don't see how you can exclude rural health
7 clinics because they get a higher rate. That does not
8 include the cost of uncompensated care.
9 DR. CHERNEW: Got it. Next in the queue, Dana.
10 MS. KELLEY: Jonathan.
11 DR. JAFFERY: Thanks, Dana. Again, great
12 chapter. I'm going to try and run through the five
13 questions you pose on Slide 16, not in order because I'll
14 come back to sort of 2 and 3 together.
15 First of all, yes, this is important work and I
16 fully support continuing to develop it.
17 Jumping down to the fourth bullet point, I think
18 the complexities that you laid out around the different
19 states, lesser-than policies, and lots of moving targets,
20 good questions, I think, about whether or not there might
21 be some influence on what states do based on a Medicare
22 policy. But, nonetheless, I think trying to game that out,

1 I think it's okay to permit them to exceed the allowed
2 amount in this situation.
3 In terms of the safety-net add-on payments to MA,
4 I definitely favor direct payments to providers analogous
5 to, as Jim described, what exists for IME to hospitals. I
6 really worry about what would happen if it's just given
7 directly to the MA plans and how that impacts provider or
8 beneficiary decisionmaking, or anything along those lines.
9 And, in fact, I think, you know, if it was done in some
10 sort of -- I don't know how logistically you might do that,
11 maybe a quarterly lump sum payment, that might actually
12 have some psychological advantages to providers who care
13 for a lot of low-income and safety-net providers.
14 So then coming back to kind of the meat of the
15 topic and the four options, despite the fact that we're
16 really trying to really focus in on this one topic, I do
17 think there are sort of two issues that come together in
18 this policy proposal in terms of how do we provide more
19 support for clinicians who care for a lot of low-income
20 beneficiaries, and then also are we addressing disparities
21 at all between payments to primary care physicians and
22 specialists?

1 So those are kind of wrapped into our options.
2 And, you know, to the extent that there are some
3 specialists who do care for lots of low-income
4 beneficiaries, I mean, I definitely appreciate the previous
5 discussion about -- and your points, Geoff, about that kind
6 of self-adjusting. On the other hand, our proposals where
7 specialists are getting only 5 percent, you know, doesn't
8 really cover that cost-share loss.
9 Now, that said, having said that, I actually am
10 in support of actually trying to decrease that disparity.
11 And so I do like the options where there's a split between
12 primary care and specialists for all the reasons we've
13 talked about in terms of specialists already having more
14 robust compensation because of the history of the payments
15 as we've seen over the last several decades.
16 But I think even more to the point around that, I
17 think to the extent that primary care has some additional
18 responsibilities to build in this advance ambulatory care
19 model to address health equity and social determinants, I
20 think that giving them extra payments to help support that
21 -- even though some of the specialty providers are
22 addressing some of those things, I think that, you know,

1 the trends we're seeing in population health and value-
2 based care movements are really designed around primary
3 care doing the heavy lifting around creating those
4 additional models of care. And this may actually help us,
5 you know, help them, primary care, prepare more for
6 advanced alternative payment models and population-based
7 payments even more.
8 So with that in mind, I guess I don't have huge
9 strong preferences between 3 and 4, but I favor a little
10 bit Option 4, actually. The total add-on payments, maybe
11 I'm being cavalier about what $200 million looks like these
12 days, but I think the additional support to primary care to
13 get them to cover that loss of the co-pay and, again,
14 support the additional capabilities that are required to
15 really care for this complex patient population is
16 warranted and probably overdue.
17 Thank you.
18 MS. KELLEY: Stacie.
19 DR. DUSETZINA: Thank you. So I also am very
20 enthusiastic about this work, and I think the chapter is
21 excellent, so I'm really glad we're doing this. I think we
22 should keep going. And I would say that of the options

1 presented, I thought that Option 3 to me seemed very
2 sensible. I liked the rationale that that was kind of
3 about what can't be collected when you look at it on
4 average across beneficiaries, so the 15 percent to primary
5 care added on, 5 percent to specialists, felt like a good
6 place.
7 I am interested to hear more for people's
8 thoughts on the MA question. I'm just not sure I know
9 enough to know whether they should be wrapped in, but I do
10 think that if they are payments directly to the physicians
11 rather than the plans makes a lot of sense.
12 MS. KELLEY: Jaewon.
13 DR. RYU: Thanks, Dana. A couple comments.
14 I'm also in favor of continuing to develop this
15 area of work. I think, yes, there's the co-pay issue or
16 the foregone co-pay payments, but I think the other driver
17 is also equally compelling, which is the higher cost
18 related to taking care of the safety-net population, so to
19 speak. So, you know, I don't think it's uncommon that you
20 would see longer appointment visits. I don't think it's
21 uncommon that you would see social workers in some of the
22 clinics that see high proportions of the LIS population.

1 And, also, you know, a lot of extra staff time in terms of
2 coordinating with other social programs and so forth.
3 So I think we shouldn't lose sight of the fact
4 that it's not just the co-pay issue. There is a higher
5 cost to taking care of these populations.
6 For that reason, I support Option 3. I think
7 Option 4 is -- I'm warm to it, but I probably prefer 3. I
8 like the fact that there's an across-the-board component
9 but also a differential component for the primary care
10 providers.
11 The one thing that I think would be good to see
12 in subsequent iterations is a fine-tuning on who qualifies
13 as a primary care provider. We talked a little bit earlier
14 about, you know, there are some specialties that do a lot
15 of "primary care," whether it's nephrology, cardiology,
16 what have you. And I think just understanding more deeply,
17 you know, would those qualify, what would be the indicators
18 by which a provider would qualify as primary care, I think
19 that would be helpful.
20 As far as the MA issue, I think I'm also in favor
21 of applying it to the MA population as well, and I like how
22 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

1 centered around one issue, which is I think we also have to
2 be mindful that we are making -- we would be making these
3 adjustments in the context of also pursuing adjustments in
4 the hospital safety-net sector. And so the setting I think
5 actually matters quite a bit, and I think we should be
6 quite thoughtful about what the mechanism here is that
7 we're trying to actually effect change through.
8 If you imagine that we're paying for safety-net
9 hospitals that have an outpatient facility as well as an
10 inpatient facility dimension, then there are going to be
11 dollars that are moving into the outpatient facility,
12 outpatient hospital care, to hopefully account for the fact
13 that these beneficiaries might need additional resources
14 and coordination and management and what have you.
15 And so, accordingly -- and I'll also mention that
16 I think work that MedPAC has done and that other peer-
17 reviewed literature supports is that the access gap that we
18 see the most, if you will, for LIS benes, certainly for
19 duals, is in the outpatient setting, so ambulatory care,
20 particularly for specialists but also for primary care.
21 And so if we're really trying to meet that need to keep --
22 essentially keep them out of the hospital, because duals

1 and LIS benes utilize a lot of specialty care, but they
2 utilize that specialty care in the context of having to go
3 to the hospital. And so that's, I think, what in large
4 part what we're trying to avoid here. And so we may want
5 to think about trying to target our targeting, if you will,
6 to that outpatient safety net in a sense. And so that's
7 where, Geoff, I think it would be very helpful for us to
8 look at this and calculate what this would look like if we
9 separated out ER and inpatient billings from other
10 outpatient billings, if you will, or Part B billings,
11 because I think that would help us potentially make each
12 dollar go the furthest.
13 One of the principles that we have outlined that
14 I wholeheartedly agree with is that we want the dollars
15 that we put here to make a difference for the LIS benes.
16 We want it to improve their access. And we do see, I think
17 on page 23 of the readings, there was a note that primary
18 care access is worse than specialty access for LIS benes.
19 But, again, that's not taking into account the setting of
20 how that access is happening, and I think we want to be
21 mindful of that setting. The mechanism here, in other
22 words, really matters, and I think if I'm an LIS bene and

1 I'm picking a hospital to go to and that's how I end up
2 seeing a specialist, that's very different than I can find
3 an outpatient cardiologist or nephrologist to keep me out
4 of the hospital from a hospitalization perspective.
5 So that was the one really major point, which is
6 we need to coordinate with the safety network and we need
7 to think about this in the context of setting.
8 I definitely want to voice support that we should
9 be careful around -- I support basically the idea of the
10 payments following the beneficiary, but then going directly
11 to the clinician so we can avoid some of these potential
12 issues on the MA benchmark inflation or some element of
13 that. So I wanted to make sure to point that out.
14 The next comment, on Table 5, I think it would be
15 very helpful to see the distribution of each of these
16 options across clinicians based on the share of LIS benes.
17 And I think we know, again, from the Commissioners, the
18 Commission's work, that there's a large concentration -- in
19 other words, a disproportionate amount of -- sorry, a small
20 share of clinicians take care of a disproportionate number
21 of LIS benes. And so hopefully this targeting will, in
22 fact, address Larry's comment, for example, that are these

1 going to be meaningful deltas for revenue for a particular
2 practice or a particular clinician? So I think actually
3 seeing what that distribution is will be really helpful to
4 inform which option we might pick, and I think that will,
5 again, vary by setting, which will influence the specialty
6 piece.
7 So the last point is, since Mike asked us to
8 comment, I think in some sense I in principle support
9 Option 3. I also like Option 2 in a sense if we can be
10 oriented around setting, because I think if we orient that
11 around setting, it will actually -- it will naturally
12 accrue more for primary care because primary care is not
13 doing a lot of facility-based care. And so I think it may
14 be preferable in some way to target the primary care via
15 the setting piece rather than having to set a different
16 rate for primary care versus specialties.
17 Thank you. Very happy that we're pursuing this
18 work.
19 MS. KELLEY: Greg.
20 MR. POULSEN: Thank you. Yeah, I agree with a
21 lot of what has been said already. As I mentioned, I asked
22 our data team to look at a whole bunch of physicians and

1 see what we saw, and we saw it ranging up as high as about
2 a 6 percent impact. But we saw it taper off pretty quickly
3 to a smaller amount, which I think is a big deal, because I
4 agree with Jaewon's point on the higher cost to serve.
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.
11 So I really like the idea of doing something. I
12 like the idea of doing something that's simple. I like it
13 being tied to the fee schedule because people get that. I
14 think that makes a whole lot of sense.
15 I fully agree that there is a market in equity
16 between payments between different practitioner types and
17 that this inequity probably has not been fully addressed by
18 other things that have been done. However, I think it
19 should be addressed globally rather than embroidering
20 around the edge, which I think this would be doing. I do
21 not think that this directly addresses that.
22 And particularly, I think separating primary from

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

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

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

20 Let's see. Oh, and that might actually influence
21 some states to reevaluate their Medicaid payment policies,
22 either good or bad. But either way, I think that what we

1 should do is try and make sure that we encourage access for
2 the LIS population where we can.
3 The third point, where I may be the lone ranger
4 on this, is I feel strongly that this LIS payment
5 enhancement should not be applied to MA, either directly to
6 providers or indirectly. I think inserting ourselves
7 further into the MA provider relationship has the potential
8 to create a lot of mischief. We could do much more by
9 incentivizing or, in my preference, requiring that MA plans
10 pass along a majority of their population-based capitation
11 payment to providers. Today it is largely a fee-for-
12 service world, and that is why we are even having this
13 discussion.
14 If we look at the original goal of MA it was to
15 provide incentives to providers, and if we look at
16 provider-sponsored plans today I think we find much greater
17 equity in the way that payments are distributed to provider
18 organizations between primary and specialty care, between
19 low-income and high-income populations, and it seems to me
20 that would be a much more effective MA approach than to try
21 and insert ourselves into a direct payment on top of the MA
22 payment from the plans to practitioners.

1 So for me, Option 2 comes closest to what I think
2 is ideal. Thanks.
3 MS. KELLEY: Betty.
4 DR. RAMBUR: Thank you. I have to also share my
5 enthusiasm for this chapter and your work.
6 Briefly, to me one of the most important things
7 is not only the money, it is the message, and I think Greg
8 and others have sort of been referring to that. So to me
9 the option that aligns both the money and the message the
10 best is Option 4. We have underinvested in primary care in
11 this country. I understand that if we look at traditional
12 primary care, we do not get at some of the cognitive
13 specialties that Scott and others have mentioned. But just
14 because a policy can't do everything doesn't mean it
15 shouldn't do something.
16 Option 3 would be fine as well, but I really
17 prefer Option 4, primarily for the message as well as the
18 money. And maybe like Jonathan I am becoming cavalier
19 about the difference in the amount between these two, but
20 it seems like a good direction to me.
21 In terms of MA, my initial impression was that
22 lump sums to the providers is exactly right. I am now

1 taking what Greg has said, I would like to think about all
2 that a little bit more.
3 But overall I am very enthusiastic about
4 continuing with this work. Thanks.
5 MS. KELLEY: Kenny.
6 MR. KAN: I am enthusiastic about the body of
7 work here. I really like the underlying messaging and the
8 thoughtful acknowledgment of pay disparities between PCPs
9 and specialist and the overall approachable load.
10 I do not have a point of view yet because I
11 actually would like to better understand the following.
12 Number one, the setting issue, which Amol articulated, I am
13 concerned about double payment to hospitals. Number two,
14 the MA issue which had been raised in the discussion today.
15 And then the last issue of how this could get implemented
16 in the states.
17 Great work. Thank you.
18 MS. KELLEY: Dana.
19 DR. SAFRAN: Thanks. I will add my voice to the
20 chorus of support for this area of work.
21 I think that the question I have been sitting
22 with is what exactly is the problem that we are trying to

1 solve, whether it is a problem of access or whether it is a
2 problem of fairness or financial sustainability for the
3 providers that serve LIS population, or disproportionately
4 serve that population, or whether it is a problem of the
5 outcomes and quality that we are trying to achieve for
6 those populations.
7 And depending on which of those things we are
8 trying to solve, I land in a different place. If we are
9 trying to get at financial sustainability or even at
10 access, I find myself struggling to believe that the dollar
11 amounts that we are talking about make an important
12 difference in provider willingness to see LIS patients.
13 I think I am influenced by an experience that is
14 kind of seared in my brain of being in a meeting with a
15 clinician who, in front of a group of people, opened a
16 piece of mail that was from a Massachusetts Medicaid. It
17 had a check and he said, "Does anybody want this?" because
18 it was just such a trivial amount that he just was kind of
19 insulted by it. And yet I worry a little bit about the
20 lump sum as being so disconnected from encounters that will
21 it actually influence clinician behavior and willingness to
22 see these patients. So I am struggling with that.

1 I do find myself connecting it up, and I think
2 some of Jaewon and Jonathan's comments pointed to this, to
3 the issue of quality of care, outcomes of care, and the
4 signaling that we want to do about the additional resources
5 it takes to think outside the literal and figurative
6 clinical box to where patients live and work and what they
7 need in order to achieve good outcomes.
8 So that brings me to some of the thinking we have
9 done in past year around social drivers of health and sort
10 of investing in health equity by beginning to frontload
11 some payments or give differential bonuses for providers
12 who care for a disproportionate share of LIS.
13 So boiling all that down, I think in my own mind
14 I'm very supportive of differentiating, if we are going to
15 do this, of differentiating the percent that primary care
16 clinicians would get versus what specialists would get. Of
17 these options, I am tending toward Option 3 for many of the
18 reasons described. But I am struggling with whether it
19 should be further differentiated based on fee-for-service
20 versus, you know, an ACO or global budget contract.
21 So lastly that brings us around to MA. I too am
22 quite undecided there, but I was really struck by Greg's

1 points, and definitely feel if we are going to extend this
2 to MA, I agree with others that it should be to the
3 clinician directly. But listening to Greg and thinking
4 about how that really muddies the waters between what the
5 plan's responsibility is and what the clinicians, it does
6 leave me a little bit leery about having this apply to MA.
7 So I realize that I'm probably raising more
8 questions than putting down my own stake of where I think
9 we land, but I do feel a little bit uncertain at the end of
10 the day of how much good we can do with this and which
11 problem we are trying to solve, and I would like us to be a
12 little more specific about that in order to shape which
13 option we choose. Thanks.
14 MS. KELLEY: Robert?
15 DR. CHERRY: Thank you, and I also want to throw
16 in my enthusiasm for the report and the presentation. I
17 think this was very well done, and also for teeing up
18 really the important questions that the Commission needs to
19 answer regarding what has been proposed so far.
20 I would like to take a little bit of a contrarian
21 approach to many of the Commissioners' comments. I really
22 favor number 2 as an option, which is the 10 percent option

1 for all physicians. And the reason why -- and first let me
2 say that I understand the rationale for primary care taking
3 sort of priority here, given the fact that there is so much
4 alignment with population health and value-based purchasing
5 and so on. However, I think that we shouldn't
6 underestimate the need for specialty care, particularly in
7 LIS beneficiaries where the acuity is higher and there may
8 be a need for specialty access.
9 So I do think the 15-to-5 percent spread seems a
10 bit large and could actually exacerbate access to specialty
11 care, maybe even disincentive specialists from seeing these
12 patients because there is a 5 percent option here.
13 So I would tend to favor a much more equitable
14 approach. I do think that there is room for that,
15 particularly when you look at the uncollected amounts,
16 which totals about $3.6 billion. So in my mind that is
17 sort of the budget that we are looking at, so I think there
18 is room for a 10 percent or maybe some other option too
19 that increases the amount of a specialist, that it is not
20 too low.
21 I will say as far as the MA beneficiaries, I
22 think we should definitely include them as well. I have no

1 concerns or issues with the direct payments. I think it
2 might actually assist in collecting encounter data as well,
3 which we discussed at our last meeting.
4 And then as far as should we exceed the allowable
5 amounts, I don't really have an issue with that exceeding
6 the amount, in terms of those states that have dual
7 eligible cost-sharing. And the reason why I say that, I
8 think that the Commission should generally sort of be
9 independent of state decisions with regard to Medicaid
10 rates. I think if we put those in sort of a different
11 category and just look at the Medicare rates and what we
12 are trying to accomplish in terms of access to care and
13 equitable payments, then I think it makes the decision a
14 lot easier.
15 So thank you very much again for a really great
16 report.
17 MS. KELLEY: Cheryl.
18 DR. DAMBERG: Great work. Kudos to the staff.
19 This was a really interesting chapter and I too am going to
20 voice my support for both this work and the Commission
21 taking on this particular issue.
22 I do think that we should continue to develop the

1 clinician safety net policy, and I like the fact that this
2 extra payment would be tied to the patient and go directly
3 to the physician. So I very much support that.
4 I am also supportive of trying to get a better
5 understanding, to follow on Amol's comment, about the
6 distribution of these payments by the percent of LIS
7 patients that any given physician would have.
8 And this comment was made in Round 1 -- I think
9 it was made by Marge -- though I am somewhat challenged
10 about how to think about this in terms of potential
11 unintended consequences, whether states would back off from
12 the copayments that they make in this space. So we need to
13 consider what the implications might be there because this
14 is a very dynamic kind of endeavor in terms of downstream
15 effects.
16 In terms of whether the payments should exceed
17 the allowed payment amount, it strikes me that if we just
18 take them to the allowed payment amount, we are essentially
19 achieving parity and not really sort of going that extra
20 distance if we think that these patients actually cost more
21 to take care of. So I think we should do a little more
22 thinking in that space.

1 I too am struggling a bit, and Dana, thank you
2 for laying out your issues so eloquently, in terms of what
3 we are trying to solve for here. I do think that there are
4 legitimately extra costs of caring for these patients, so
5 that obviously falls within payment policy. But I think we
6 should be clear that these extra payments are not going to,
7 as they might under MA, go to address other social
8 determinants, social service kinds of issues that these
9 patients might need to help improve health and health
10 outcomes.

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

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

22 MS. KELLEY: David.

1 DR. GRABOWSKI: Great. Thanks. This is super
2 work, Geoff. In answer to the first question, I am very
3 enthusiastic about continuing with this line of inquiry. I
4 think this is exactly what the Commission should be focused
5 on.
6 In terms of the different options, I would favor
7 Option 4. Others have made this case already -- Betty,
8 Jonathan, and others -- but I really think there needs to
9 be an emphasis on primary care here, and I think the
10 dollars have to be meaningful. To Dana's point, I don't
11 know if that's still going to get us to a meaningful amount
12 for a given physician, but putting as much into primary
13 care here is, I think, the right step forward. And that
14 would actually be something interesting to model, and I
15 think Greg talked a little bit about that, of what dollar
16 amounts here we are thinking about for a given physician.
17 I didn't want to take this opportunity -- this is
18 a great example of this disconnect for duals and Medicare
19 and Medicaid and these lesser of policies are really
20 challenging. We have studied them a little bit in the
21 nursing home context, and Medicare's cost-sharing is very
22 strange. For SNF care it kicks in at day 21, but you see

1 this real difference in states with lesser policies versus
2 full cost-sharing. Lots of beneficiaries go home much
3 sooner in states where they do not have full cost-sharing.
4 So these certainly influence how providers behave
5 around these patients. I know that is a very different
6 setting but I think it comes up in the physician context as
7 well. So anything we can do to sort of make up some of
8 that gap. I don't have a problem, similar to Cheryl, with
9 exceeding the payment amount or equaling it, but sort of
10 modeling that out, as Cheryl described, is really
11 important.
12 Final comment. I really came in kind of
13 indifferent about MA, but I was really taken by Greg's
14 comment and really think maybe we want to pull back there.
15 I will stop there and just say, Geoff, great
16 work. Thanks.
17 DR. SARRAN: Thanks. First, I will reinforce the
18 overall quality of this work and the importance of it.
19 You know, I think in terms of whether the order
20 of magnitude of the dollars going out the door via any one
21 of these proposals is sufficient to create the behavior or
22 change we want to see, I do think there is value in the

1 signal it sends. So in my mind, whether it is Option 3 or
2 Option 4, we may achieve much of the value we are trying to
3 achieve by Option 3 at a slightly lower cost.
4 I have no problem with the money going on being
5 above the allowable in certain circumstances because I
6 strongly agree with Jaewon that the true cost of treating
7 these beneficiaries is hard to measure but is often
8 consequentially higher.
9 On the MA, I noodled on that one a lot since I
10 started reading this, and I would lean against passing the
11 money through to MA, Greg's comment. Although on one hand
12 MA plans, on average, do a pretty lousy job of aligning
13 incentives with providers--most of them take the easy way
14 out and just say fee-for-service and find other ways to
15 make the numbers work--I think we all are agreeing that we
16 are overpaying. We are certainly adequately, if not
17 overpaying MA plans today, so why not just get more
18 directive and more stringent and rigorous about what we
19 expect in return for what we are paying, rather than
20 putting more money alongside MA?
21 I also think if we do the MA direct provider
22 payment there will be an unintended consequence that is

1 around the reality that some MA plans pay some providers
2 the full allowable amount for duals, and if we start
3 passing this money through those MA plans I would bet you
4 anything we will immediately change those contracts or work
5 real hard to change those contracts and say to providers,
6 hey, we will stop paying you this because CMS is paying you
7 directly, and that is not an unintended consequence we want
8 to see.

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

10 MS. GINSBURG: Yes.

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

21 And I was -- as many of you have said, I'm very
22 grateful for the comments Greg made about MA because that

1 was my initial reaction right off the top.

2 Now there could be a quid pro quo, if we could

3 start getting information from the MAs that we've been

4 asking for, for the last 10 years or so, about how they do

5 their -- all of their cost stuff. Everything that we've

6 been wanting to know about MAs that we have been unable to

7 get, they start giving us that information. Then we might

8 consider adding them into this, but until that happens, I

9 really don't think we want to do anything that would

10 encourage more business for MAs when we haven't -- when

11 we've learned so little about how they're actually doing

12 their business and what their costs actually are.

13 Thank you.

14 MS. KELLEY: So that is the end of the queue. I

15 do have a message from Larry Casalino that he wanted me to

16 read, so I'll go ahead and read Larry's comment now.

17 Larry favors Option 4. The cost to Medicare is

18 not very high. The amounts paid to the average clinician

19 are too small to have an impact, if you consider as a

20 percent of primary care and of specialist income. It is

21 extremely low, but I think this is perhaps okay for the

22 average physician. Larry would like to see the amounts for

1 the quintile of physicians who care for the most low-income
2 payments.
3 And separately, he strongly agrees with Jaewon's
4 comment about the higher cost of taking care of low-income
5 patients.
6 DR. CHERNEW: Great. So we're about to break for
7 five minutes, and then we're going to come back, and we're
8 going to do the post-acute PPS, but before we do -- Wayne--
9 DR. RILEY: Sorry, Dana. I sent a hands-up.
10 I too salute the staff and Geoff for the great
11 work around this. This is critically important that we
12 continue this in parallel with the work on safety-net
13 hospitals, so I salute that.
14 I tilt strongly to four, for many of the reasons
15 that have been voiced by Betty and Larry just now and
16 Jonathan. Primary care has been undervalued far too long,
17 and just knowing the demographic shifts we're dealing with,
18 the rural issues that Lynn has talked about, and the large
19 asymmetry, quote/unquote, of physician salaries, I think we
20 should, you know, embrace No. 4. Even in terms of its cost
21 to the federal outlay of $2 billion higher than Option 3,
22 $7 billion higher than if we did it 10 percent across the

1 board for everybody. So I think when you frame it that
2 way, I strongly favor Option 4.
3 DR. CHERNEW: We're going to have a Round 1 which
4 turns out like 1, 2, 1.
5 [Laughter.]
6 DR. CHERNEW: But we are then going to break, but
7 we have -- yeah. No, go ahead.
8 DR. RAMBUR: I'm assuming that we're not able to
9 break out physician, nurse practitioners, and PAs in terms
10 of serving this population. I'm curious, because my
11 experience is a lot of nurse practitioners and PAs do work
12 with more vulnerable populations, so just a question.
13 MR. GERHARDT: I mean, we can and we do break it
14 out in certain tables. Are you looking for it to be broken
15 out for a certain --
16 DR. RAMBUR: No. I'm just thinking that that's
17 another piece of the story that isn't fully clear here, and
18 I'm not sure we can make it clear. We have incident-to
19 billing and other kinds of things.
20 MR. GERHARDT: Right.
21 DR. RAMBUR: But my experience is that NPs and
22 PAs work with many disadvantaged populations, and they make

1 half of what the physicians and primary care do, so --

2 DR. CHERNEW: Okay. Great. So this has been a

3 really good discussion. We've heard from all of you. We

4 have a lot to think about. The one thing that I can say

5 with some certainty is no one likes Option 1.

6 [Laughter.]

7 DR. CHERNEW: I've heard reasonably strong

8 support from different people for 2, 3, and 4, and a few

9 other nuances there regarding things like non-facility,

10 facility distinctions, and several folks have spoken on the

11 role of MA that I think we will take to heart.

12 But given that, I think this has been a

13 particularly important and good discussion, so I want to

14 thank you all.

15 We're going to take a five-minute break for those

16 of you here. Stay logged into this session, and we're

17 going to be back to talk about post-acute PPS in five.

18 [Recess.]

19 DR. CHERNEW: We're going to jump in. Dana, you

20 can get us going when it's time to get us going, which is

21 kind of now.

22 MS. KELLEY: I think whenever Carol's ready to

1 start.

2 DR. CARTER: I'm ready. Okay. Hello, everybody.

3 DR. CHERNEW: We have to --

4 DR. CARTER: We're not ready?

5 DR. CHERNEW: Okay. We are now actually really

6 officially ready, Carol, so I'm turning it over to you to

7 talk about post-acute PPS, which has been a road we've been

8 going down for some time now.

9 DR. CARTER: Yes.

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

11 us home.

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

13 [Laughter.]

14 DR. CARTER: Today we begin a series of

15 presentations to prepare a mandated report on a prospective

16 payment system for post-acute care.

17 Before I get started, I want to thank Kathryn

18 Linehan for her help with this work, and to remind the

19 audience that they can download a PDF version of these

20 slides in the handout section of the control panel on the

21 right hand of the screen.

22 Today we'll start with outlining why the Congress

1 was interested in a unified payment system for post-acute
2 care, and then I'll summarize the mandate.
3 Next, I'll review the Commission's extensive body
4 of work on a unified payment system. Then I'll highlight
5 important changes that have occurred in the PAC landscape
6 since our earlier work was completed and point out the key
7 challenges to implementing a unified PAC PPS.
8 Finally, I'll outline the analyses we plan to
9 complete for the mandated report. We will begin to present
10 that work at next month's meeting.
11 Our work and that done by others has found that
12 some beneficiaries who look similar in terms of their
13 condition and comorbidities are treated in different
14 settings -- that is, home health agencies, skilled nursing
15 facilities, inpatient rehab facilities, and long-term-care
16 hospitals. But because Medicare uses separate payment
17 systems for each setting, payments can differ
18 substantially.
19 In addition, there were shortcomings in the home
20 health and SNF PPSs that encouraged providers to furnish
21 unnecessary rehabilitation therapy and to selectively admit
22 certain types of patients over others.

1 Further, quality measures and patient assessments
2 made it difficult to compare patients, costs, and outcomes
3 across settings.
4 To begin to make sense of this disarray, the
5 Congress passed the IMPACT Act in 2014 that required the
6 Secretary of Health and Human Services to develop and
7 implement uniform patient assessment items and quality and
8 resource use measures.
9 It also required MedPAC and the Secretary to
10 design prototype payment systems to span the four settings.
11 The Congress required three reports on designs
12 for a PAC PPS. We completed the first work in 2016. A
13 second report by the Secretary was submitted to the
14 Congress in July 2022.
15 The Commission is required to submit a third
16 report, including recommendations, that is due on June 30,
17 2023.
18 The Congress required that the designs span the
19 four PAC settings and base payments on patient
20 characteristics not the setting.
21 Our work on a PAC PPS has been fairly
22 comprehensive and has spanned six years. Much of this work

1 was done in response to mandates from the Congress. I'll
2 summarize the work over the next few slides, and the paper
3 includes links to the various chapters in past reports.
4 In our June 2016 report, the Commission supported
5 the rationales for a unified payment system and concluded
6 that it was feasible to design a PAC PPS using existing
7 data.
8 Based on strong Commissioner interest, we
9 proceeded to build out this policy idea over the next three
10 years and focused on various implementation issues.
11 The Congress required us to review the existing
12 value-based incentive program for SNFs and to consider a
13 design for all post-acute care providers.
14 Our work started with identifying key features of
15 a PAC PPS, including:
16 A stay, using a stay as the unit of service;
17 An adjustment for home health stays; otherwise,
18 these stays would be way overpaid and institutional care
19 would be substantially underpaid;
20 A uniform set of risk adjusters;
21 A targeted rural payment policy;
22 An adjustment for home health stays that occur

1 late in a sequence of post-acute care; otherwise, these
2 later stays, which have lower costs, would be overpaid;
3 A short stay outlier policy and a high-cost
4 outlier policy;
5 We found no need for an additional adjustment for
6 teaching status that IRFs currently receive.
7 We noted that further analysis was needed to
8 assess if there should be an adjustment for providers
9 treating high shares of low-income patients.
10 The Commission underscored the importance of a
11 design that has uniform features (except for the home
12 health adjuster) and acknowledged that while setting-
13 specific features would yield more accurate payments, they
14 would undercut the purpose of a PAC PPS.
15 To evaluate the design, we examined three
16 aspects:
17 First, the accuracy of PAC PPS payments for
18 various patient groups, and we concluded that they would be
19 accurate.
20 Second, to examine the equity of payments, we
21 looked at the profitability of different types of cases.
22 We concluded that a PAC PPS could increase the equity of

1 payments.

2 Third, we modeled the impacts on providers and
3 found that there would be considerable redistribution of
4 payments, from rehabilitation to medically complex patients
5 and from more costly to less costly settings.

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

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

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

18 To address regulatory alignment, we proposed an
19 approach that would shift requirements from being based on
20 setting to being patient-centered. For example, if a
21 provider opted to treat patients on ventilators, it would
22 have to meet additional requirements specific to that care.

1 We also examined the current differences in
2 benefits and cost-sharing and outlined the inherent
3 tradeoffs in aligning them.
4 In its early work, the Commission noted that a
5 value incentive program should accompany the implementation
6 of a PAC PPS. Otherwise, providers could generate
7 unnecessary volume to increase revenues or lower their
8 costs in ways that would harm beneficiaries, such as
9 stinting on care.
10 In response to additional congressional mandates,
11 the Commission completed two reports.
12 The first report on the SNF value-based
13 purchasing program included a recommendation to eliminate
14 the program and replace it with a different design.
15 The report on a PAC value incentive program
16 outlined the key decisions policymakers would need to make
17 when designing such a program.
18 Both reports build on the Commission's principles
19 for value-based payments.
20 Since our early work, there have been key changes
21 in the PAC landscape that could shape the design and
22 impacts of a PAC PPS.

1 First, the PPSs for SNFs and home health agencies
2 were overhauled and are likely to have shifted payments
3 towards medically complex care and away from rehabilitation
4 care. The new criteria for LTCH payments have changed the
5 complexion of this sector.
6 Second, the impacts of COVID-19 have been
7 considerable. Providers' costs, staffing, and service
8 provision changed, and while some of those changes will be
9 temporary, others are likely to be permanent.
10 Beneficiaries' use of PAC also changed, as they avoided
11 nursing homes, and those who sought post-acute care may
12 have been sicker.
13 Last, the continued expansion of alternative
14 payment models illustrates the shifts in PAC use that are
15 possible. Participating entities generally shift PAC use
16 to lower-cost settings and encourage shorter stays.
17 There are many challenges to implementing a PAC
18 PPS. First, aligning regulatory requirements so that
19 providers face the same costs will be a multi-year
20 undertaking. Some of the requirements will be relatively
21 easy to align, while others -- such as staffing and
22 physician presence -- will not be.

1 The second challenge will be how to address the
2 quality of the function data. We think there's no
3 realistic timely fix for this information, and in the paper
4 we outline strategies CMS could take to dampen the effect
5 of these data on program payments.
6 CMS will also need to consider how to address
7 anomalies in data from years with large COVID-19 effects.
8 We think there are reasonable strategies to take so that
9 CMS could proceed with its work on a PAC PPS.
10 A key rationale for a PAC PPS remains; similar
11 patients are treated in different settings with different
12 payments. Our work has shown that a PAC PPS can be
13 accurate and is feasible using existing data. The changes
14 home health agencies and SNFs have made in response to
15 their new case-mix systems are entirely consistent with
16 those that would need to be made under a unified payment
17 system.
18 Concerns about using data from years that include
19 large COVID-19 effects are relatively straightforward to
20 address by using a more recent year of data when testing a
21 design and with periodic revisions to the PPS.
22 We acknowledge that aligning regulations, cost

1 sharing, and benefits will be challenging, but we think it
2 is possible.
3 Now shifting gears, in July, the Secretary issued
4 his report on a prototype design. This report was prepared
5 by RTI International under the direction of CMS and ASPE.
6 At the November meeting, I'll go into more detail about the
7 design and its findings, but I wanted to give you a sense
8 of what's in the report. And there is a link to the report
9 in the paper.
10 The report includes a prototype design to set
11 payments for all PAC providers. A base rate would be
12 adjusted for the case-mix group assignment, comorbidities,
13 and rural location. The design includes an adjustment for
14 the setting where the patient was treated, and the report
15 states that this adjuster could be modified over time.
16 The report is clear that the prototype should be
17 updated with more recent data. Data from 2017 through 2019
18 were used to develop the design.
19 The report includes estimates of the prototype's
20 accuracy and impacts on payments to providers.
21 It does not include recommendations or policy
22 options but includes discussions of the topics we have

1 outlined as key companions to a PAC PPS: a value-based
2 purchasing program, regulatory alignment, and aligned cost
3 sharing. And as I said, we'll discuss the report in detail
4 in November.
5 To examine the Secretary's prototype, we plan to
6 do the following:
7 First, we will update our analysis of design
8 features that are needed to keep payments aligned with
9 costs. Then we'll compare those features to the features
10 of the prototype.
11 We will report the prototype's accuracy and
12 equity of payments and its ability to explain the variation
13 in costs across stays.
14 We'll also report the prototype's estimated
15 impacts on providers.
16 Then we'll also outline additional diagnostics
17 CMS should conduct as it proceeds with an updated prototype
18 using more recent data.
19 We'll present analyses that help assess certain
20 implementation features, such as whether the level of
21 aggregate spending should be lowered when a PAC PPS is
22 implemented and whether there should be a transition.

1 We'll also review complementary policies that
2 should accompany a PAC PPS.
3 Here's the timetable for future presentations.
4 In November, we'll present our analysis of the
5 Secretary's prototype design.
6 In March, we'll outline additional diagnostics
7 CMS should undertake as it evaluates an updated design and
8 outline the implementation issues. This will be your first
9 chance to review the entire report and to consider a draft
10 recommendation. Given the constraints, we don't envision a
11 set of detailed recommendations but rather one similar to
12 that made in 2016 -- to recommend forwarding the entire
13 report to the Congress.
14 April will be your last chance to review the
15 entire report, and you will vote on the draft
16 recommendations.
17 During your discussion today, we're interested in
18 your comments on the proposed analytic plan. Over the next
19 month, we'll want to know if there is other information you
20 will need to get to a recommendation.
21 And with that, I'll turn things back to Mike.
22 DR. CHERNEW: It is so good to see the progress

1 that has been made. I know we're going to be talking about
2 this several other times, but I think we should go through
3 the queue and see where we end up.
4 MS. KELLEY: All right. I have Lynn with a Round
5 1 question.
6 MS. BARR: I want to focus specifically on the
7 rural issues in the report that, you know, weren't quite
8 maybe addressed. So many rural beneficiaries end up in
9 swing beds, and I know that's under a different payment
10 system, and we're talking about a payment system, but we're
11 also talking about a quality system and value-based care
12 system, and we talk about, you know, accountable care
13 organizations. And there's a lot of complexity around
14 this, and I don't want to derail the work. But is there
15 any way to think about how elements of the PPS plan can
16 include swing beds other than the payment side?
17 DR. CARTER: So what kinds of elements --
18 MS. BARR: Like quality. So if we're going to --
19 because they're completely exempt from any kind of quality
20 reporting; we don't do any -- there's no oasis. You know,
21 we have no way of evaluating the quality of care, and we
22 pay a ridiculous amount for this. You know, and so I don't

1 know if this is appropriate in -- you know, someday Mike's
2 going to give me my own chapter on rural, I'm sure.
3 DR. CHERNEW: I can't believe that book isn't
4 somewhere being written on your computer.
5 [Laughter.]
6 MS. BARR: 2012 was a good year, but it's been a
7 long time. Anyway, so just is there any way to think about
8 -- because we have nothing on the value of that care, and
9 it would be very important, I think, to try to see if
10 there's an element we could share.
11 The other piece that came out in this that struck
12 me was the home health recommendations don't really --
13 there doesn't seem -- there's a big disconnect, I think,
14 between the rurals' perception of home health access and
15 MedPAC's perception of home health access. And I'm
16 wondering -- and I've been trying to think about this for a
17 long time, because if you go to Iowa and Michigan, they'll
18 tell you they have no access. In Texas and Oklahoma,
19 they've got more access than they need, and so maybe it's
20 an averaging issue. But there are many, many states -- not
21 in the South, in the South -- that have no access to home
22 health and everyone thinks they do. So is there a way to

1 dig in more on that access issue? Because if you talk to
2 the rural constituents, they all agree, we have a terrible
3 problem. But if we talk to MedPAC and CMS, there's no
4 problem. And I don't know what the disconnect is, but I
5 think it might be because we're averaging things. And we
6 do know that there are states that have huge
7 overutilization issues in rural and the waste, fraud, and
8 abuse, and that might be skewing the data. So those are my
9 Round 1 questions.
10 DR. CARTER: So in terms of thinking about the
11 requirements for, say, rural swing bed providers, we can
12 think about including some discussion of that.
13 In terms of access, that's not really a focus of
14 this report. We're really looking here at a prototype
15 design, so I --
16 MS. BARR: How do you evaluate equity then in the
17 design if -- I mean, like I said, the constituents say
18 there's a huge problem; no one's recognizing it. So I feel
19 like that disconnect -- how you design -- if you design
20 this, we're still going to have the same problem, unless
21 we're all delusional about the problem. I don't know what
22 the issue is. My data, I saw it.

1 DR. CARTER: So I can talk to my home health
2 colleague and think about how to include maybe some
3 perspective on whether this payment system redesign would
4 help with that, but I don't think it will be a key -- we
5 won't be able to evaluate whether this payment system's
6 going to improve access. We can tell you what's going to
7 happen, what we would estimate the impacts to be, but that
8 would be kind of by the case type level or at the provider
9 level, but we can try to include -- at least think about
10 how to get at --
11 MS. BARR: Yeah, the problem is in the paper you
12 say there's not an access issue, and that's been the
13 position. And so I don't know where to get at the data
14 that says, you know, if all the constituents are saying
15 there's an access issue but the data says there isn't, and
16 we're evaluating payment models, how can we be evaluating
17 whether or not this is affecting access when there's a
18 potential data disconnect. I don't know how to solve it.
19 DR. MATHEWS: Yeah, Lynn, if I could jump in
20 here, just a reminder. Last year, actually, June of 2021,
21 we reported out an update of our prior work on access to
22 care in rural areas where we looked at utilization of

1 services as a proxy for access. And across the sectors
2 that we looked at -- hospital, physician, SNF, home health
3 -- we found comparable levels of utilization across all
4 gradations of rurality, if that's the right word, until you
5 got to frontier areas.
6 MS. BARR: Right.
7 DR. MATHEWS: And at that point, utilization
8 understandably tails off. But with respect to, you know,
9 per capita utilization, with respect to financial
10 performance, we don't see large differences among rural and
11 urban, financial performance under the Medicare program.
12 Those are the things that lead us to conclude that there is
13 not, you know, in the aggregate a problem with rural
14 beneficiaries' access to home health care. I don't know
15 what the industry might be telling you, but --
16 MS. BARR: And I agree in the aggregate, but I
17 think it's being skewed by we have overutilization in Texas
18 and Oklahoma that's swamping the data. And so I don't know
19 how to get at this. I had this same complaint when we had
20 that chapter, and so I don't know how to get at this. But
21 the constituents, it was our experience, we couldn't get
22 home health in the majority of our rural communities, not

1 frontier. I don't know where the disconnect is. I don't
2 want to dominate this, but I'd love to talk to somebody
3 about it because there might be a way to look at this.
4 MS. KELLEY: David?
5 DR. GRABOWSKI: Great. First, thanks, Carol.
6 This is great work, and I'm really excited we're continuing
7 our work on the unified PAC.
8 I just want to confirm a detail. I'm less
9 familiar with the ASPE work, but all of the coding,
10 correct, is done in the prior hospitalization? There's
11 nothing from the assessments once they're at the SNF or
12 the, you know, OASIS? And so it's all done kind of in the
13 sort of hospital setting. Am I correct in that in both
14 ours and their work?
15 DR. CARTER: No. So some of the -- some of the
16 information is taken from claims, so like the --
17 DR. GRABOWSKI: Yeah.
18 DR. CARTER: -- primary reason to treat and
19 comorbidities are pulled --
20 DR. GRABOWSKI: Yeah.
21 DR. CARTER: -- from claims.
22 Things like whether a patient is on a ventilator

1 is during the PAC stay, not in the prior hospital stay.
2 DR. GRABOWSKI: Right.
3 DR. CARTER: We did use the hospital data to
4 assess things like -- for measures of severity. Like how -
5 - if a patient stay was in an ICU, how many days were they
6 there?
7 We ran those claims through the severity of
8 illness adjusted APR-DRGs, as another measure of severity.
9 So there's some information from hospital claims, but of
10 course, the majority of home health don't have hospital
11 claims. We were trying to use PAC information and then
12 pull from hospital stays when we had them.
13 DR. GRABOWSKI: Thanks.
14 DR. CARTER: Yeah.
15 MS. KELLEY: Robert?
16 DR. CHERRY: Yeah. Thank you. A great report.
17 My question is regarding clarification on Slide
18 No. 11. There was mention that one of the challenges
19 implementing a unified PAC PPS system is accurately
20 measuring the functional status of patients, and I just
21 wanted to clarify that statement with our pre-read
22 materials because, in the pre-read materials, the problem

1 with assessing functional status was incomplete data,
2 whether it's lack of reporting or it's reported but not
3 sort of translating back into our databases. So is that
4 what you're referring to, or are you questioning the actual
5 functional status model that providers rely on to report
6 on? Because there's different models for assessing
7 functional status. Thank you.
8 DR. CARTER: So we're referring to both. There
9 are some missing data, but we also have done work looking
10 at whether there is inaccuracies or how function is
11 recorded, and particularly when that's used for payment,
12 there are incentives to assess patients as lower than they
13 actually are to set the payment at a higher rate. So we're
14 worried about the quality of the information as well as
15 missing data.
16 DR. CHERRY: So I think what you're saying is
17 that there is a need also to recommend a functional model.
18 So there's also consistency across --
19 DR. CARTER: Well, we have consistent measures
20 across the settings. Those already are included in the
21 patient assessments. The four settings now have uniform
22 measures of function. So it's less that -- than some of

1 the biases that we're a little worried about, and I don't
2 think that the data are entirely wrong, but there is a --
3 at least in the work that we've done, there's bias in the
4 information.
5 DR. CHERRY: Thank you for clarifying.
6 DR. CARTER: Yeah.
7 MS. KELLEY: Amol?
8 DR. NAVATHE: I realize that we're still looking
9 at the ASPE model, but I was curious if you have any sense
10 of why they included the setting, kind of given, in some
11 sense, this notion of trying to get to a unified PPS.
12 DR. CARTER: So we'll talk more about that next
13 month. My sense was the model was trying to accurately
14 predict cost of care, and including the setting as an
15 indicator helps with that.
16 DR. CHERNEW: I'm just going to say one thing in
17 response, though I don't know the answer to the question.
18 This is a bigger-picture comment about cost in general.
19 There's a statistical aspect that if you see a bunch of
20 costs, you want to predict it, and there is a behavioral
21 aspect, which is the costs reflect how you pay and a bunch
22 of things that happen. And so we constantly have this

1 tension across what we're doing here.

2 So I agree with your point. It's this aspect of

3 the extent to which setting is designed to adjust for cost

4 per se versus some, for lack of better word, unobserved

5 case mix in ways you can't get it.

6 But I think we might save a deeper discussion of

7 that for a month-ish.

8 DR. CARTER: That's right. We'll go into that,

9 and the tradeoff in a model that's fully uniform versus one

10 that isn't, because there are clearly tradeoffs there.

11 MS. KELLEY: Kenny?

12 MR. KAN: On the last slide, regarding the

13 timeline -- by the way, I am wildly enthusiastic about

14 this. I definitely look forward to the November analysis,

15 and I like the proposed analytic plan.

16 Mike actually captured my thoughts. I'd like to

17 better understand the dynamic that he just mentioned in

18 terms of when you were to back-test it. No model is going

19 to be ever perfect when you back-test it, but does it sort

20 of like even out in general? I think that would be helpful

21 for me to understand.

22 Also curious is that as the society transitioned

1 from a pandemic to an endemic, I'm curious about, you know,
2 if there's any impact from long COVID. I realize there's
3 not a lot that we know about this, but, you know, perhaps
4 the model may want to be a little bit flexible. So I
5 definitely look forward to learning more.
6 MS. KELLEY: That's all I have for Round 1.
7 DR. CHERNEW: Great. So we're going to move to
8 Round 2, and I think, if I'm right, we're going to start
9 with David.
10 DR. GRABOWSKI: Great. Thanks, Mike, and once
11 again, Carol, this is great work, and I'm very supportive
12 of the direction we're headed.
13 I wanted to make four comments. The first is a
14 big-picture comment. I think the problem we're trying to
15 solve here is that Medicare is paying a very different rate
16 for similar patients across four post-acute care settings,
17 and that obviously leads to some big inefficiencies and
18 distortions. In that regard, I think the PAC PPS is a real
19 step in the right direction, but I would say I hope it's
20 not our destination. And you say this well in the chapter.
21 It's still based on fee-for-service. It's going to help
22 with sorting individuals to the model that best meets their

1 needs, but I don't know on a population level that it's
2 going to do as strong a job as an alternative payment model
3 might in terms of curbing low value post-acute care. And I
4 think that's really the problem here.
5 Yes, I think it's helpful, but it's not sort of
6 addressing this bigger value issue that we have in post-
7 acute care. But I do think it can help in terms of the
8 matching issue. So that's the first comment.
9 The second comment, however, is beyond just
10 harmonizing payments, I think there's real value in this
11 exercise of harmonizing cost sharing, harmonizing quality
12 measures, and harmonizing the regulations across these
13 different PAC settings, and I think that's going to have
14 value wherever this kind of model ends up.
15 We've had such differences in how we think about
16 quality. Even the assessment instruments, the OASIS, yes,
17 and the FIM are so different across these settings that
18 it's been hard to compare applies against apples in the
19 past. And so I think there's going to be tremendous value
20 here in this work, even if we don't get to the unified PAC,
21 which I hope we do get to.
22 Third comment, in thinking about my challenge

1 with unified post-acute care payment, it's always been home
2 health, and it's different -- and, Carol, you've talked a
3 lot about that over the years. I'll say the obvious. It's
4 noninstitutional. It really relies on family caregivers
5 and paid caregivers as this complement to what you would
6 get in these institution-based settings, like a nursing
7 home or an inpatient rehab facility. And so it's always
8 been challenging to kind of make that comparison because in
9 the home health setting, we're sort of putting that on the
10 family. We're bringing the therapy to them but not the
11 sort of assistance with activities of daily living.
12 For this reason, I'm a really big fan of that
13 home health agency adjuster that you have in the model,
14 Carol. I think that's a super important part of all of
15 this, but I did want to push a little bit on how we think
16 about social factors and how we account for them here.
17 Just very quickly, we did a paper several years
18 ago with a group over at Mass General where we were able to
19 leverage their electronic health records, and we looked at
20 where individuals were being discharged from the hospital.
21 And we thought, oh, we'll find health characteristics are
22 the most important predictors. It turned out living alone

1 was the most important predictor as to whether you went to
2 a SNF and not home, and that's a hard thing to account for
3 here.
4 I think some of our beneficiaries have the family
5 support, have the ability to kind of fill in the gaps.
6 Others don't, and I think I just don't want this to lead to
7 more sort of distortions in terms of the haves and the
8 have-nots in our system.
9 Final comment. And you said this well on Slide
10 10, Carol, that the landscape has really changed -- I don't
11 have to bring us up to speed on COVID -- shifting folks out
12 of SNFs into the home. APMs obviously cut down a lot on
13 utilization.
14 But I did want to touch on that third point you
15 made about both home health and skilled nursing facilities
16 now have payment systems that much more resemble like what
17 we've proposed here and that they no longer pay based on
18 therapy. They pay based on patient characteristics.
19 And we've been doing an evaluation of the
20 patient-driven payment model, which is the SNF version of
21 that. It came online just before the pandemic. So we had
22 this very narrow evaluation window, and then the world

1 completely changes. It was hard to really tell what was
2 going on, but it came online fourth quarter of 2019. And I
3 think the results are important here.
4 The one result is not surprisingly. Nursing
5 homes pivoted very quickly. Therapy came way down. That's
6 not going to shock anyone. Patient characteristics,
7 however, went way up, and how much of that is real, we
8 think very little based on the hospital claims. I think a
9 lot of that is up-coding.
10 The other good news is there doesn't seem like
11 any outcome shifted, so that's sort of supportive of a lot
12 of other work, like the ACO work, that you can really
13 change kind of the amount of post-acute care, the amount of
14 therapy, and not see big results.
15 But I think the big takeaway here is as we rely
16 on coding from the different post-acute care providers,
17 let's make certain that it's accurate, and that's really
18 the tension, how much we can get from the hospital claims
19 and how much we have to rely on kind of them telling us
20 what the characteristics are, because I'm very suspicious
21 based on what's happened in PDPM that we're going to get
22 back accurate information.

1 All right. Mike is going to give me the hook
2 here in a second, so --
3 DR. CHERNEW: I'm not. For those watching at
4 home, I'm not.
5 [Laughter.]
6 DR. GRABOWSKI: All right. Well, I have five
7 more comments -- no, no, no.
8 I'll sum up here and just say that I'm very
9 supportive of this work. These comments shouldn't be taken
10 as criticism, more -- more ways in which I think we can
11 enhance and some things we want to look out for. So thanks
12 again, Carol. Great work.
13 MS. KELLEY: Greg?
14 MR. POULSEN: Thanks.
15 David really got a lot of the key points that I
16 wanted to make. As opposed to being wildly enthusiastic,
17 I'm sort of cautiously positive, honestly, because I think
18 the challenges here are enormous.
19 I certainly like the goal. Anything that moves
20 us upstream and pays for patient condition as opposed to
21 setting treatment, I think, is a good thing. Obviously,
22 total population payment is by far the most effective in

1 that direction.

2 I worry that we're in a place where we may be
3 finding it very difficult to tease out the different
4 patient beneficiary characteristics. Our current work
5 suggests that we can do this, I think, reasonably well, but
6 maybe, to David's point, I think the coding and other
7 things that this is based on are so variable that I'm
8 concerned that we may not be catching all of it and in a
9 way that's really meaningful.

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

17 And that troubles me that we may be not making a
18 completely embracing argument around this, and I guess I
19 would suggest to all of us who have been watching all of
20 these areas for a while, the capabilities are increasing
21 dramatically. The things that we used to do in ICU are now
22 often done not only not in an ICU, they're not even done in

1 a hospital. They're done in a long-term care facility, for
2 example. And that's happened in a relatively short period
3 of time.
4 The phrase "hospital at home," I think, was a
5 buzzword a little while ago, but now it's reality. There
6 are literally people at home who would have been in a
7 hospital not very many years ago.
8 So to essentially say, well, home health is
9 different because it costs less troubles me, that if we
10 think that we can accurately and sufficiently capture
11 differences in population based on patient characteristics
12 -- and in those patient characteristics, I would include
13 family support or other social considerations, which
14 clearly are there -- I think, David, you just mentioned
15 that the biggest differentiator in some instances was the
16 presence of family as opposed to clinical differences. To
17 the extent that we can capture all those, it seems to me
18 what we would really like to do is to identify a payment
19 mechanism that's holistic and then identify the lowest-cost
20 setting where that can be provided.
21 And that should be true across the three
22 institutional settings, but I think it's probably in

1 sufficient to say, well, but it shouldn't include home
2 health because, oh, by the way, it's cheaper. I think we
3 need to find a mechanism that's more embracing to say why
4 should we not consider the person's total needs, clinical
5 and social, and then allow organizations to find the most
6 effective, cost-effective setting that meets those needs.
7 As I said, I'm positive about this, but I'd be
8 wildly enthusiastic if we were able to break that down
9 because I think that would take us to a place where we can
10 actually find significantly lower-expense settings and
11 really enhance the whole concept of moving people into the
12 lowest-cost setting that fully meets their needs.
13 And technology is going to allow us to do things
14 in five years that we can't really even envision today, and
15 the payment mechanism, we should make sure that our payment
16 mechanism proposals don't make that more difficult. They
17 should make that more easy, so thanks.
18 DR. CARTER: So I just wanted to point out that
19 at least in our work, we're averaging costs. So we pull
20 everybody in together, and so we're not trying to find the
21 lowest-cost setting. We're trying to set payments based on
22 the cost of the average. So I just wanted to make sure

1 that you understand.
2 MR. POULSEN: No, I get that.
3 DR. CARTER: Okay.
4 MR. POULSEN: I appreciate it.
5 I guess what I'm saying is, as we look at it,
6 there clearly are significant differences between settings
7 for patients with apparently the same characteristics. To
8 the extent that they really do have the same
9 characteristics, then I would hope that as a policy
10 approach, we would encourage people to find the lowest-cost
11 setting. And that's going to hopefully happen by default.
12 To the extent that we assume similar
13 characteristics, but the clinicians who are making the
14 recommendation on where people go identify something, we're
15 making that assumption for home health. We're assuming
16 that the clinician is including something that we don't
17 have in the medical record, which is are there people there
18 that can be the caregivers.
19 There may be things as well that are being made
20 that aren't being captured in the coding as well would be
21 my thought and my worry.
22 MS. KELLEY: Scott.

1 DR. SARRAN: Yeah. Excellent work, and I
2 thoroughly support it.
3 I'm going to largely, I think, reinforce what
4 David's comments were and go perhaps one step beyond that
5 in terms of a point that I don't think we're yet
6 addressing.
7 So I think the work is really good as far as
8 speaking to how we distribute money between settings, and
9 as David pointed out, the PDPM work was an attempt, I think
10 a good attempt, to try to allocate money based on patient
11 characteristics, the failings of which are around, as you
12 pointed out, the accuracy of the underlying information
13 around which to base that.
14 But what we're not getting at -- and I recognize,
15 Michael, this may be a little bit out of scope, but I think
16 we should take every opportunity to comment on it -- is not
17 just the distribution of money between settings or between
18 patient types, but it's to me the more important issue of
19 what are we getting for each patient, each beneficiary.
20 Are we getting what we want for what we're paying?
21 And I think the answer, as we all know, is we're
22 not getting what we should be in terms of the outcomes, and

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

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

18 And what I'm saying is I think the big
19 opportunity, as we're sort of opening up this space for
20 changes, is changing to a payment system that isn't just an
21 incentive. It isn't just a tweak but substantially pays
22 each of these settings based on the clinical outcomes that

1 are achieved, consistent with the beneficiary preference,
2 right, so outcomes based on beneficiary preference as well
3 as clinical reality, safety which is -- you know, these are
4 the settings that are the least safe settings in the
5 American health care system by far and an element of a
6 markedly improved service, communication and coordination,
7 which are really pretty poor, by and large, in these
8 settings as far as experience by the beneficiaries or
9 families.

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

17 MS. KELLEY: Robert.

18 DR. CHERRY: Yeah, thank you. I am also very
19 supportive of the work that has been done to date.

20 You know, my comments are around some of the
21 methodology used because we did not have much of a choice,
22 and that is the dependency on patient-related

1 characteristics, you know, risk scoring, cognition, age, et
2 cetera, because we really did not have the data to look at
3 functional outcomes.
4 And so there is a correlation between patient
5 characteristics and functional outcomes, and you did
6 explore that a bit, at the individual level it may not
7 translate so well. So at the macro level, from a
8 population health perspective and across these different
9 four post-acute setting, the correlation makes sense, but
10 you are probably going to lose it in translation at the
11 individual patient stay where those functional outcomes are
12 really critical in determining whether or not the payment
13 is appropriate, because in some cases if we just rely on
14 patient characteristics there may be overpayment or
15 underpayment, and it could lead to upcoming, what David was
16 implying, as well.
17 So I do think that at the end of the day it is
18 really necessary to understand in terms of what we are
19 paying for and what we are getting. Those functional
20 outcomes are going to be really critical. But we do not
21 have the opportunity right now to actually tease it out.
22 So I think whatever we do at the onset it is

1 probably temporary. You know, we will have to rely on
2 these patient characteristics for now. But I think that
3 the functional outcomes needs to be sort of a mandatory
4 report out at the end of the day, so that we can study it
5 over a couple of years and then refine the payment model
6 accordingly. But I think if we continue to overly rely on
7 the patient characteristics and now have the functional
8 outcomes as a force function then we will continue to
9 probably have a payment model that is not quite as optimal
10 as we would like to have.
11 DR. GRABOWSKI: Yeah, Robert, I am really glad
12 you raised that because that was something that really
13 struck me as well. We invest this huge amount of money in
14 these assessment instruments across the four post-acute
15 settings. We do millions of these MDSs, minimum dataset
16 assessments, millions of OASIS assessments every year. And
17 the fact that we cannot pull an accurate measure of
18 functioning, it is really kind of depressing that this is
19 not a variable that is usable. So I am with you, that that
20 is really what post-acute care is about, is improvement in
21 functioning, and yet we do not have a measure of. And that
22 is true for quality. That is true for assessment, that

1 baseline. It is really unfortunate.

2 DR. CHERRY: I totally agree, because at the end

3 of the day, at the individual level, you want to know, are

4 they able to transition to home in a way that's optimal and

5 improves their quality of life. And we just will not know

6 that until we get that data, and it is really critical that

7 we do.

8 MS. KELLEY: Dana.

9 DR. SAFRAN: Thanks, and Carol, thanks for this

10 really great continuation of such important work.

11 I think my comments really are limited and build

12 on the exchange that David and Robert were just having.

13 David made the comment earlier that this is a kind of stop

14 along the road to value-based payment, full-fledged value-

15 based payment in this area. But I think where we have

16 struggled is the relative absence of robust quality, and in

17 particular, outcome measures for post-acute care, the small

18 sample sizes that plague us in terms of being able to

19 really create a strong accountability model, and the fact

20 that what matters, as this exchange was just showing, is

21 really the functional outcomes, and yet we do not have

22 good, reliable ways to collect that information. We worry

1 about bias when it is systems-reported functional outcomes
2 for patients. There are so many challenging cognitive
3 issues with patients for getting patient reported.
4 So all of that has led me to wonder whether one
5 piece of this work -- and I imagine that timeline, which,
6 by the way, I really appreciate having this timeline slide.
7 I would love us to incorporate that as a kind of standard
8 thing for our work. It's so helpful to understand like
9 where we are and where we are going over the cycle with a
10 piece of work.
11 But anyway, I imagine the timeline might not
12 allow this, but somehow for MedPAC to start to be involved
13 in how are we going to solve this problem, which isn't
14 limited to post-acute care but is very much critical in
15 post-acute care, of being able to have scaled use of
16 patient-reported functional outcome measures in health care
17 accountability models.
18 You know, there are many barriers, and I am happy
19 to talk with you offline about a framework that I have for
20 what are the barriers. But I think if MedPAC, specific to
21 the past work, were able to even just do some expert
22 interviews, or I don't know if we ever do a convening of

1 experts, but do a convening of experts of like how do we
2 solve this problem, maybe we start to get some ideas for
3 where to begin and how to proceed from there. And to use
4 the overused phrase of not letting the perfect be the enemy
5 of the good here. Let's just start somewhere. But I think
6 we are stuck on where to even start, and it gets in the way
7 of progressing in value-based payment for this area of
8 care, where it is just so important.
9 So those are my thoughts. Thank you.
10 MS. KELLEY: Amol.
11 DR. NAVATHE: Thanks. I'm also very supportive
12 of the work, generally, and Carol, it is an excellent
13 chapter that you have prepared here.
14 I am struck by the challenges that we have here,
15 and I think David's points, some of them actually kind of
16 brought that into stark relief. If you think about it, we
17 are saying we should be paying for similar patients
18 similarly, and that, of course, depends on being able to
19 identify similar patients.
20 If we also take a step back and say, if we could
21 design the system perfectly where would we want the system
22 to be, I think we would want the system to be essentially

1 no overlap between the settings, because we would want to
2 match the level of acuity to the patient, for the patient
3 to level of acuity to the setting.
4 And so our ex-post destination, in some sense, is
5 that there is no similar patients across these different
6 settings, which means that it fundamentally depends on our
7 ability to differentiate appropriately. And I think there
8 I wholeheartedly agree with Robert and David's response
9 there, which is we are ultimately very dependent on this
10 data that we can't rely on, because if we can't actually
11 differentiate I think we all probably believe that often
12 claims data a priori, at least it's a very difficult to try
13 to do that. So we are heavily reliant on these functional
14 assessment measures that are problematic, as we have
15 discussed.
16 It was interesting that the -- and I look forward
17 to what happens in our analysis of the ASPE report, but it
18 looks like they are including that in their case mix
19 adjuster. And so that gives me pause as well.
20 I think to some extent if I ultimately take a
21 step back, you asked the question on the slide, you know,
22 what information would we need to get to a recommendation,

1 I think in some sense the question is what do we have to
2 believe here about how data like the functional status
3 assessments, how reliable are they going to be and how
4 practical do you think that we can get there with something
5 like a mandatory reporting of it, and then how long is it
6 going to take us to validate that?
7 I think those are some of the core questions that
8 I think we have to wrestle with to be able to get to this
9 point. Placing it in the context of what Dana said also,
10 which is we do not want the perfect to be the enemy of the
11 good, and David's point that this is a pathway to APMs or
12 an APM-like system, which is really where I think we want
13 to eventually get, so that way we are not necessarily stuck
14 with the burden, if you will, of the administrative parts
15 of the system that I'm describing in some sense.
16 So I think a lot of challenges, really important
17 work. I think we know that there is a lot of opportunity
18 for the Medicare program to be more efficient in the post-
19 acute care setting. We can't find a more important sector
20 to work on, but I think the challenges are pretty apparent.
21 So thank you.
22 DR. CHERNEW: Let me jump in. I have two more

1 people in the queue. We are going to go a little bit long.
2 We started a little bit late. We have lunch next, so just
3 to give you some idea of where we are.
4 I will say that this issue about sort of, quote,
5 "case mix adjustment" when we can observe, and functional
6 status, and home support, that plagues how you pay for
7 APMs. That plagues how you deal with MA. And, you know,
8 that's a whole broader discussion. But I will simply say
9 my own personal view is we should keep trying and go into
10 the task with a lot of humility, because it is not going to
11 be something that is solved with a report.
12 But in any case, I think the first of those two
13 people next is Cheryl.
14 MS. KELLEY: Yes.
15 DR. DAMBERG: Okay. You just stole some of my
16 thunder.
17 First let me say this is really interesting work.
18 I am obviously new to this work, but I found it
19 fascinating, and I think that the Commission should be
20 weighing in on this space and trying to think about ways to
21 pay differently. Particularly I was really struck by the
22 payments are 14 percent higher than costs.

1 And I think that some of what is proposed here,
2 what I like about it is it will potentially redirect future
3 investment in terms of the types of care settings that
4 communities make available to Medicare beneficiaries, so I
5 liked that. And I agree that we need to be working toward
6 something that is more accountable, value-based, and moving
7 away from fee-for-service.
8 You know, per Mike's point and many others have
9 made this, the coding is a real challenge. It is not just
10 unique to this setting. And I think, to me, the larger
11 question is what is it that we can do to maybe do more
12 auditing in this space, you know, hold providers
13 accountable for what they actually put down on paper.
14 And also, I'm sort of eyeing a lot of changes
15 that are going on within health care organizations to
16 collect more information. So whether it's, David, you had
17 access to the electronic health record and there was more
18 detailed information, whether there are opportunities in
19 here to capture more information, that would give us a
20 better sense of whether the person is in the right setting
21 for their circumstances.
22 And then lastly, I wholeheartedly agree that we

1 are not where we need to be in the space of measuring
2 functioning, whether it is in the post-acute care space or
3 elsewhere, and that we need greater investment thinking
4 about how to do that and bring that online.
5 MS. KELLEY: Betty.
6 DR. RAMBUR: Thank you, and my computer just died
7 so I think that's a message that it's almost time for lunch
8 I just wanted to say how much I appreciate this
9 conversation and the comments from the other Commissioners.
10 I did want to follow up on what Greg said about questioning
11 the lower cost in home health.
12 I was recalling that the largest expense in most
13 agencies is the cost of the people doing the work -- the
14 nurses, the RNs, the nursing assistants -- and salaries are
15 lower in that setting. And at one time people were willing
16 to do that work, but in the current labor situation will
17 people be continue to be willing to do that work at a lower
18 salary? There is more autonomy and people have been
19 attracted to it.
20 But as we think about moving more towards value-
21 based payment, many of them are nurse sensitive or even
22 nurse centric. So this idea of is it really less expensive

1 is just a question, and maybe it is a rhetorical question
2 we cannot answer, but I just wanted to raise that staffing
3 challenge and cost. Thanks.
4 DR. CHERNEW: Okay. So first let me do a very
5 quick summary of where we are and then I am going to remind
6 the public that we are interested in their comments, and
7 then we can go to lunch.
8 So for the summary, there is obviously a lot of
9 enthusiasm for this work, or this topic, which is good
10 since we were mandated to do it. And there has been a lot
11 of work before, and other people that have been mandated to
12 do other stuff in this area.
13 There is train that has been going, if noticed
14 the dates on those reports before me and before many of
15 you, and the train is still going to go, and I think some
16 of the things that Carol mentioned, the Commission has had
17 recommendations on in the past about specific details
18 there. So that is sort of the good.
19 The challenges are, I think, there is reasonable
20 consensus around the table -- I'm going to use David's
21 phrase, it's a good step but it's not the destination, or
22 some version of that. And I think we agree there is sort

1 of some conceptual type challenges about how you would move
2 to the broader population-based payments, which if you
3 follow our APM work you know I'm enthusiastic about. And
4 then there are sort of technical issues about like what we
5 can observe and how hard this is to do.
6 And I think there is this tension about whether
7 setting is the de facto case mix adjuster. And that is
8 what I really think the debate here, and the answer is
9 well, sometimes, for some patients, kind of, but sort of in
10 some cases no, really not. And certainly with the work we
11 have done on long-term care hospitals, for example, you can
12 see that their situations are not long-term care hospitals
13 and the people can be treated in other settings.
14 So this is a very complicated area, and so I want
15 to manage expectations about what this chapter can achieve
16 in this way, both because it is the culmination of a lot of
17 work and so we are not sitting here for Report 1, waiting
18 to get to Report 3. We are sitting here at Report 3,
19 building off of Reports 1 and 2. And so I want to build
20 that expectation.
21 And certainly we are not going to broaden what we
22 do to get to some of these other big issues, which I think

1 the discussion here raised. And while we might not put
2 that in this report, that does not mean we do not think
3 they are unimportant. Measuring functional health, how we
4 do case mix in general, how we deal with social supports
5 and supports sort of at home, these are issues that will be
6 perennial MedPAC issues, mostly because of the perennial
7 Medicare and Medicare beneficiary issues.
8 So that is sort of where we are. I believe some
9 folks at home may have some thoughts on an interesting
10 topic, like the clinician safety net work we did or this
11 post-acute PPS work. And so I strongly encourage the
12 people that are listening, the public writ large, to send
13 their comments. You can go to meetingcomments@medPAC.gov.
14 You can go to the website and there is a place there where
15 you can leave comments. You can reach out in a number of
16 other ways. But we really do encourage feedback from the
17 public on these topics.
18 So with that I'm going to call this morning's
19 session to a close. We are going to have lunch, and we
20 will be back -- Betty will surely be the first one in the
21 seat -- when we are going to talk about nursing facility
22 staffing, which is going to be a beautiful segue since your

1 comment was we could pay what we pay but if there are not
2 people to do what we need then we have a bigger issue. And
3 I think that will be a continuation of a broader concern
4 about just the workforce writ large.
5 So in any case, thank you for spending the
6 morning with us, those of you that did, and hopefully come
7 back for the afternoon.
8 [Whereupon, at 12:37 p.m., the Commission
9 recessed, to reconvene at 2:00 p.m. this same day.]
10
11
12
13
14

1 AFTERNOON SESSION

2 [2:01 p.m.]

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

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

19 MS. STUBBS: Thank you.

20 Good afternoon. Today we will be discussing
21 nursing facility staffing. We would like to thank Carol
22 Carter for her contributions in this work.

1 The audience can download a PDF version of these
2 slides in the handout section of the control panel on the
3 right side of the screen.
4 The effects of the COVID-19 pandemic have renewed
5 and intensified long-standing concerns about the adequacy
6 of nursing facility staffing. The high cost of labor,
7 health care worker burnout, and worker shortages
8 particularly complicate policy discussions around minimum
9 staffing requirements. In today's presentation, we will
10 provide some background on staffing nursing facilities,
11 review both federal and state nursing facility staffing
12 requirements, and update the Commission on recent
13 developments in CMS's collection, reporting, and use of
14 improved nursing staffing data.
15 This material will not become a chapter in our
16 March or June 2023 reports to the Congress, but parts may
17 be used as background in future work.
18 At this meeting, we would like to get your
19 feedback on this material and discuss how data on staffing
20 could inform future Commission work on the health care
21 workforce.
22 To be covered by Medicare, skilled nursing

1 facility services must be provided in a facility that meets
2 Medicare requirements to provide Medicare-covered, short-
3 term skilled nursing care, and rehabilitation services.
4 In 2020, 1.2 million Medicare fee-for-service
5 beneficiaries used Medicare-covered skilled nursing
6 facility services at least once.
7 Almost all skilled nursing facilities are also
8 certified as nursing facilities, which typically provide
9 less intensive long-term care services that Medicare does
10 not cover. Since skilled nursing facility care is
11 generally provided in the same facilities that provide
12 long-term care, we refer to the entire nursing facility
13 when discussing nursing staff. We want to note here that
14 most nursing facility residents are Medicare beneficiaries.
15 There are about 1.2 million people who work in
16 about 15,000 nursing facilities in the United States.
17 Among those workers are three types of nursing staff that
18 provide care to nursing facility residents: registered
19 nurses, or RNs; licensed practical nurses, or LPNs; and
20 certified nursing assistants, or CNAs. These three nursing
21 categories account for about one half of a facility's cost.
22 RNs have at least a two-year degree and must

1 become licensed in their state. They supervise patient
2 care, perform the more complex skilled care services, and
3 assess patients for the need for physician or hospital
4 care.

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

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

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

16 MS. LINEHAN: The 1987 Nursing Home Reform Act,
17 drawing on recommendations from a 1986 IOM Commission,
18 merged Medicare and Medicaid standards for nursing homes
19 and established the federal licensed staffing requirements
20 that remain the standard to this day. Nursing homes
21 certified for Medicare and Medicaid must have a director of
22 nursing who is an RN; an RN on duty eight consecutive hours

1 per day for seven days a week; and a licensed nurse, either
2 an RN or an LPN, on duty for 24 hours per day for seven
3 days a week.
4 Nursing facilities must also have sufficient
5 nursing staff with the appropriate competencies and skill
6 sets to provide nursing and related services to assure
7 resident safety and attain or maintain the highest
8 practicable physical, mental, and psychosocial well-being
9 of each resident.
10 Nursing facilities are also subject to state
11 regulations. According to a 2022 study that Abt Associates
12 conducted for MACPAC, 38 states and the District of
13 Columbia have more prescriptive minimum staffing
14 requirements than the federal requirements. But states
15 vary in the level of minimum staffing required and whether
16 their requirements specify levels for RNs, LPNs, or CNAs.
17 Studies have generally concluded that state
18 minimum staffing standards raised staffing levels, though
19 the effects can be small, and improved results for at least
20 some quality measures. However, some unintended
21 consequences have also been observed, including a decrease
22 in indirect staffing and in skill mix, which is the number

1 of RNs or LPNs relative to CNAs.
2 Studies also found that staffing minimums may
3 have differential effects on facilities, raising staffing
4 for those with levels below the new requirements but
5 reducing or maintaining staffing at facilities already
6 above the requirements.
7 In addition to minimum staffing requirements,
8 states have other policies in their Medicaid programs to
9 encourage spending on staffing.
10 Specifically, 11 states use wage passthrough
11 policies, which require nursing facilities to spend a
12 specified portion of Medicaid rate on staff wages or
13 benefits.
14 Thirty-two states plus the D.C. have cost-based
15 payment policies that tie a portion of Medicaid rates to
16 the allowable costs of direct care.
17 In addition, 16 states have adopted value-based
18 payment programs that include staffing measures.
19 Performance on staffing measures either augments the base
20 rates or triggers an additional quality-based payment.
21 CMS has investigated nursing facility staffing
22 requirements but has not, to date, changed requirements

1 from those noted earlier. In 2001, CMS issued a
2 congressionally mandated report that concluded residents
3 were at a substantially higher risk of quality problems
4 when they received care in homes with staffing ratios below
5 critical levels.
6 In rulemaking in 2016, CMS again revisited
7 staffing requirements but was concerned, at the time, that
8 it did not have accurate data to determine appropriate
9 minimum staffing levels. CMS noted that the payroll-based
10 journal, or PBJ data, which CMS had just begun collecting,
11 could assist CMS in evaluating staffing requirements in the
12 future.
13 Prior to the PBJ data, the Certification and
14 Survey Provider Enhanced Reporting, or CASPER system, was
15 the only source of staffing data on all nursing homes.
16 Concerns about the accuracy of the CASPER data stem from
17 the fact that they are self-reported by facilities and were
18 not subject to routine audits. CASPER staffing data also
19 are reported for a narrow period of time immediately
20 preceding an annual inspection.
21 One study found that nursing facilities increased
22 their staffing in the period prior to and during annual

1 inspections in ways that were not representative of non-
2 inspection periods.
3 Because of concerns about the accuracy of
4 staffing data in the CASPER system, the Affordable Care Act
5 required CMS to collect nursing facility staffing
6 information based on payroll and other auditable data.
7 To fulfill the requirement to collect nursing
8 facility staffing information, CMS maintains the PBJ
9 system. The detailed, day-level PBJ data for each provider
10 allow for more consistent and accurate nursing facility
11 staffing data than CASPER.
12 The publicly available PBJ data contain daily
13 paid nursing staff hours by staffing category and
14 distinguish between employed and contract staff for each
15 facility.
16 While the PBJ data are auditable and based on
17 payroll systems, CMS and researchers have noted some
18 limitations. Data may not reflect all staff hours worked
19 for salaried staff because they count only paid hours. In
20 addition, the PBJ does not measure the intensity of the
21 workload. For example, during the COVID-19 pandemic, where
22 hours per resident day remained relatively consistent, the

1 intensity of the workload may have increased. These
2 limitations should be kept in mind when interpreting PBJ
3 data.
4 In early 2022, the White House announced that CMS
5 will conduct a study of the level and type of staffing
6 needed to ensure safe nursing homes. Consistent with this
7 announcement, in the SNF final rule for fiscal year 2023,
8 CMS announced it will conduct research to determine the
9 level and type of staffing needed to ensure safe and
10 quality care. This mixed methods research, which includes
11 analysis of PBJ staffing data, site visits, and a
12 literature review, is currently underway. Based on this
13 research, CMS has announced its intention to propose
14 minimum standards for nursing facility staffing within one
15 year.
16 Now I am going to turn to reviewing how CMS
17 currently uses the PBJ staffing data.
18 CMS uses the PBJ data to publicly report nursing
19 hours per resident day, weekend staffing levels, and staff
20 turnover measures on its Care Compare website.
21 Six staffing measures, adjusted for facility case
22 mix, are included in the nursing facility star rating

1 staffing domain.

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

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

14 Now that we've reviewed some background
15 information on nursing facility staffing and the utility of
16 the PBJ data, we turn to our preliminary analysis of PBJ
17 data from 2019 through 2021.
18 For those years, on the next three slides, we show sector-
19 wide aggregates of total staffing, resident days, and staff
20 hours per resident day, and changes in the use of contract
21 labor. These aggregates can conceal variation in shorter
22 time increments and among individual nursing facilities or

1 facility subgroups, which we could explore in future work.

2 MS. STUBBS: Now that we've reviewed some

3 background information on nursing facility staffing and the

4 utility of the PBJ data, we turn to our preliminary

5 analysis of PBJ data from 2019 through 2021.

6 For those years, on the next three slides, we

7 show sector-wide aggregates of total staffing, resident

8 days, staff hours per resident day, and changes in the use

9 of contract labor. These aggregates can conceal variation

10 in shorter time increments and among individual nursing

11 facilities or facility subgroups, which we could explore in

12 future work.

13 This figure shows total nursing staff hours,

14 shown as the yellow line, and resident days, shown as the

15 green line, for each quarter from 2019 through 2021 for all

16 reporting nursing facilities, which vary by year. We want

17 to note that CMS suspended PBJ reporting of data for the

18 first quarter of 2020. So data for that quarter does not

19 include all nursing facilities, which explains part of the

20 change you see in the figure.

21 Staff hours and resident days both declined in

22 2020. The reduction in resident days is due in part to the

1 high rates of COVID-19 mortality among nursing facility
2 residents, avoidance of nursing facilities, and declines in
3 hospitalizations and surgeries.
4 At the end of 2021, neither resident days nor
5 staff hours had returned to pre-pandemic levels, and staff
6 hours continued to decline.
7 Taken together, changes in staff hours and
8 resident days during the period resulted in small changes
9 in hours per resident day across all nursing facilities
10 combined. Accounting for changes in resident days, nurse
11 staff hours per resident day remained generally consistent,
12 but were lower at the end of 2021 compared to 2019.
13 Nurse aides, shown in green, exhibited the
14 largest change in staff time per resident day from the
15 first quarter of 2019 to the fourth quarter of 2021, about
16 a six-minute decline per resident day. RN and LPN hours
17 per resident day trends, shown in yellow and light blue,
18 exhibited minimal changes in aggregate, increasing slightly
19 in 2020 before returning to near pre-pandemic levels in
20 2021.
21 Consistent with general workforce shortages and
22 the sector's reports of greater reliance on contract labor

1 during the pandemic, we found that the use of contract
2 staff increased in 2020 and 2021, compared to 2019.
3 In aggregate, contract staff provided 3 percent
4 of total hours per resident day of care in the first
5 quarter of 2019. By the fourth quarter of 2021, this had
6 nearly tripled to 8.4 percent of total hours per resident
7 day of care.
8 Increases in hours per resident day for contract
9 LPNs and nurse aides were greater than for RNs. This kind
10 of information, available from the PBJ data and additional
11 analysis, can provide context for sector-wide cost changes
12 associated with reliance on more expensive contract labor.
13 MS. LINEHAN: PBJ data could be useful to the
14 Commission in examining the nursing facility workforce.
15 For example, as we have shown today, we can examine sector-
16 wide trends in mix of nursing staff types, use of contract
17 staff, staff and staff hours per resident day. We could
18 also examine facility-level variation in these metrics.
19 Specific to payment adequacy analysis, where we
20 examine access to care, we could examine beneficiaries'
21 access to facilities by staffing level. We could also use
22 staffing data to better understand the relationship between

1 staffing and facilities' costs and margins.
2 This concludes our presentation on nursing
3 facility staffing. We invite Commissioner feedback on the
4 background material presented and thoughts on whether and
5 how staffing data could be used in the Commission's future
6 work, either in our payment adequacy analysis or other
7 research on the nursing facility workforce that may be of
8 interest.
9 And with that, we turn it back to Mike.
10 DR. CHERNEW: Great. So I'll say this again when
11 we talk about the Part D work later tomorrow, but it's just
12 so exciting to see the data. And it opens up a lot of
13 possibilities.
14 So we have a very broad charge in this
15 discussion. It's not as focused as, say, some of the other
16 ones were asking about specific options, but that, in some
17 sense, is soothing because we're kind of at the beginning
18 of the mountain. And so your broad ideas are very welcome.
19 So I think we'll start with Round 1, and if I
20 have this right, Stacie, is starting.
21 DR. DUSETZINA: Thank you. This is really
22 interesting work.

1 I just had a question about, I think, the data on
2 Slide 14, and in general, in the PBJ data, are you able to
3 tell -- I saw sick hours were referenced as being part of
4 what you can see in there. I don't know if it can be seen
5 separately, and part of me wondered about unpaid sick time
6 and how that might factor into some of those changes that
7 you saw during the pandemic.
8 MS. LINEHAN: That's a great question. I think
9 what we referenced in the paper is something that's been
10 noted as a limitation of the PBJ data that I didn't
11 mention, which is that because it covers paid hours, it
12 could include sick time or vacation time that we can't
13 distinguish from working time, but -- so does that answer
14 your question?
15 DR. DUSETZINA: Yeah. I think that that's great.
16 I think the one thing that I would be curious about is if
17 policies, especially for lower-wage workers, are unpaid
18 sick time, and then you see dips in hours. Is it because
19 people are out because they're sick, or is it because
20 you've lost those people altogether? But that just was one
21 of the things that popped up, especially given the timing
22 and the pandemic.

1 I do see also your suspension of data collection.
2 A huge contributor to not knowing.
3 MS. LINEHAN: And I think there's been some
4 research on looking at staffing declines during --
5 immediately around the period of COVID outbreaks -- one of
6 your fellow Commissioners has done this work -- that shows,
7 shows those kinds of dips in hours immediately. So that, I
8 think, is support for the hypothesis that's part of your
9 question.
10 MS. KELLEY: Kenny?
11 MR. KAN: This is very powerful data. So thank
12 you for doing this body of work.
13 Do you see like future iterations of this work
14 possibly involving potentially minimum staffing
15 requirements that differ by facilities, or how do you
16 envision it? Any other thoughts?
17 MS. LINEHAN: I think we're looking for direction
18 from the Commission on where to take this work.
19 DR. MATHEWS: Yeah. So a couple of things. Not
20 on slide 18, but the one before that, I think we had talked
21 about a couple potential avenues that we could pursue in
22 examining the PBJ data. I do not know at the moment that

1 we are positioned or capable of making determinations about
2 minimum staffing requirements. But, as Kathryn and Lauren
3 mentioned, CMS has publicly committed to evaluating the
4 current standards and updating them as warranted, and given
5 some of the even basic foundational analytic work that we
6 are planning at the staff level, we think these analyses
7 could help inform CMS's development of new standards where
8 they are warranted. Is that helpful?
9 MR. KAN: Jonathan?
10 DR. JAFFERY: Thanks. So, yeah, I think this is
11 a great start, and sort of building on Mike's earlier
12 comment and what Jim was just saying, this is -- we're
13 starting off and trying to figure out how we can use data
14 and what questions we can ask and answer.
15 I guess my question is about what other
16 information we might have at the state level, and thinking
17 about this not only in terms of sort of staffing
18 requirements that people have already brought up, but
19 clearly, staffing is usually important, but that's got to
20 match to beds. And so I don't know if we have information
21 about all the different requirements and regulations that
22 occur state to state. I'm thinking about -- and, David,

1 maybe you know some of this. I was thinking about in
2 Wisconsin we have a cap to the number of nursing home beds,
3 and when a nursing home closes, that cap actually goes
4 down. So during COVID we lost, you know, 7 or 8 percent of
5 our beds and the long-term ramifications.
6 And so just thinking about how we're going to
7 make policy suggestions and recommendations at the Federal
8 level when they're so much intertwined with state payment
9 and other policies. Are you able to explore some of that
10 to the level of detail that we might need to know in order
11 to continue this work?
12 MS. LINEHAN: Well, I think we certainly could
13 look at state-level policies, and they clearly have a role
14 here. And if we did do analytic work where we thought
15 there was a state component, we would at the very least
16 sort of qualitatively describe what state policies are in a
17 particular dimension like the things you're describing, and
18 like some of the stuff that we addressed here with just
19 state variation and among different payment policies. So
20 it's, in my opinion, an unignorable factor here.
21 So I think it would be something we would look at
22 in any work that we did if we see -- you know, if we want

1 to explore state-level variation, which isn't something we
2 normally do, but we could consider whether -- you know, to
3 explain findings, we would need to look at state policies.
4 DR. JAFFERY: Yeah, I guess that's why I sort of
5 brought it up, too, because it's not typically what we do,
6 but it is unignorable. If we're going to pursue certain
7 things, we want to be eyes wide open on that. Thanks.
8 MS. KELLEY: Scott.
9 DR. SARRAN: Yeah, excellent work. Thanks. I'm
10 wondering, in an ongoing way, what's our ability to use
11 this data, now that we've got some pretty good -- not
12 perfect but pretty good data and match it up against
13 measures of acuity, outcome measures, safety events,
14 hospital readmission rates for custodial versus skilled, as
15 well as any ability to source state data on what the
16 Medicaid per diem payment rates are for long-term-care
17 residents living in nursing facilities, so we can start to
18 see how staffing actually correlates with and potentially
19 results from some downstream measures like the Medicaid
20 payment rates and results in some other outcomes like
21 safety events, for example.
22 MS. LINEHAN: I think part of the work that CMS

1 is currently doing is looking exactly at that, looking at
2 the relationship between staffing and some quality
3 measures. That's going to help them, I think, get at
4 potentially their recommendation. And then you had another
5 question -- oh, about Medicaid payment rate. I think
6 that's harder to get your arms around than it might seem.
7 MACPAC did some work on this recently or Abt did some work
8 for MACPAC on this, and they presented it last week at
9 their meeting, actually, where they kind of looked at their
10 relationship -- they haven't published anything on it yet,
11 as far as I know, but there was a presentation where they
12 looked at requirements, payment rates, and staffing levels
13 to see how they kind of fit together. So we could share
14 that if there was interest.
15 DR. SARRAN: Right, because we look at adequacy
16 of payment rates, but we're looking at it through the lens
17 of the skilled component. And as you pointed out, these
18 facilities basically have two lines of business, maybe
19 three if you count private pay in there. And I know if you
20 talk to people who run nursing facilities, they will
21 describe a lot of this work as being in the domain of
22 unfunded mandates, that they see that they're going to be

1 told to raise staffing to at least a minimum level, but
2 that Medicaid doesn't pay them enough to do that. So I
3 think the more we can shine a light on any disconnects that
4 may exist in those relationships, the better we'll be.
5 DR. CHERNEW: So let me just jump in and say this
6 has been a post-acute, particularly SNF, conundrum for as
7 long as I can remember. And we have a longstanding
8 although often somewhat troubling view in how we view the
9 MedPAC/Medicare funding of the post-acute part interplaying
10 with the Medicaid program, which supports so much of what
11 goes on in these nursing homes. And so to the extent to
12 which your point -- and I agree with this -- is
13 acknowledging the importance of that connection, I think
14 that is true.
15 Knowing what that means in terms of Medicare
16 policy is complex because this is why I think Kathryn just
17 said MACPAC has a view about what this might mean for
18 Medicaid policy, although the connection between Medicaid
19 policy is more complicated because there's a lot of
20 different states.
21 So I think in this sense, I think the more we can
22 know and point out, the better, but at least in terms of

1 when we get to what we do when we talk about things, we are
2 going to try and stay in a MedPAC lane, which is
3 complicated in an industry that relies so heavily on
4 Medicaid funding.
5 DR. SARRAN: I mean, our legitimate interest, of
6 course, for the Medicaid-funded beds is that its own
7 beneficiaries who are living in those, and their safety
8 outcomes are --
9 DR. CHERNEW: Yes, right, exactly. So we'll have
10 a longer discussion about challenges with fragmentation in
11 the way we pay for things in this country and how the
12 different authorities lie. I have no disagreement that it
13 is problematic if the support for institutions that care
14 for our beneficiaries is challenged by folks that aren't
15 Medicare. I might add, just in the sense of
16 evenhandedness, there's other situations where the
17 institutions that care for our beneficiaries are supported
18 by more generous payers which help us, and there's a
19 symmetry at some level, although it doesn't always pay out
20 -- you know, some people have different payer mixes, and
21 that ends up being a big deal. And we do worry about that
22 a lot.

1 I think the purpose here, I'll just take from
2 your question, and I just want to say it to be, as we go
3 through the staffing data, to your point, I agree, we have
4 to acknowledge that what's happening is a function of a lot
5 of the funding streams that flow through to nursing homes,
6 absolutely. Absolutely true. When we get to broader ways
7 in how this data is going to be used, then we get into this
8 complicated connection of where's our purview or not. But
9 that might have been more therapy than comment.
10 MS. KELLEY: Cheryl.
11 DR. DAMBERG: I had a clarifying question. So I
12 know that PBJ data don't collect information on acuity, but
13 as I think about trying to use this data -- and I'm not a -
14 - I'm looking to David. I'm not the nursing home person at
15 the table. Do we have ways of measuring acuity so we can
16 link other information to, you know, be able to...
17 MS. LINEHAN: We do.
18 DR. DAMBERG: Great.
19 MS. LINEHAN: And the staffing measures used in
20 the star ratings are acuity adjusted, so it is doable and
21 it is done for the star ratings using some staffing
22 measures that are fairly old for the different case-mix

1 groups. And I can share that if you're interested in how
2 that's done. But the short answer is yes or the sort of
3 short answer is yes.
4 MS. KELLEY: That's all I have for Round 1 -- oh,
5 Betty, did you want to go ahead?
6 DR. RAMBUR: One quick question. One quick
7 question in Round 1. Does the staffing data that's
8 available there also include geriatric nurse practitioners
9 that are in-house, either full-time, part-time, or
10 whatever, is that not included?
11 MS. LINEHAN: It is not included. We've talked
12 about the nursing staffing data. There's also actually a
13 therapy staffing data set that we have not touched. But
14 the nurse practitioners are not included in the nursing
15 staffing data.
16 DR. RAMBUR: Thanks.
17 MS. KELLEY: So now that's all I have for Round
18 1, and now we'll go to David for Round 2.
19 DR. CHERNEW: Now we're going to go to David for
20 Round 2.
21 DR. GRABOWSKI: There we go. Thanks, Kathryn and
22 Lauren. I'm super excited we're doing this work. If you

1 talk to individuals in nursing homes, all they want to talk
2 about, all they do talk about is staff. Right now it's
3 just workforce, and so I'm really glad we're also talking
4 about it. This is really important.
5 So the first point, I couldn't help but juxtapose
6 this discussion versus our last one before the break. You
7 know, we had really, you know, this functional improvement
8 measure that's terrible and we can't use, and here we
9 actually have the opposite experiment. We for years had
10 terrible staffing data. Now we have this sort of payroll-
11 based journal data, or PBJ, really powerful data, not just
12 that it's improved in accuracy but the types of measures.
13 Now we can measure daily fluctuations. Now we can measure
14 turnover, and so I really think we should take advantage
15 not just of the level of staff, but also all these other
16 features. We're getting a day-to-day measure of who's in
17 the building, and you can see on weekends staffing is
18 lower, on holidays, you know, and it's just really powerful
19 what you can do with this data and kind of looking at
20 turnover, for example.
21 So that kind of leads into my next point, which
22 is that I think MedPAC and CMS should both use these data

1 more. Let me start with CMS. I don't know if this would
2 ever rise to the level of a recommendation, but when I
3 think about the CMS five-star rating on Care Compare, I
4 really believe they underweight staffing data on there, and
5 I think that's an artifact of the really poor historical
6 data where you had this self-reported two-week lookback
7 measure. We couldn't trust it, and so it was reported on
8 there, but it wasn't heavily weighted. They have this
9 great measure. They should weight that more heavily. I
10 would be very much in favor of recommending that to CMS.
11 Also in terms of MedPAC use, I really like the
12 suggestion in the chapter and also on Slide 17 of how we
13 can incorporate this into our payment adequacy work. There
14 were a lot of good ideas there, and these are strong data,
15 and we should use them more.
16 Kathryn, I'm really glad you raised, in relation
17 to Cheryl's question, I believe, that kind of therapy
18 measures. For our short-stay population, RNs, LPNs, and
19 CNAs can be kind of tricky because you don't know how
20 they're allocating their time. But we can look at
21 therapists, and we've done some work related to the
22 patient-driven payment model. I think there's more MedPAC

1 can maybe do around the therapy data. I think there would
2 definitely be upside there.
3 Next point is around that great graph you have,
4 and Kathryn already knows what I'm going to say because
5 I've said it to her twice offline, but I'll say it a third
6 time here in public, and I apologize, Kathryn, but I just
7 can't help myself. I really think we have to be careful
8 about the tone in terms of trends in staff and trends in
9 residents. If you just look at that kind of crudely, it
10 doesn't look like there's much of a crisis there. They
11 kind of trend together. Yes, they're getting more narrow.
12 But all the qualitative work we've done in nursing homes
13 suggests the residents -- you know, case-mix is much more
14 intense today than it was pre-pandemic. Time with
15 residents, much greater. We had a period of time where
16 family weren't allowed in the building and able to help out
17 with care. All of these factors kind of have contributed
18 to a greater burden. So I want us to be very careful with
19 language.
20 Kathryn, you also mentioned the paper we have
21 where, when there's an outbreak, that leads to staff
22 shortages. I think this idea that, oh, things at a high

1 level look similar, I just want to be careful about that
2 and how we kind of talk about that in the chapter.
3 Another place around tone was I thought we were a
4 little negative on Medicaid wage passthrough policies.
5 These are policies that allow states to target Medicaid
6 dollars directly to staff. I actually think those studies
7 suggest better wages, better staffing when they're
8 implemented. Some of the studies are a little dated, but I
9 just think kind of updating that. And I think what's
10 really challenging about those policies is just some of the
11 leakage, when you have dollars targeted to staff, are there
12 offsets elsewhere? Are they really putting all these
13 dollars directly into staffing? And I don't think it's one
14 to one, and I think that's why a lot of folks have sort of
15 questioned sort of the accountability around those policies
16 and if they're doing what they intended to do.
17 That really comes to my fifth point which is
18 really around the Biden administration's minimum staffing
19 standard. I think in a vacuum this is a good policy.
20 However, I'd worry about kind of Scott's earlier comment,
21 you know, how much dollars are in the system right now to
22 kind of pay for this and how much new dollars are going to

1 be necessary. How much of that is going to be Medicare?
2 How much of that is going to be Medicaid? And I think
3 there's issues around transparency that are really
4 important here. How are nursing homes spending their
5 existing dollars? Are those actually going into staff or
6 are they going to other kind of parts of the business? And
7 do we believe that when we put these minimum staffing
8 standards in place, nursing homes can kind of find the
9 money to just staff up to those levels, or do we think
10 there's going to be new dollars? I think we're probably
11 going to need some new dollars ultimately if these are
12 meaningful staffing standards. And I think that becomes a
13 MedPAC issue if that entails Medicare dollars.
14 I promise, my final comment, is really around the
15 issue of immigration. We have a working paper right now
16 suggesting that in those parts of the country that have
17 seen increases in immigration, they have better staffed
18 nursing homes and better quality. I don't think
19 immigration is the only answer to the staffing crisis in
20 nursing homes, but it is a big part of it. We need to do
21 everything we can -- I know that's outside the purview of
22 MedPAC, kind of in a broad sort of set of things we can

1 control, but I think that's a really important point that I
2 wanted to raise here, that any kind of limits to
3 immigration are really going to limit our staffs.
4 I'm going to stop there, but once again, I'm very
5 excited about this work and look forward to seeing how it
6 progresses. Thanks.
7 DR. CHERNEW: Tying together that comment and
8 Scott's comment and our payment -- for people watching,
9 this is not about our payment update recommendations,
10 although we will get to payment update recommendations.
11 And there is a challenge, which you alluded to briefly,
12 about if there's a problem in staffing in SNFs, which is
13 related to staffing in nursing homes more broadly, to what
14 extent is it our problem? And I don't mean to say it that
15 way because I think obviously, as Scott pointed out, it is
16 clearly our problem. There are beneficiaries that are
17 Medicare beneficiaries, and we are concerned about them as
18 people, not just concerned about them during their SNF
19 stay, right? So that makes it our problem.
20 On the other hand, we have payment adequacy rules
21 for how we think about what Medicare's paying and others
22 are paying, and we have struggled with how to deal with

1 that in particular ways. And I don't have -- so, again,
2 when we get to the -- when we actually get to implementing,
3 where the rubber hits the road, when we come to our payment
4 recommendations, this will arise. I think what is
5 uniformly true is this will give us insight as to what's
6 going on that we otherwise didn't have. How we react to
7 that is a broader, more complicated issue.
8 Anyway, sorry.
9 MS. KELLEY: Betty.
10 DR. RAMBUR: Thank you very much. I'm very
11 enthusiastic about this and appreciate the comments.
12 In the time that I have, I'm going to talk about
13 this particular piece, but also sort of the broader piece,
14 because at least I hope that our aim not just as a
15 Commission but as a nation is that we create a system that
16 any one of us would be very happy to work in, and that any
17 one of us would be very happy to be a resident in. And we
18 are very, very far from that.
19 It might surprise you to know that I've only been
20 tepid about minimum staffing ratios. I think it's actually
21 necessary, but it's a regulatory response to a market flaw
22 in that the people actually providing the work are not

1 providers getting paid directly; they are staff. And so
2 there is always this incentive to keep the staffing as low
3 as possible.
4 And so to that end, wouldn't it be amazing if we
5 tripled the salaries of CNAs and we really had competitive
6 jobs for those individuals and they didn't actually have to
7 quit to go to Walmart, because I think people are out
8 there. I heard what you said about immigration, and on the
9 one hand, I don't disagree. On the other hand, I'm very
10 troubled that we're unwilling to create a world that any of
11 us would be happy to work in, whether we're foreign-born or
12 here. So that would be my goal.
13 One thing I'm very concerned about is that
14 skilled nursing facilities and nursing homes compete for
15 RNs, not just in that market but across the market, and we
16 pay them much less. So if you are a new graduate and you
17 have student loans, you're certainly not going to think
18 about going to the beleaguered local SNF with all this
19 responsibility where you will quickly be a charge nurse.
20 So I think we really need to get those salaried so we're
21 not depending on altruism, whether economics is the
22 solution.

1 I tend to agree with David about the minimum loss
2 ratios. To me that's actually a very appealing idea if
3 it's done correctly. Do we actually get the revenue in the
4 hands of the people doing the work? And I looked at some
5 of the studies that were cited. One was looking at the
6 years 1996 to 2002. They found a 3 to 4 percent increase
7 in CNAs and no drop in percentage of RNs, and another time
8 when others were dropping. But those studies did not say
9 the impact on wages. I mean, the point is I don't know
10 exactly how much of a difference it made in terms of
11 competitive salaries, so I think that's really important.
12 We've talked about value-based purchasing in
13 different settings. What if a portion of that score
14 actually went back to the nurses and the nursing
15 assistants? That would be quite a different model.
16 And then, finally, I wanted to throw out the idea
17 of adult-gero nurse practitioners. There's a fair amount
18 of data that there's less readmissions to hospitals, better
19 outcomes, and maybe we should recommend something really
20 bold like graduate nurse education funding that goes to
21 nursing homes to help prepare geriatric nurse
22 practitioners. There is a specialty there. In my

1 experience of working with many, many students over 20
2 years, many nurse practitioners are very interested in this
3 population. In my time in Vermont, of the 30 nursing
4 facilities, 10 had GNPs that were precepting students and
5 the students loved it. But did they go into it afterwards?
6 No, because the salaries are too low.
7 So I know not everything can be done with the
8 data, but the data can really be a pointer dog to getting
9 us to where we need to go.
10 MS. KELLEY: Greg.
11 MR. POULSEN: Thanks. I really, really
12 appreciated the comments of both David and Betty. I think
13 Betty's comment that we would love to have these be places
14 that we would all like to work or be cared for I think is
15 really good, and really, really good information. I have
16 not seen such cohesive information presented before and it
17 is really, really helpful.
18 I'm afraid what I'm going to say is going to be
19 at least, in one sense, a penetrating glimpse into the
20 obvious, which is this is really exciting, hard to find
21 money, hard to find people, and that it makes it really
22 difficult place to look.

1 But the second one, which I think may be
2 something that I haven't seen talked about in this context
3 is that this may make this a particularly difficult time to
4 have this discussion because 10 years from now it will be
5 different, 10 years ago it was way different. But I think
6 we are on the cusp of seeing real, safe alternatives to
7 human beings for some of the services that are required in
8 these settings. And we are seeing it in the acute care
9 setting but there is no reason that that shouldn't be
10 transferrable to having telehealth, monitoring, support
11 services, things that provide multiplication of the skills
12 and capabilities of the human beings that are there.
13 And some of it, I think, really does address
14 making the place both a more enjoyable place to work and a
15 more productive place to work, but also potentially a safer
16 place for people to receive care. And we're seeing things
17 that can really make an assistance in terms of ambulation,
18 falls, exercise, med administration, dietary, and other
19 things, which consume a nontrivial part of caregivers' time
20 in these settings.
21 And so as we are thinking about it, I hope that
22 we will broaden our thinking a little beyond just human

1 beings and look for the needs that are addressable for
2 other people, for the residents, in ways that will be
3 meaningful. If done well, I think it's something that we
4 are a little behind a couple of the leading countries in
5 the world on. Japan may be the example I'm most familiar
6 with, in terms of being able to substitute certain kinds of
7 technologies for humans on these kinds of examples.
8 And we have seen the obvious concern, I think,
9 that at least was in my mind is that that may be able to
10 meet some clinical needs but it may fall short on some of
11 the social needs.
12 But I think some of us, I suspect many of the
13 organizations that we work in, in this room, have seen the
14 ability during COVID to use technology to bring people into
15 facilities virtually, not only because they couldn't visit
16 physically, for COVID reasons, but also -- and I think this
17 one is actually exciting -- we have seen families visit
18 patients more frequently than they did before because they
19 didn't have to combine it with a significant trip in order
20 to get there. And so we have seen some of our patients get
21 more family visits than they've ever gotten before. We
22 don't have experience in nursing home care, but I wouldn't

1 be surprised if that were true there, were it available.
2 So again, I guess my thought would be as we
3 contemplate all of these things we ought to factor in the
4 evolving technology and capabilities that we haven't seen
5 before, which may be able to address both some of our
6 staffing shortages as well as the staffing expense. So
7 thanks.
8 MS. KELLEY: Cheryl.
9 DR. DAMBERG: I want to thank the staff for a
10 really interesting chapter. I know it was a lot of work to
11 pull this together, and I am very appreciative.
12 I am going to stay in my lane, as Michael reminds
13 us. Yes, I think there is potential to use this when we
14 get to discussions around payment adequacy, but I think in
15 the very near term I think there are ample opportunities
16 for the PBJ data to either be used alone or in combination
17 with other pieces of data to give us a better understanding
18 of the relationship between staffing and quality of care.
19 So despite the fact that CMS is going to embark
20 on this literature review, and they're basic it on
21 historical studies that have a lot of limitations, and you
22 know, we're not nationally scope. So I think we could get

1 greater insights into to what extent there is some
2 relationship with quality of care.
3 I also like the fact that this is a much stronger
4 measure than has been used in the past. So whether it's
5 Nursing Home Compare, just greater transparency about
6 actually what's going on, and particularly if it is
7 intensity or acuity adjusted, I think that would be really
8 critical.
9 You know, I'm particularly interested in better
10 understanding how staffing levels vary by, say, the
11 Medicaid mix of patients in a nursing facility or the
12 percent private pay, to the extent that that's information
13 that's available, as well as trying to understand the
14 relationship between staffing levels and profit margins.
15 MS. KELLEY: Robert.
16 DR. CHERRY: Yes. I also want to thank the staff
17 for the great work behind the report. I think it is very
18 well done and the discussion has been great so far.
19 I think in terms of the staffing model in skilled
20 nursing facilities I think a lot of this has to be really
21 linked to two primary objectives. One is fairly obvious,
22 is that staffing, as a measurement, is truly a quality and

1 safety tool for delivering care in our skilled nursing
2 facilities. So it is something that I think we have to pay
3 attention to. It can be linked to Medicare reimbursement
4 and therefore again be potentially our business as well.
5 The other, which I don't think we've discussed
6 too much because we've been focused on what do skilled
7 nursing facilities need to take care of the residents that
8 are actually there, but the other issue is also access to
9 skilled nursing facilities. Because of the lack of
10 staffing on weekend hours it is very difficult sometimes to
11 place patients over the weekends, on Saturdays and Sundays,
12 for example, which makes it very challenging for hospitals
13 and health systems to be able to decompress and keep their
14 throughput going, reduce length of stay, and also drive
15 reduced costs within that population of patients as well.
16 So as we start to think about staffing, weekend
17 hours are quite critical as well in order to make sure that
18 throughput throughout our health care delivery is paid
19 attention to as well.
20 Although we are primarily focused on nursing
21 staffing issues, it is also, I think, important to pay
22 attention to social services, case management resources

1 that would allow for those patients to be able to be
2 successfully managed throughout their stay within a skilled
3 nursing facility.
4 Otherwise, very well done, and I am looking
5 forward to additional discussion on this issue.
6 MS. KELLEY: Scott.
7 DR. SARRAN: As we think about how to use data
8 such as this to help us better understand correlates of
9 high-performing nursing facilities, I had two additional,
10 perhaps, lines of thought on other data with which to
11 integrate this, if it is available.
12 One is -- and this takes off a little bit on
13 Betty's earlier comments -- I wonder if we could look at
14 how this data matches up against Part B provider visits,
15 physician and nurse practitioners, in terms of helping us
16 understand what does a high-performing nursing facility
17 look like in terms of not just their own direct employed or
18 contracted staff but providers coming in the facility and
19 doing clinical care.
20 And the other is recognizing how limited the
21 penetration of institutional SNPs has been and still is. I
22 wonder if there is any data at all that would let us look

1 at staffing ratios as well as other sets of outcomes based
2 on the penetration rate of institutional SNPs within a
3 nursing facility, the underlying premise being that
4 institutional SNPs, if executed, regulated, managed well,
5 offer a significant lever for improved outcomes. And the
6 question is are they actually getting those improved
7 outcomes? If they are, what are the levers for those
8 improved outcomes? Are they driving higher staffing
9 because they are gain-sharing, for example, with
10 facilities? There is a whole sort of body of inquiry I
11 think that is appropriate to that as well.
12 MS. KELLEY: Okay. I have a short comment from
13 Larry also, but first I'll see if anyone else has a Round 2
14 comment.
15 Okay. Larry wants to make sure that any study of
16 staffing and quality account for the three different types
17 of staff, which are very different from each other in ways
18 that can contribute to quality.
19 So back to you, Mike.
20 DR. CHERNEW: Thank you, Larry.
21 So this has, on the plus side, opened up a lot of
22 exciting opportunities, and I think what is clear from this

1 discussion is we are grappling with how to build it in the
2 spirit of what Cheryl said, understanding correlative
3 quality, which is slightly different than things that
4 causally related to quality. But nevertheless, the
5 relationship between staffing and outcomes I think
6 something that will be important. That doesn't imply that
7 we would then immediately decide, oh, staffing has to be
8 this.
9 I actually resonate a lot with what Greg said,
10 which is we do have to allow some flexibility for new care
11 modalities, new approaches in a range of ways. So we want
12 to both make sure that the beneficiaries get the care that
13 they need without being overly prescriptive about how that
14 is prescribed, particularly in situations where it turns
15 out that the facilities couldn't attract the people they
16 are told they have to attract in a bunch of ways.
17 I think one of the particularly interesting
18 things that we didn't dwell a lot on in this set of
19 discussions is the role of contract nurses. There are
20 several ways in which that plays out. It plays out in
21 terms of a source of labor, but it also plays out in terms
22 of a drain of labor within the nursing space. And I think

1 there is some material in here that talks about that
2 briefly, and I think that is going to end up being
3 important.
4 So I am excited that we have this data and
5 excited that we will be able to track what is going on. It
6 remains unclear to me exactly in what context we will use
7 it for specific recommendations, but I think seeing it and
8 knowing we have it is really an improvement over where we
9 were. So as happened in the meeting before lunch in post-
10 acute PPS, the more we can understand what's going on in
11 these facilities, the more we can think about a whole range
12 of things. This is just one window of that.
13 Anyway, so that's where I am on this. We are
14 ahead of schedule, which is fine by the way, because the
15 next topic we are about to switch over -- and I will wait.
16 We might as well take a five-minute break if
17 people want to take a five-minute break since we are ahead
18 of schedule and then come back, and that will just give us
19 time to do the technical transition. And we are going to
20 come back and talk about telehealth.
21 Lauren and Kathryn, thank you so much. I hope
22 you heard the enthusiasm and appreciation from around the

1 table for the stuff that you did. I hope you are half as
2 excited at the Commissioners are. So great job.
3 [Recess.]
4 DR. CHERNEW: So, if I follow this, we are
5 actually live. So welcome, everybody. We are now going to
6 deal with an issue which I think will be a continual issue
7 over the coming set of cycles, and we've been asked to
8 study it explicitly. But, frankly, sometimes you're asked
9 to do things you don't want to do. Sometimes you're asked
10 to do things you do want to do. I'd put this in the
11 category of asked to do something we do want to do.
12 So I'm going to turn it over to Ledia or Ariel.
13 Okay, Ledia.
14 MS. TABOR: Okay, great. Good afternoon.
15 The audience can download a PDF version of these
16 slides in the handout section of the control panel on the
17 right-hand of the screen.
18 Before getting started, we would like to thank
19 Corinna Cline for her assistance on this work.
20 During today's presentation, we will review the
21 requirements of our mandated report on telehealth,
22 Medicare's temporary expansion of telehealth during the

1 public health emergency, the Commission's policy option for
2 covering telehealth after the PHE that was in our March
3 2021 report, and permanent changes to telehealth policy
4 since the PHE began.
5 Next, I'll review our analytic plan for the
6 mandated report. Ariel will then cover alternative
7 approaches to paying for telehealth services under the
8 physician fee schedule and by FQHCs and RHCs.
9 Following the presentation, we would like your
10 feedback on this material.
11 In the Consolidated Appropriations Act, 2022,
12 Congress mandated that MedPAC submit a report by June 2023,
13 which should include five elements: first, the utilization
14 of telehealth services; second, Medicare program
15 expenditures on telehealth; third, Medicare payment policy
16 for telehealth services and alternative approaches to such
17 payment policy, including for FQHCs and RHCs; fourth, the
18 implications of expanded Medicare coverage of telehealth
19 services on beneficiary access to care and quality; and
20 finally, other areas determined appropriate by the
21 Commission.
22 Before the PHE, Medicare's coverage of telehealth

1 was flexible in Medicare Advantage, two-sided ACOs, and
2 other payment systems. However, coverage of telehealth was
3 limited by statute under the physician fee schedule because
4 of concerns about its impact on spending and program
5 integrity. Under the fee schedule, Medicare paid for a
6 limited set of telehealth services provided to
7 beneficiaries in rural areas in certain settings, such as
8 physicians' offices and hospitals -- in certain settings
9 such as physicians' offices and hospitals, with some
10 exceptions; for example, telestroke.
11 As a result, use of telehealth was very low. It
12 accounted for less than 1 percent of fee schedule spending
13 in 2019. This low use was consistent with other payers.
14 To allow beneficiaries to maintain access to care
15 and help limit community spread of COVID-19, Medicare
16 temporarily expanded coverage of telehealth under the fee
17 schedule.
18 This table lists the key policy changes that
19 apply during the PHE. First, Medicare began paying for
20 telehealth services provided to beneficiaries in both rural
21 and urban areas in any setting, including patients' homes.
22 Second, Medicare expanded coverage to over 140

1 additional telehealth services and began paying for audio-
2 only interactions for certain services.
3 Third, CMS began paying either the facility or
4 non-facility rate for a telehealth service, depending on
5 the clinician's location.
6 Before the PHE, Medicare always paid the facility
7 rate, which is usually less than the non-facility rate.
8 In our March 2021 report to the Congress, we
9 described a policy option for covering telehealth after the
10 PHE. Under this option, Medicare would continue to cover
11 certain telehealth expansions for a limited duration, such
12 as one to two years, after the PHE ends.
13 These expansions would include paying for
14 specified telehealth services provided to all beneficiaries
15 regardless of their location; covering additional
16 telehealth services if there is potential for clinical
17 benefit; and covering certain telehealth services when they
18 are provided through an audio-only interaction, if there is
19 potential for clinical benefit.
20 Continuing these expansions for a limited period
21 of time would allow policymakers to gather more evidence
22 about the impact of telehealth, when combined with in-

1 person care, on access, quality, and cost. This evidence
2 should inform any permanent changes to Medicare's
3 telehealth policies.
4 Our policy option also calls for returning to
5 some of Medicare's prior telehealth policies after the PHE,
6 along with establishing some additional safeguards. First,
7 Medicare should go back to paying the fee schedules
8 facility rate for telehealth services. Second, providers
9 should not be allowed to reduce or waive beneficiary cost
10 sharing for telehealth services. Further, there should be
11 additional safeguards to protect Medicare and beneficiaries
12 from unnecessary spending and potential fraud related to
13 telehealth. These include applying additional scrutiny to
14 outlier clinicians, requiring clinicians to provide an in-
15 person, face-to-face visits before ordering costly DME and
16 lab tests, and prohibiting incident-to billing for
17 telehealth services provided by any clinician who can bill
18 Medicare directly.
19 Since the PHE began, Congress and CMS have made
20 other changes to telehealth policies. Congress extended
21 the Medicare telehealth flexibilities for five months after
22 the PHE.

1 Another change is that Medicare permanently began
2 covering tele-behavioral health services received at home.
3 After the PHE ends, an in-person visit must be provided
4 within six months prior to the initial telehealth service.
5 For subsequent mental telehealth services, there
6 is an annual in-person visit requirement. However, the
7 policy does not apply if the practitioner and patient agree
8 that the benefits of an in-person service are outweighed by
9 the risks and burdens.
10 Also, CMS extended the time frame for covering
11 services provided by telehealth until the end of 2023.
12 These include services that likely have a clinical benefit
13 when furnished via telehealth but for which there is not
14 yet sufficient evidence available to consider the services
15 as permanent additions to the allowable telehealth services
16 list.
17 CMS has proposed requiring a claims modifier for
18 audio-only services, which will allow policymakers to study
19 the impact of audio-only telehealth services. The proposal
20 of an audio-only modifier is consistent with the
21 Commission's recent recommendation to the Secretary.
22 I'll now switch to our analysis plan for the

1 mandated report. Using Medicare claims data, we will
2 examine volume and spending for telehealth services
3 provided by clinicians, FQHCs, and RHCs. We will use data
4 between 2019 and 2021, which is the most recent data
5 available. The more specific analyses are listed here and
6 described in your meeting materials.
7 Over the coming meeting cycle, we plan to analyze
8 the implications of expanded Medicare coverage of
9 telehealth services on beneficiary access to care and the
10 quality of care they receive.
11 Our analysis is limited by several factors.
12 First, before the PHE, coverage for telehealth in Medicare
13 was limited to certain services and areas; for example,
14 rural areas. So pre-pandemic literature and data are of
15 limited use in understanding the impact of an expansion of
16 telehealth.
17 Second, data from many months of the pandemic
18 when people were avoiding in-person care might not be
19 appropriate to use when analyzing the potential impact of
20 telehealth policy outside of a pandemic.
21 Third, there are technical challenges we have in
22 measuring quality of care in general. Medicare lacks

1 comprehensive data sources like lab results and patient
2 reporting outcomes. We can use administrative claims data
3 in our analysis. However, there is a significant time lag
4 in the availability of that data.
5 We are interested in the broader implications of
6 telehealth expansions on quality and access. We want to
7 understand if beneficiaries having access to multiple modes
8 of care -- in-person, audio and video, audio only -- has
9 implications for quality outcomes, access, and cost.
10 We are working with a contractor to test the
11 feasibility of using population-based measures, for
12 example, ambulatory care sensitive hospitalizations and
13 emergency department visits, to study the impact of
14 telehealth expansions on Medicare beneficiaries' access to
15 and quality of care. We are currently working with the
16 contractor to develop the methods to perform this analysis,
17 and we will provide more details in future meetings.
18 Outside of the claims analysis on volume,
19 spending, and quality, we are going to use additional
20 sources for our mandated report.
21 Our other analyses includes reviewing the
22 literature on the impact of expanded telehealth coverage,

1 focus groups with beneficiaries and clinicians, and our
2 annual survey of Medicare beneficiaries and privately
3 insured individuals.
4 I'll now turn it over to our Ariel to discuss
5 payment options.
6 Next, we're going to talk about an alternative
7 approach to paying for telehealth services under the
8 physician fee schedule.
9 The fee schedule pays separately for each
10 telehealth service, and there are downsides to this
11 approach. First, this creates an incentive for clinicians
12 to bill for more telehealth services. Second, this
13 increases the administrative burden on clinicians because
14 they need to document and bill separately for each service.
15 Third, it is difficult to price individual telehealth
16 services because some of them represent brief interactions
17 between patients and clinicians that are part of a broader
18 episode of care.
19 One option to address this issue is to bundle
20 certain telehealth services into a larger unit of payment
21 instead of paying separately for each service. This
22 approach would parallel how other Medicare payment systems

1 pay for telehealth.
2 For example, CMS pays hospitals a fixed payment for all
3 services provided during an admission, including those
4 delivered by telehealth.
5 In the next few slides, we explore the
6 possibility of creating a set of expanded codes for
7 evaluation and management office and outpatient visits,
8 which would include related telehealth and in-person
9 services provided during a given period of time; for
10 example, 30 days.
11 There are precedents in the physician fee
12 schedule for bundled payments that cover a series of
13 related services provided during a fixed period of time.
14 First, there is a monthly payment that covers
15 most outpatient dialysis-related physician services for
16 ESRD patients. For example, for patients managed in a
17 dialysis center, the monthly payment varies based on the
18 number of visits they receive during the month. In
19 addition, the fee schedule uses a global payment policy to
20 pay for most surgical procedures. The global payment
21 covers the procedure itself and postoperative clinician
22 visits that are provided up to 10 days or 90 days after the

1 procedure.

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

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

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

1 one virtual check-in.
2 The period of time covered by the bundle could be increased
3 to 60 days or 90 days.
4 Whether the same clinician provides all the
5 services in the bundle or they are provided by different
6 clinicians in the same practice, Medicare would make a
7 single payment. This type of payment would counter the
8 financial incentive for clinicians to provide more services
9 than are necessary to deliver high-quality care, and it
10 would reduce clinicians' administrative burden because they
11 wouldn't have to bill Medicare for each discrete service.
12 If CMS decided to adopt expanded E&M visit codes,
13 there would be several important design considerations, and
14 here are some key ones.
15 First, which services should be included in
16 expanded E&M codes? It probably makes sense to include E&M
17 office and outpatient visits, both in-person and
18 telehealth, ¬as well as certain other telehealth services,
19 such as virtual check-ins, remote evaluation of images or
20 videos sent by the patient, and online digital evaluation
21 services. But the code would not include the originating
22 site fee for telehealth services because Medicare pays this

1 to a separate provider, and telehealth services that are
2 not bundled would continue to be paid separately.
3 Second, what time period should be covered by the
4 codes; for example, 30 or 60 days?
5 Third, how should CMS account for the variation
6 in clinician time and resources during the time period
7 defined by the policy?
8 Fourth, how would the payment rates be
9 determined?
10 And lastly, how would CMS track changes in care
11 delivery over time to make sure that the payment rates
12 remain accurate?
13 Medicare's experience with global surgical codes
14 reinforces the importance of monitoring these changes. If
15 Commissioners are interested in exploring the concept of
16 expanded E&M codes, we could use claims data to analyze
17 patterns in the use of E&M visits and telehealth services
18 during different time periods; for example, 30 days after
19 an initial E&M visit.
20 Now I'm going to switch gears and talk about
21 FQHCs and RHCs. In general, Medicare pays higher rates for
22 services provided by FQHCs and RHCs than it pays clinicians

1 under the physician fee schedule.

2 During the PHE, Medicare temporarily expanded

3 coverage of telehealth services provided by FQHCs and RHCs,

4 as shown in this table.

5 Before the PHE, FQHCs and RHCs could only bill as

6 the originating site for a telehealth service. This is

7 where the patient is located while receiving the service.

8 They could not bill as the distant-site clinician; that is,

9 the clinician who provides the telehealth service. But

10 during the PHE, they can bill for telehealth services as

11 the distant site, and they can provide telehealth to

12 beneficiaries in any location, including at home. And they

13 can bill for any telehealth service that is payable under

14 the fee schedule.

15 During the PHE, Medicare's payment rate for FQHCs

16 and RHCs for telehealth services is based on the physician

17 fee schedule rate for comparable services. This is less

18 than what Medicare pays FQHCs and RHCs for in-person

19 services.

20 If telehealth services continue to be covered in

21 FQHCs and RHCs after the PHE, CMS could decide to pay them

22 their standard in-person payment rates for telehealth. CMS

1 has already decided to do this for tele-behavioral health
2 services, which will be covered after the PHE.
3 But another approach would be to pay FQHCs and
4 RHCs a rate that is based on the physician fee schedule
5 rate for telehealth services, which would be about 50
6 percent less than their standard FQHC or RHC payment rates.
7 This is how Medicare pays them for telehealth during the
8 PHE. Continuing to pay a lower rate for telehealth
9 services than for in-person services would reflect the
10 lower facility costs of providing telehealth.
11 In addition, it would align payment rates for
12 telehealth services across FQHCs, RHCs, and clinicians who
13 bill under the fee schedule, thus, achieving payment parity
14 across settings. It would also balance the dual goals of
15 ensuring access to care for beneficiaries and prudent
16 fiscal stewardship of the Medicare program.
17 This policy would likely require a change in
18 statute.
19 For your discussion, we are interested in getting
20 your feedback on our analytic plan for this mandated
21 report, the alternative approach we outlined to paying for
22 telehealth services billed under the fee schedule, and the

1 alternative approach to paying for telehealth billed by
2 FQHCs and RHCs. Also, is there other material you would
3 like us to include in this report.
4 I'll conclude with a reminder that this report
5 will be a chapter in our June 2023 report.
6 And now I'll turn it back over to Michael.
7 DR. CHERNEW: Terrific. We're going to start
8 Round 1. If I have that correct, it's Marge.
9 MS. GINSBURG: I guess I just wanted to start
10 first of all with a comment. Was that you, Mike, that said
11 earlier this morning about how -- was it another
12 Commissioner who said once you provide something, you'll
13 never be able to take it back? I can't remember.
14 DR. CHERNEW: That was David quoting Bill
15 Scanlon.
16 MS. GINSBURG: Okay. Well, anyway --
17 DR. CHERNEW: Bill, if you're listening, we love
18 you.
19 [Laughter.]
20 MS. GINSBURG: This one really shouts it out, and
21 so I just want to make my own personal comment. We need to
22 be extremely careful about going forward or I personally

1 believe we're going to be facing a disaster financially and
2 no good health care that comes out of it.
3 Okay. But I do have a question. We keep saying
4 after the PHE. Have we actually determined when the PHE is
5 ending? I mean, so far, I've seen no evidence that it is.
6 I'm under the assumption that it's basically here to stay,
7 but I think we need to somehow define when we imagine this
8 is going to start. I know it's not up to MedPAC to decide
9 when the public health emergency is over, but I would think
10 this needs to be, in some way, part of our discussion here.
11 Is that outside our domain? Anyway, that's my Round 1
12 question.
13 MS. TABOR: My thought would be it is a bit
14 outside of our domain.
15 DR. CHERNEW: That's a yes.
16 MS. TABOR: Yes.
17 DR. CHERNEW: There will be people deciding when
18 the PHE ends. It will not be us.
19 MS. KELLEY: Marge, do you have another question?
20 MS. GINSBURG: No.
21 MS. KELLEY: Okay. Greg. With a Round 1
22 question?

1 MR. POULSEN: Yeah. On the global surgical code
2 example that you guys gave, which I thought was great, it
3 was very illustrative, do you capture virtual check-ins
4 today or is that in-person, when we said there weren't as
5 many as had been anticipated?
6 MR. WINTER: The data were collected beginning in
7 2017, from clinicians in nine states. And so the virtual
8 check-in code was not introduced, I think, until 2018 or
9 2019, so it was not even an issue then. And I think they
10 were focused on post-operative visits as in like E&M
11 visits. Virtual check-in is a much shorter interaction, a
12 much lower payment rate. So that would not have been
13 captured.
14 MR. POULSEN: Yeah, thank you.
15 MR. WINTER: The data was analyzed by RAND.
16 MR. POULSEN: Yeah, I think that's great. The
17 reason I asked that is we may be seeing, and already have
18 been seeing, virtual being inserted in place of face-to-
19 face because it was convenient for the patient and the doc.
20 MS. KELLEY: Kenny.
21 MR. KAN: Great work. I am very enthusiastic
22 about where this could be headed.

1 On Slide 18, a clarifying question. Are FQHCs
2 and RHCs in rural and frontier areas also paid at 50
3 percent less than the standard rates for telehealth?
4 Because I'm trying to think about the whole access and cost
5 question.
6 MS. TABOR: So RHCs and FQHCs, regardless of the
7 location, are currently, during the public health
8 emergency, being paid at the physician fee schedule rate of
9 about 97 percent.
10 MR. KAN: Okay.
11 MS. TABOR: Regardless of location.
12 MR. KAN: Okay.
13 MS. KELLEY: Okay. Larry has a Round 1 question.
14 Larry's first question is, would the expanded E&M code
15 apply to all visits, and if not, at what point would it be
16 billed?
17 MR. WINTER: This is really a design question,
18 but the concept is that it would include at least E&M
19 visits provided during a certain period of time, and
20 certain telehealth visits but not all telehealth visits.
21 For example, a telehealth visit for behavioral health
22 probably would not make sense to include, or a telehealth

1 visit for physical therapy, assuming that continues to be
2 paid after the PHE.
3 And his other question is when would it be
4 billed? So it probably makes sense for the clinician to
5 bill this either at the end of the period defined by the
6 code or towards the end of that period, because then they
7 can determine what level to bill this at. For example, did
8 they provide one E&M visit and that is it in the 30-day
9 period? Did they provide four or more visits? That would
10 influence the payment rate. So it would probably make
11 sense for it to be billed towards the end or at the end of
12 the period covered by the code.
13 MS. KELLEY: Okay. And his second question is,
14 if I have an E&M visit for a patient with asthma and that
15 patient comes in a week later with a sprained ankle, does
16 the second visit get billed under a second expanded E&M
17 code? I can see problems with that, but it doesn't make
18 sense to have the ankle sprain included in the asthma
19 expanded E&M claim.
20 MR. WINTER: Right. That is a good question. I
21 think that is another design issue to think about is
22 whether it would allow clinicians to bill for separate

1 expanded codes, for different conditions. And you could
2 make an argument that it makes sense to do that because the
3 kinds of services might be different, and to pay for two
4 very different conditions under one expanded code might not
5 reflect the resources used to treat two very different
6 conditions.

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

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

16 MR. WINTER: We were thinking of focusing on E&M
17 office and outpatient visits, not E&M inpatient or ED or
18 E&M visits in nursing homes. If the question is would you
19 pay all E&M office and outpatient visits under an expanded
20 code, I think it probably makes sense to do that. And if
21 the episode, let's say, includes only one E&M visit, well
22 then that would be probably the lowest level of the coding

1 system, of the coding levels. And so that is all you would
2 be paid. But if you did more things within that period
3 then you would get paid a higher-level code. That is how I
4 was thinking of this.
5 MS. KELLEY: Okay. I have David with a Round 1
6 question.
7 DR. MATHEWS: If I can just jump in -- another
8 way to interpret Larry's question would be do we envision
9 scenarios where a clinician is providing an E&M visit only
10 and does not anticipate billing or having any subsequent
11 telehealth interactions with the patient around that visit.
12 And in that case does the physician or the clinician have
13 no other option but to bill an E&M visit that does include
14 some degree of subsequent telehealth assumed in the rate.
15 Maybe Larry will respond via chat to see if I am
16 anticipating what his question is getting at.
17 DR. GRABOWSKI: In the meantime maybe I will ask
18 my question. So you had asked for feedback on the proposed
19 evaluation by the contractor, and I wanted to ask about
20 Slide 11. In the lower bullet there you said "Working with
21 a contractor to test feasibility of using population-based
22 measures." What do you mean? Just so I understand, what

1 are population-based measures?
2 MS. TABOR: Yeah. So it is the avoidable
3 hospital use or ambulatory care-sensitive hospitalization
4 and ED visits that we use in our payment adequacy work in
5 the physician chapter. So it is kind of a measure of both
6 accessing quality, because it is for those with chronic
7 conditions and certain acute care, like pneumonia, for
8 example, are patients going to the hospital, either
9 hospitalized or going to the ED. And the idea is that if
10 they had diabetic care that was appropriately monitored and
11 get access to primary care and/or their specialist, they
12 wouldn't need to be hospitalized.
13 DR. CHERNEW: I am going to follow up on David's
14 question now, to make sure that I understand your
15 clarification to his clarifying question. So that is a
16 design where you would take -- this is truly a question. I
17 am going to say it as a statement. You would take people
18 that had telehealth visits and look at their, say,
19 ambulatory-sensitive admissions and compare them to people
20 without telehealth visits. And the population-based part
21 of it is the ambulatory-sensitive admissions.
22 MS. TABOR: It would be -- actually, it is an

1 element of both. The measures themselves I think are
2 population-based, but we were planning to look at markets
3 with high telehealth intensity versus markets with low
4 telehealth intensity, in doing that diverse and difference
5 analysis. That would control for their risk factors, which
6 we will be very excited to tell you all about in April once
7 we have the results.
8 DR. CHERNEW: That was quite clarifying.
9 MS. KELLEY: The Round 1 queue is rapidly
10 multiplying. I have Dana next.
11 DR. CHERNEW: Oh, there we go.
12 DR. SAFRAN: Yeah, the answer to the previous
13 question may have answered my question, but my question is
14 also about the analysis plan. I may have misunderstood but
15 I thought from what you shared that you are planning to use
16 methods that do not involve claims. But now you are
17 planning to use methods that do involve claims.
18 MS. TABOR: Yes. We only are going to use
19 claims, because we do not have access to clinical data.
20 DR. SAFRAN: Right. I thought you were saying
21 that you were going to use focus groups and Medicare
22 beneficiary survey and literature review.

1 MS. TABOR: So we are doing all of those things.
2 I think in the mandate we even have to look at access and
3 quality. So we are testing this proof of concept of can
4 you use claims-based population-based outcome measures to
5 compare the quality and care with telehealth access. So
6 that is one that we are doing. And then we have also been
7 talking to beneficiaries and clinicians about their
8 experiences with telehealth, and we are continuously
9 tracking the literature that is coming out.
10 DR. SAFRAN: Got it. Okay. You have answered my
11 question.
12 MS. KELLEY: Lynn.
13 MS. BARR: Thanks. Great work, guys. I'm really
14 excited about this, and I have some comments in Round 2.
15 But getting back to Round 1, the thing that
16 happened with global payments on surgery is kind of
17 interesting to me because when we want to get physicians to
18 do things, we pay them to do them and they do more of them.
19 And so have you looked at the number of patients that had
20 follow-up visits prior to global, and did it drop off?
21 Because my concern would be that we're going to pay them
22 and we are going to pay more and get less, not an equal

1 amount. Have you looked at that?

2 MR. WINTER: I do not think the data exist to

3 look at that because from the beginnings of the resource-

4 based relative value scale fee schedule, the fee schedule

5 as we know it today, which began in the early '90s, at

6 least for the work RVUs, they always had built-in the

7 global surgical codes with 0-, 10-, or 90-day global

8 periods.

9 Now I guess if there were codes that kind of

10 switched from, let's say, 10 days to 90 days, then you

11 could exploit that change and look at whether there was a

12 change in the number of visits. The problem is that we

13 have very limited data on the number of visits that are

14 actually provided. It is not routinely reported. CMS

15 began collecting this information in 2017, from clinicians

16 in practices of 10 or more in only 9 states, for 299

17 procedures, and I don't know if that data are public,

18 publicly available, and I don't know if they've continued

19 to collect it or if it stopped. So I'm not sure the data

20 exists for us to be able to answer that.

21 MS. BARR: Okay. Fair enough.

22 The next Round 1 question I have is, do you know

1 what the impact of telehealth in the PHE was on traditional
2 telehealth? So we have been pushing that traditional
3 telehealth rope forever and not really getting a lot of
4 uptake. You know, the rural would be the originating site.
5 Did that just go away or did it maintain at about the same
6 level?
7 MR. WINTER: We can look into that, and if you
8 look at 2020 claims data, and we talked about that last
9 November, you still see telehealth being provided in rural
10 areas. You still see originating site claims, although as
11 a percentage of the total they've gone way down because
12 most telehealth is provided at home now and there is no
13 originating site to claim for that.
14 But when we look at 2021 data, as we are just
15 starting to do, we will keep an eye. We will look at
16 whether patterns of telehealth use in rural areas and
17 originating site, where there is an originating site claim.
18 MS. BARR: That is interesting, because it seemed
19 to me, when I observed that telehealth in rural areas it
20 was more of a consult. You know, because the provider is
21 almost always there, right, so that was a big problem. They
22 were not getting paid for that, and that kept utilization

1 down. So if you have this, do you still need that other
2 system? It is just a question of whether one replaces the
3 other.
4 And how would you propose to deal with providers
5 -- 50 percent of rural providers refused to do telehealth
6 during the PHE, mostly, according to what I heard, because
7 of the payment rates. But how would you deal with
8 providers that say, "I don't want to do telehealth, and I'm
9 not going to do virtual check-ins." Are you going to pay
10 them this extra as well?
11 MR. WINTER: Is that a question regarding the
12 expanded E&M code?
13 MS. BARR: Yes. Now we are into the expanded E&M
14 code. I'm sorry.
15 MR. WINTER: Okay. The lowest level code could
16 be one that is only for an E&M visit. That does not
17 include virtual check-ins or other related telehealth
18 services. It would just be regular, in-person E&M visit,
19 and that's one level. You know, you bill one code for
20 that, that kind of service.
21 MS. BARR: Right.
22 MR. WINTER: But if you do provide, let's say,

1 some telehealth associated with that, that would be a
2 different code with a higher payment.
3 MS. BARR: So E&M with 30 days of telehealth
4 access, E&M with 90 days of telehealth access.
5 MR. WINTER: Right.
6 MS. BARR: Maybe those kinds of things. Great.
7 Thank you very much. Those are my Round 1 questions.
8 MS. KELLEY: Larry has a clarification that kind
9 of builds off what you were asking, I think, Lynn. He
10 wants to be clear on what the proposal to bundle would
11 actually mean. You can't tell whether there will be
12 subsequent telehealth visits. So either all visits would
13 need to be billed as expanded E&M at the time of service or
14 no visits would be billed as expanded E&M at the time of
15 service. This would mean that all visits would need to be
16 billed 30 days later as expanded or not, depending on what
17 happened in the meantime, which would be administratively
18 complex and also complex with regards to billing the
19 patient.
20 MR. WINTER: I think that is a fair point. And I
21 might argue in favor of a shorter time frame, like 30 days
22 instead of a longer one, like 90 days. But if a clinician

1 knows up front that I am just going to see this patient
2 once, provide one E&M visit and no telehealth afterwards --
3 it could be, let's say, an acute visit for a one-time-only
4 issue -- then they could go ahead and bill for that code or
5 they could decide to wait.
6 There is also a process for submitting, for
7 amending claims. So if the nature of that service changes
8 you could submit an amended claim.
9 MS. BARR: Can I just follow up on that? So you
10 are not proposing then that they would be able to bill for
11 an E&M and then, oh gosh, I have to do telehealth so I'll
12 bill for a telehealth visit on top of that? Is the
13 proposal there that the telehealth codes go away?
14 MR. WINTER: I don't think so. So you would need
15 like a triggering service to initiate this bundle or
16 episode. So I think it makes sense for that triggering
17 service to be an E&M visit. And then once you have that
18 E&M visit, if you do, let's say, a virtual check-in, a
19 remote evaluation of images or video, that then becomes
20 bundled with the E&M visit. But if you only do a virtual
21 check-in or some other kind of minor telehealth service,
22 without an E&M code within a certain time frame, then you

1 just bill for that separately.

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

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

4 MS. BARR: Okay.

5 DR. CHERNEW: here is what I think is going to

6 end up happening. We are going to get a lot of clarifying

7 questions to try and understand exactly what the proposal

8 is, and you're going to be thinking, well, some of these

9 are design issues. The proposal isn't as tight. So it's

10 hard to ask a clarifying question about what do you mean

11 because I think some of what you mean would depend on how

12 the Round 2 questions go.

13 If that is accurate, what I want to do is I want

14 to go into -- I think I have this right, that Cheryl, or I

15 could be wrong, Cheryl had a Round 1 clarifying question.

16 If it's not related to -- excuse me? Oh, Cheryl and Betty.

17 And then I want to have our Round 2 questions, because I

18 think our Round 2 questions are going to get to these

19 comments about design.

20 MS. BARR: I have an unrelated Round 1.

21 DR. CHERNEW: Yeah, so that is fine. You can ask

22 that. But I do want to make clear there are a lot of

1 design issues here, so I think it is hard to try and pin
2 folks down on what the proposal is when the answer is we
3 are going to develop the proposal or not, depending on how
4 Round 2 goes. So I just didn't want to spend all of our
5 time in Round 1 to circle.
6 Lynn has one more question, then Cheryl, then
7 Betty, then Round 2.
8 MS. BARR: Okay. So my last question was because
9 we're using this to pay for virtual check-in, what has been
10 the adoption rate of virtual check-ins?
11 MR. WINTER: Yeah. So the code was introduced in
12 2018 or 2019, and it increased a lot between 2019 and 2020,
13 which would have been related to the pandemic and all the
14 people that were not going to the doctor's office anymore.
15 And we will track it in 2021. We will come back to you
16 with that information. But it did increase between 2019
17 and 2020.
18 MS. BARR: The only reason I bring that up is
19 because most of the physicians we talk to about
20 implementing virtual check-ins refuse to do it because the
21 cost of billing was higher. So I would be nervous that we
22 are pricing in a service that was only used during the PHE,

1 and I would welcome other clinicians to speak whether your
2 organizations use that code to any extent.
3 MR. WINTER: And in 2020, CMS introduced a high-
4 level virtual check-in for a longer phone call, that is
5 paid more. So we will see what the utilization of that was
6 like.
7 MS. KELLEY: Cheryl.
8 DR. DAMBERG: I think this is a quick question.
9 My understanding is CMS is going to start tracking, as of
10 January 1, 2023, the HCPCS claim modifiers saying whether
11 it was audio only, right? But it seems as though, in your
12 analytic plan, that you are going to look at patterns by
13 type of service, whether it is telephone only or
14 telehealth. So I was confused on how you're going to be
15 able to do that in the time frame you're looking at.
16 MR. WINTER: Good question. So there are certain
17 E&M telephone codes, where you do an E&M service only by
18 phone. That has a separate CPT code or HCPCS code. And so
19 we can identify that in a claim stream.
20 There are other telehealth services which you can
21 provide either by audio-video or audio-only, but you bill
22 the same HCPCS code or CPT code for that, regardless of the

1 modality you use. And we cannot tell in the claims was it
2 audio-only or not. So for those we cannot tell if they
3 were audio-only, until we get 2023 data with a modifier.
4 MS. BARR: Okay. So you're --
5 MR. WINTER: But there are certain codes we can
6 already tell that were definitely performed by telephone.
7 MS. BARR: Yeah. So you'll get an initial look
8 but then you'll be adding on with the 2023 data.
9 MR. WINTER: Correct. It will be a conservative
10 estimate.
11 MS. BARR: Okay. Thanks.
12 DR. CHERNEW: Okay. Now, if I have followed --
13 and I'm not sure I have -- we are now transitioning to
14 Round 2, and that's going to put us to Amol, if I -- got
15 it.
16 DR. NAVATHE: Great. So, first off, really
17 important work. Thanks, Ariel and Ledia, for the
18 thoughtful nature of this chapter. I have sort of one big
19 conceptual comment and then a couple of really specific
20 suggestions on analyses that we can add to.
21 The big conceptual comment, I think some in part
22 relates to many of the design questions that are happening

1 here, which is I'm concerned -- and I will say as somebody
2 who supports the notion of bundling or episoding, generally
3 speaking, as we have done with PPS and dialysis and a whole
4 bunch of things, I'm concerned about the suitability of
5 this with an episode or bundle-like structure, because,
6 Ariel, you've pointed out already several of the features
7 that we intend to look for. We looked for some sort of
8 defining, triggering event for a clinically defined episode
9 that ideally has a start and a stop. I think in this case
10 it's unclear -- maybe the start is clear. It's perhaps
11 unclear what the stopping point is.
12 I think there's -- ideally you want to create
13 some kind of accountability structure that comes with any
14 payment that's happening where there's a lot of degrees of
15 freedom underneath what that -- what activities can
16 actually be captured by that. In the general fee-for-
17 service system, we don't have an accountability mechanism.
18 I think we're inherently going to end up with some kind of
19 cliff at some point. It's a 30-day bundle, it's a 90-, 60-
20 , whatever-day bundle, and then there's going to be a
21 strong incentive to clump around that cliff. And I think
22 that might be something that's concerning, again, from a

1 design perspective.

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

16 So I think we should be careful around these
17 different dimensions and think about the suitability and
18 whether -- I understand in some sense you're asking about
19 what are design features. I'm worried that I'm not sure we
20 can come up with a cohesive set of design features that are
21 going to appropriately check the box, or check the
22 different boxes that we would want for consistent with

1 Commission principles kind of design here.

2 I think Larry in his questions and others have

3 highlighted to the extent that you have levels of these

4 codes that are influenced by the activities that happen in

5 the episode, that also undermines the concept of having the

6 episode where you're kind of bundling a set of activities,

7 again, with some accountability.

8 So I don't want to belabor the point, but I'm

9 concerned about that. I think it struck me that in the

10 request, however, there was a request for a design, and so

11 I understand that we're trying to come up with something.

12 This is very raw and off the cuff. I wonder if it makes

13 more sense potentially to think about something that is a

14 telehealth-only bundle that is triggered, can be triggered

15 with the first telehealth visit so we avoid some of the

16 issues that some folks have had around every E&M code has

17 some telehealth packaged in and maybe telehealth doesn't

18 happen, so then we're paying without getting telehealth

19 services. Here we could potentially at least guarantee

20 that we'd have a telehealth service.

21 Again, it's going to have all the same problems

22 that I mentioned, so I'm not sure it's a solution. I just

1 wanted to throw something out there because I know we're
2 searching for something there.
3 That's the kind of broad conceptual point. Now
4 the specific tiny things.
5 So on page 10, there's a list of analyses in the
6 paper. I think it would be helpful to understand also the
7 dimension of by specialty, particularly primary care versus
8 specialty, in terms of the various types of telehealth use.
9 On page 12, there's a list of dimensions that
10 we're interested in. I think in part we're really
11 concerned around appropriateness. We probably can't get at
12 that specifically, but I wonder if there's a way to try to
13 understand something about the substitutive versus additive
14 element of how telehealth is being used. I know there are
15 some estimates from the literature that suggest that 85
16 percent of telehealth visits during the pandemic seemed to
17 be more additive except for the very acute phases where
18 people are sort of sheltering at home, and so that should
19 give us budgetary concerns, if you will.
20 I do agree, on page 12 you kind of outline what
21 the orientation is here, that we're not trying to compare
22 in-person versus telehealth, and I think that's totally

1 right. I think we're thinking about what this system would
2 be in-person plus telehealth versus what the prevailing
3 system is. So I just wanted to voice support for that
4 perspective. I think that's really important.
5 And then I think the last small point I wanted to
6 make is kind of in sync with this accountability piece. I
7 think it would be nice somewhere in here, consistent with
8 what we've said in previous telehealth chapters, that it
9 would be nice to layer in flexibility aligned with APM
10 participation, and that might be one way to think about
11 aligning some of the design elements with a system that
12 actually could work, even if there are some of these
13 potentially volume-enhancing or number of episode-enhancing
14 kind of design features.
15 So thank you very much. Interesting work. I
16 think we have our work cut out for us to make a design
17 recommendation.
18 MS. KELLEY: Okay. Larry is next, and he has a
19 couple of points.
20 The first point -- and I will use the "I" word,
21 so just pretend I'm Larry. I suggest that MedPAC give some
22 attention to the question of whether organizations that

1 provide only telehealth services should be paid for these
2 services at the same rate as telehealth services provided
3 by bricks-and-mortar provider organizations that mainly
4 provide in-person clinical services. I think there are
5 three justifications for arguing that telehealth-only
6 organizations should be paid at a lower rate.
7 First, telehealth-only organizations are likely
8 to have lower costs of providing the service since they
9 don't have to support the fixed cost of having bricks-and-
10 mortar infrastructure, invoking the principle that Medicare
11 should not pay a lot more for a service than it costs to
12 provide the service.
13 Second, if telehealth services are paid at the
14 same amount for telehealth-only and for bricks-and-mortar
15 provide organizations, the latter may be quite harmed, but
16 they are, of course, fundamental to providing care, so
17 harming them may not be a good thing.
18 Third, arguably, the telehealth service provided
19 by a bricks-and-mortar organization within its in-person
20 service area is a very different service than the
21 telehealth service provided by a telehealth-only
22 organization. For example, the bricks-and-mortar providers

1 can easily order lab, imaging, and other ancillary services
2 as well as make referrals for in-person visits for patients
3 who need them. They are likely to be able to choose
4 convenient, high-quality services, make referrals to the
5 appropriate specialist, arrange for patients who need care
6 very soon to receive it, et cetera.

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

1 payment policy for telehealth services and alternative
2 approaches to such payment.
3 This would be helpful even if the issues are not
4 explored in depth in this report. I would like to see us
5 explore at least some of them in depth going forward. It's
6 extremely important and likely to move quickly.
7 And so our next Round 2 comment is from Lynn.
8 MS. BARR: So I'd like to address the FQHC/RHC
9 question. You know, as you saw in your data, there was
10 limited uptake in rural communities and there were
11 significant barriers. And a lot of it was the fact that
12 the providers in rural health clinics -- and I am just
13 going to talk about provider-based rural health clinics
14 that are cost-based reimbursed -- it's a nightmare to carve
15 out issues like this and try to make this work from a
16 financial perspective. And so it's important for us to
17 think about, you know, if our policy prevents access,
18 that's a bad policy. And, you know, they're cost-based
19 reimbursed, so all of their costs -- you know, I mean all
20 of their costs are divided by the number of visits, right?
21 And that's what we pay them. So why do we care, you know,
22 whether or not we're paying them this and then we're going

1 to cost-based reimburse them on everything else if it
2 creates such a barrier to care and it makes -- and it
3 creates a big administrative burden? I don't understand
4 why we would care, and then we have to have legislation to
5 change it. So I am not a fan of cost-based reimbursed
6 facilities having that type of situation.
7 Now, FQHCs are different because, although they
8 have an all-inclusive rate, they're not cost-based
9 reimbursed. So if they do more, they lose money, right?
10 It doesn't scale. So I think that would be -- you know, I
11 don't feel strongly about FQHCs as I do about cost-based
12 reimbursed RHCs.
13 My other comment on design is if I was designing
14 this, I would design something very similar to the chronic
15 care management program where, if you want to have -- if
16 you want telehealth services from your provider, you sign
17 up for a monthly fee where you have a co-pay and you get
18 telehealth services. This is sort of like -- this is
19 somewhere between concierge medicine and, you know, where
20 we are today. But you can pay -- say it's $50 a month,
21 right? And so I have a $10 a month co-pay. We know from
22 our experience with chronic care management services that

1 $10 co-pay is an incredible barrier for the beneficiaries
2 to adopt. So they're not going to say, oh, I don't care,
3 I've got supplemental insurance. They all had supplemental
4 insurance. It's still a huge issue.
5 So we could use that as a potentially different
6 mechanism. You still want to have it triggered by an E&M,
7 and as the beneficiaries I think said in earlier work that
8 you've done, they want telehealth from their provider.
9 They don't want it from some -- they don't want to call
10 Teledoc. They want this just as a convenient way for them
11 to get care, and so they don't go to the emergency room.
12 And so I would be a big proponent of doing this, but
13 perhaps in a way that doesn't allow as much gaming.
14 Thank you.
15 MS. KELLEY: Stacie.
16 DR. DUSETZINA: Well, I was going to see if Dana
17 would just read my comments because I think it would sound
18 better.
19 [Laughter.]
20 DR. DUSETZINA: So, guys, I think this work is
21 fantastic, and I'm really -- I think the chapter is
22 excellent, and it was really fun to think through where

1 this work could go, because I think it is super important,
2 beneficiaries seem to really like it, but there is that
3 whole problem of gaming and how do we pay for this and not
4 overpay and not underpay.
5 I guess there were a couple of big-picture
6 thoughts I had when reading the chapter, and one was that I
7 don't think I fully understand how people use telehealth
8 today. And I know that's part of what you can look at.
9 Are people using this before going to a face-to-face
10 encounter? You know, a lot of our Round 1 questions and
11 the idea of bundling are you start face-to-face and then
12 you have telehealth follow-up. But I often think about
13 telehealth as I don't want to go to the doctor, and that's
14 what we saw during the pandemic. I want the services, like
15 medication orders or whatever. But can I avoid a face-to-
16 face visit? And I think as we're thinking about bundling,
17 should we be also thinking about from that other side of
18 the coin of you get some sort of visit and then what if you
19 trigger a face-to-face visit shortly thereafter? Then
20 should you have paid the same amount for that telehealth
21 visit that subsequently ended up in an encounter? So kind
22 of maybe a reverse bundling or -- so that was one thing I

1 think would be helpful for context of just how are people
2 accessing it.
3 I really like the analysis plan that was laid out
4 and the use and spending measures that you specified. One
5 of the things I wondered about, though, is being really
6 intentional about looking at how service use has changed
7 over time, even though we don't have a long time frame.
8 But with the pandemic, we know that use was probably really
9 different than it maybe is today. And I also wonder, you
10 know, is there learning going on between beneficiaries and
11 their clinicians where they understand what services really
12 they can't do well by telehealth. So if you look at the
13 most recent period, do you really get a good sense of what
14 we should pay for or what we should encourage under
15 telehealth?
16 One other thing that I was thinking about for the
17 analysis plan is the avoidable hospital use I think is a
18 good outcome to look at, but, again, I think that we might
19 be missing an opportunity to think about avoidable face-to-
20 face visits and how often did you have telehealth that did
21 not result in a face-to-face visit, or the reverse of how
22 often did you have telehealth and very soon thereafter come

1 in for a face-to-face visit, to maybe flag where we should
2 be paying attention, like this is not an appropriate type
3 of care for telehealth.
4 And then for the E&M code options, I think that
5 that in the bundling -- some of the conversation, I think
6 Amol's comments in particular, like, oh, should we bundle
7 it or should we not bundle it, I like the idea of it on its
8 face, and I think in general I like the concept that you
9 could have access to this additional care. I do worry a
10 little bit about, like, would everybody just start to
11 overpay, like, would everybody just bill assuming they'll
12 get some telehealth visits? And then does that mean that
13 beneficiaries have overpaid for services they don't
14 ultimately receive?
15 If there is flexibility around that billing, so
16 if you're able to do something that says, okay, well, you
17 billed as though you were going to provide it and you
18 didn't, or if you billed that you weren't and you did, we
19 give you kind of like a combined rate later. I just don't
20 know from, like, a payment perspective how much of that
21 accounting can happen.
22 But I'm very excited to see this work moving

1 forward and think you guys did a great job with the
2 chapter.
3 MS. KELLEY: Jonathan.
4 DR. JAFFERY: Thanks, Dana. So, first, like
5 others have said, this is a great chapter, great work, and
6 there's so much that I think we're all excited about trying
7 to get to something here. It also feels like you're tasked
8 with -- you know, with all the moving parts, you're tasked
9 with sort of carving something out of a boulder while it's
10 rolling down a hill. So I think I really appreciate the
11 fact that this is challenging work.
12 And I also appreciate, you know, the plan you've
13 laid out for analyzing some of the changes, and, again, one
14 of the challenges is a lot of that analysis might be very
15 important for informing some of these other alternative
16 payment plans. So it's a little bit of a chicken-and-egg
17 thing.
18 All that said, like some others have said, I'm
19 very concerned about the alternative approach with this
20 bundle, and a lot of what Amol started off with were some
21 of the things I was thinking about. I'm not convinced that
22 the analogies in the chapter and the presentation work that

1 well. So like Amol was saying, hemodialysis is -- you
2 know, we're talking about bundling payments to physicians,
3 but that's got a clear-cut definition around clinical
4 encounters of, you know, a dozen a month, where there are
5 other clinicians or people providing care, you know, many
6 hours a day, several days a week. And the one example that
7 maybe speaks more to it is the global surgical one, and as
8 we've talked about, there are some issues with that.
9 I think Stacie's comments are really important
10 about, you know, what is the point of the telehealth
11 service? Are we saying that it is just an add-on to an in-
12 person visit? Sometimes that may make sense. Maybe it
13 makes sense that, you know, you have an in-person visit
14 every six or 12 months related to ongoing mental health
15 telehealth care. But for every service, I think the goal
16 here and the idea, the beauty of it is that it becomes much
17 more convenient and substitutable for an in-person visit,
18 and not every condition requires multiple visits.
19 So I think maybe channeling Dana from this
20 morning, like, what is the problem we're trying to solve?
21 And when I look at Slide 13 and you lay out some of the
22 problems with paying separately for each telehealth

1 service, incentives to bill more services, increased
2 administrative burden, and even difficulty knowing what's
3 the right price to pay, that doesn't strike me as problems
4 for telehealth services. That strikes me as those are
5 problems with fee-for-service.
6 And so at the end of the day, I feel like what we
7 really want to get to still are these four -- the things
8 we're talking about, our population-based payments. From
9 the beginning, years ago, we started talking about could we
10 use telehealth as something that folks in APMs are allowed
11 to use with more freedom and flexibility? And I still
12 think that's a good approach. And I just hate to decrease
13 the availability of this for people based on all these
14 other -- you know, patients, beneficiaries, providers,
15 based on all these other potential barriers. I actually
16 think a CCM-type approach where you've got somebody paying
17 co-pays on a monthly basis is very problematic for a lot of
18 beneficiaries and they just wouldn't -- I'd have a real
19 concern about disparities being exacerbated with that.
20 I'd love to see this get to more of -- from a
21 telehealth perspective, how do we think about putting it
22 into population-based payments and then allowing health

1 systems and providers to innovate around delivering this
2 care in whatever combination makes the most sense for their
3 patient population and for their systems?
4 Thank you.
5 MS. KELLEY: Scott.
6 DR. SARRAN: Yeah. So taking off on the points
7 already raised, particularly Jonathan's, I wonder if it
8 would be conceivable or feasible to pilot the idea of this
9 bundled with just three chronic diseases, two or three
10 chronic diseases. diabetes, heart failure, COPD, right?
11 The big three that drive the high volume of preventable
12 admissions, that have a lot of quality gaps, and where sort
13 of the round peg of fee-for-service payment does not fit
14 with the square hole of what people with serious chronic
15 diseases really need. And that might be a way of taking
16 off the table some of the concerns about waste and fraud
17 and overpayment and administrative complexity. If you
18 limited it to just beneficiaries with one of those three
19 chronic diseases, maybe do it as a zero-dollar copay. So
20 you take away any barriers because, really, we don't want
21 barriers for beneficiaries with those diseases to access
22 the ongoing chronic disease, the exact opposite of what we

1 want.

2 So I don't know if that would need to be a CMI,

3 you know, explicit pilot, but it seems to me that could be

4 a way to get our foot in the door in the way that would be

5 most likely to create new value.

6 MS. KELLEY: Great.

7 MR. POULSEN: Well, I'm grateful that we've heard

8 what we've just heard. I'm glad for the good work on this.

9 This is obviously an incredibly complex area, lots and lots

10 of good information, thoughtful insights.

11 But amen to everything Jonathan said and that

12 Scott just said. I agree with both those points as well,

13 really for three reasons. One, telehealth, I think, has

14 just unbelievable potential value. It's much less

15 expensive when it's appropriate than is face-to-face care.

16 It's often safer, not always but often. Even in the

17 absence of COVID, we've seen just huge benefits there.

18 Again, when appropriate, it's incredibly satisfying to

19 patients and their families.

20 I think that we may underestimate the ability

21 that telehealth leads -- can lead to entire system

22 redesign. Thoughtful systems have been using telehealth

1 now for two to three decades of change, just dramatically.
2 Now, the systems that have done that have all
3 been prepaid. It seems to only work, as Jonathan said, in
4 a prepaid world, but where that exists, it radically
5 changes the fundamental organizational imperatives of the
6 organization.
7 Those positives all said, however, I think that
8 the fear of abuse is absolutely legitimate. It's so easy
9 to -- it takes something -- I mean, abuse is real in the
10 world as it is, and this just makes it just significantly
11 easier to do.
12 So I think those are all -- you've called them
13 out. I'd just reinforce that we've -- I think we've all
14 seen it.
15 So I guess my thought would be to the extent that
16 we have to fall short of the all-inclusive bundle -- the
17 capitation, the pre-payment -- I still like the idea of
18 looking, with a degree of skepticism, at some bundles. I
19 was going to the same place Scott went where looking at
20 some chronic diseases would be a place, because that most
21 approximates capitation, and if you're really caring for a
22 bundle of somebody with diabetes, you're caring for all of

1 the needs associated with it, and that makes sense to me.
2 And then my view would be that we'd be agnostic
3 as to whether teleservices were the mechanism to do that.
4 Instead what we would do would be to recommend that there's
5 a bundle that takes care of the chronic disease, the person
6 with the chronic disease, and oh, by the way, telehealth is
7 certainly a tool that you have at your disposal. And you
8 would not be penalized for using teleservices versus in-
9 person services or vice versa.
10 And I guess my thought would be -- and this may
11 or may not be helpful to you all. There are a number of
12 prepaid organizations that have been doing this with a
13 pretty long track record that may well be willing to share
14 information that would help in your analytics that you may
15 not have. We may not collectively have access to
16 otherwise.
17 MS. GINSBURG: I have a quick follow-up question
18 because I was going to ask that as well.
19 So I'm in an MA system that uses telehealth
20 beautifully, very happy. What do we know about how MA
21 programs are currently using it? Do we have access to that
22 information at all and how that works? I would imagine we

1 have a lot to learn about that in terms of how to
2 transition it if we're going to OM.
3 MR. WINTER: We know in the past that the MA
4 encounter data are -- have problems with completeness and
5 reliability and accuracy, particularly completeness. And
6 so we're not planning to use those data for our -- for this
7 report. Hopefully, in the future, the data will -- the
8 quality of the data will improve and we'll be able to do
9 analyses, use them for analyses of telehealth. But right
10 now they're not in a state where we can use them for that
11 purpose, unfortunately.
12 DR. CHERNEW: Marge? It's me. Hi. You might be
13 talking about an MA organization that is integrated with a
14 provider organization.
15 MS. GINSBURG: [Speaking off mic.]
16 DR. CHERNEW: Thanks, Marge.
17 [Laughter.]
18 DR. CHERNEW: And then difficult to think through
19 whether that's a question about how providers are using it
20 when there's an integrated incentive between the payment
21 and the provider as opposed to MA organizations that might
22 be more common. So there's another related question which

1 is how do MA organizations that are not integrated with the
2 provider using payment to cover or not telehealth.
3 I don't know the answer to that. I do think it
4 is worth -- that's a Round 1 question that we've inserted.
5 So let's put that on the docket, but I think that's -- I
6 mean, I do believe it is the case that if you integrate a
7 provider organization with a payment model and then ask
8 them how they're going to manage telehealth, they have a
9 lot of flexibility, because they're effectively behaving
10 like an ACO in an Elliott Fisher world, right? And when
11 you separate out the payment from the provider of what
12 they're doing, you run into the problems that have clearly
13 bedeviled in large part -- can I use that word in public? -
14 - this conversation.
15 Again, I have a few thoughts, but I think we
16 should keep doing to Round 2Q, and we'll see where we are.
17 MS. KELLEY: All right. Robert?
18 DR. CHERRY: Thank you. Great discussion, and I
19 think it feels very early in the discussion, believe it or
20 not, because I think there's a lot more that has to be
21 fleshed out when you think about what's involved.
22 Putting a clinical hat on here, it's difficult to

1 figure out how to implement and operationalize some of
2 this. So you think, for example, palliative care.
3 Palliative care is a great use case for telehealth.
4 They've been able to use it across multiple disciplines and
5 one visit, even meet with different family members across
6 the country in order to arrive at decisions in the best
7 interest of the patient. It may or may not follow cleanly
8 with a first visit, for example.
9 There's dermatology, which I think has a great
10 use case for telehealth, and it's not just necessarily a
11 first visit in 30 days. It's a first visit, and it could
12 be 90 days, six months later, nine months later, because
13 following lesions that are clinically low suspicion,
14 there's some value perhaps in following lesions for a
15 longer period of time.
16 For a diabetes case, the same thing. It could be
17 one visit plus maybe three virtual visits over 90 days.
18 The end marker for that may not necessarily be avoidable ED
19 visits or hospital days because the point of controlling
20 diabetes is to reduce long-term incidence of stroke and
21 heart attacks, and you may not necessarily have the data
22 for this right now.

1 Every situation is a little bit different, and
2 because of that, it may not be cookie-cutter, and because
3 it does feel like it would take a long time to land a
4 plane, you may want to think about perhaps a phased
5 rollout. The same way we found value in mental health,
6 maybe there's a use case for, let's say, primary care home
7 models, for example, and that could be a great use for
8 telehealth before moving on to the next thing.
9 So maybe instead of thinking broadly about what
10 universally E&M codes should be like, to think about
11 particular conditions or population health models as an
12 initial phase, and then build on the learning experience
13 from there.
14 DR. CHERNEW: I have a few Round 1 questions that
15 I loosely want to ask. They're not really quite Round 1
16 questions, but I want to ask in the middle because I think
17 I don't want to get to the end -- you'll see why in a
18 minute -- and then raise this point.
19 So, first, I interpreted -- and I think Jim can
20 chime in -- loosely interpreted some of the questions we
21 were being asked by folks on the Hill was essentially how
22 would you pay for telehealth in broadly a fee-for-service

1 world. So they didn't say that explicitly, but my
2 understanding is a lot of the questions we're getting from
3 the Hill or otherwise have that sort of flavor, and so that
4 is a different response than where I think a lot of the
5 conversations is going, as well if we could bundle this in
6 particular places, which I think we would agree with that.
7 It's just not clear we're responding to a particular thing.
8 There has been, as an aside, of course, they have
9 limited and then expanded, but there's this question about
10 the scope of what services, which is slightly different
11 than what type of patients. So you could have a patient
12 with diabetes and then think could they use telehealth for
13 whatever, but the point is -- so one thing on the question
14 is we could go -- I'm trying -- I'm sensing some concern
15 with the sort of extended E&M bundle version, and I'm
16 sensing a lot of comments around the table around ways we
17 might do something that's not quite that. And those
18 comments, sort of Scott had one and we've gone back and
19 forth, involved some version of, well, this could work if
20 we paid in a fundamental different way, which is kind of an
21 APM world -- I agree -- or, well, maybe we should roll out
22 in a narrower sense, people with chronic conditions.

1 That's also quite reasonable.

2 I'm not sure how much of that is responsive to
3 what they want in a particular way. So that another
4 approach -- and again, I'm not sure it's right. In fact,
5 the article that Ariel and Ledia is referring to could have
6 been subtitled "Fee-for-Services Well Suited for
7 Telehealth." Right? Which is frustrating when you're
8 asked then how should you pay for telehealth with fee-for-
9 service. Right? You get that point.

10 But one easy way to sort of transition -- "easy"
11 might be the wrong word. In fact, I take that back. One
12 way that is simpler is you could do some combination of
13 just lower facility fee. Keep it as -- it's still fee-for-
14 service. It doesn't have the bundling complexity. You
15 don't have the issue with the patient are qualified or not
16 qualified. You don't have to get confused in how it fits
17 into your APMs, and you just start with the world in which
18 you change the facility fee, and in primary care, which
19 might be central to some of the chronic conditions, you
20 could deal with that in other mechanisms, like you could
21 then just bump that into a, say, partial cap primary care
22 fee. There's a whole bunch of other stuff that's gone on

1 in primary care, e-messages. There's a lot of other stuff
2 that's happenings in primary care that is, I think, really
3 problematic for physicians that they don't get compensated
4 for and aren't well suited to fee-for-service for both
5 patient monitoring. There's a bunch of these things that
6 are just not -- technology has sort of outgrown the fee-
7 for-service system in these ways.
8 So what I'm -- the reason I stopped in the middle
9 is what's going to happen is, obviously, we're going to
10 come back to this, and what we need to get out of this
11 session is some sort of direction. What I'm hearing is
12 concern about bundling. So I'm thinking, well, what's the
13 alternative? The alternative could be APM-ish, but that's
14 sort of in a little different place, and we're not going to
15 force every physician or everyone else into their types of
16 APMs.
17 So another alternative is just let's spend our
18 time on questions like the facility fee component or other
19 aspects of it and then keep the tone that we've had in the
20 past with -- and be cautious about what services you let in
21 because of all these other concerns.
22 In fact, to Larry, who I'll just look up to

1 Larry, you could conceptually have a different facility
2 fee. I'm not saying we should. I'm just saying you could
3 conceptually have a different facility fee for tele-only
4 versus brick-and-mortar providers.
5 Again, I wasn't advocating that.
6 [Laughter.]
7 DR. CHERNEW: We'll chat later, but I'm saying
8 you could think about how to manage this in a way that's
9 much more consistent with fee-for-service as opposed to
10 trying to move it into an awkward -- I didn't mean awkward
11 -- a more complex episode-y kind of way, which is where we
12 were going. And I just want to get folks' sense because we
13 don't want to come back again and say, well, you could do
14 it this way and have people get -- so, anyway, I made my
15 point.
16 I think we should go around the -- keep going
17 around the queue.
18 MR. POULSEN: Before you do that, though, I
19 suspect Kenny has the same question I have which is, to
20 what extent is it within our appropriate role to say
21 essentially what you just said regarding your paper, which
22 is we don't think this is well suited in a fee-for-service

1 world, and we think we ought to contemplate mechanisms that
2 are departures from that?
3 [Laughter.]
4 DR. CHERNEW: It seems to be getting late.
5 I'm not sure I have a great answer to that. I
6 think it depends on how some of the remainder of this
7 discussion goes. I don't know if Ariel or Ledia have a
8 sense of that.
9 I think that we certainly can describe in some
10 detail the complexity of trying to shoehorn telehealth into
11 fee-for-service. So that, I think, is a tonal thing in the
12 chapter, which I think we should and will do.
13 The question then is if we say, therefore, we're
14 not -- I'm not quite comfortable with that, although I
15 think, depending on how this discussion goes, I could
16 become more or less comfortable with that. That's a charge
17 issue, which is what you asked me.
18 MR. KAN: I think for me, it would be helpful to
19 know like could we as a Commission type in the scope and
20 narrow the scope of what we're trying to focus on because -
21 - I mean, the permutations involved in the design of this
22 are mind-numbing, frankly. So, to the extent we know what

1 we're trying to shoot for, that helps.

2 DR. CHERNEW: Yeah. I'm watching Jim's finger to

3 see how close it gets to the button.

4 [Laughter.]

5 DR. CHERNEW: The answer is we can obviously do

6 whatever we want to do at some level, but realize we are

7 trying to be responsive to people that asked us a

8 reasonable question. So while we can narrow or manage the

9 scope, we are, in fact, trying to give advice to

10 policymakers who have a legitimate concern that is -- very

11 much came around the table.

12 And I think, Greg, you said it spot on. When

13 used appropriately, this is an unbelievably valuable

14 service, and no one wants to be the one to tell people that

15 they can't access a service that can improve the quality of

16 life, that can get them assess to needed care, do it in a

17 way that's much more convenient. We don't want to be that

18 group. We don't want to say that.

19 On the other hand, we have had this long history

20 of being concerned that when you open up the door to that,

21 there's a bunch of unintended consequences that we worry a

22 ton about, and we have, therefore, struggled.

1 I think I will again speak for me, but I think at
2 least some subset of you believe this. In different
3 payment models, you have just a completely different worry
4 about this whole set of things, but the world isn't all in
5 those different payment models, and we have been asked for
6 a broad set of policy things. What should we do sort of
7 outside of that space?
8 So, if the narrowing question, Kenny, was, well,
9 let's think about what to do in the context of an ACO,
10 that's a fine thing to say. I don't think that's
11 particularly responsive to what we've being asked, and I
12 don't think they want the response, you know, "See our ACO
13 chapter." So I think we are struggling.
14 What I was trying to do with what I said before
15 is come up with -- again, I used the word "simple." I
16 didn't mean it, but come up with a less -- an option, if
17 you will, that's less complicated than many of the things
18 that Ariel laid out and Larry's comment went through in
19 some detail about how you know when it's triggered. Then
20 you go back. You know, it's a game, as Stacie said. A lot
21 of people have gone through with sort of issues where the
22 bundling in with E&M is problematic. So what would you do

1 if you weren't going to bundle in with E&M? I think the
2 easiest thing to do that gets at the consistence of where
3 we are is, well, let's -- the work part is the same,
4 presumably, in the televisit. So then it's just let's look
5 at the practice expense part and see if we could stay in a
6 fee-for-service world, we can say we don't like, but we can
7 say if you're going to stay in a fee-for-service world,
8 you're going to have to do something on the practice
9 expense and on the monitoring side to make sure that this
10 works.
11 DR. MATHEWS: Just to add to those comments, I
12 can't go into too much detail without betraying some inside
13 information, but going to the point about once you give
14 something, it is hard to take it back, given the changes to
15 telehealth payment that were implemented during the public
16 health emergency, as you can imagine, stakeholders got used
17 to those higher levels of payments. And with the end of
18 the public health emergency on the horizon and payment
19 policy in line to revert back to prior payment, the
20 appetite for ideas about what the appropriate level and the
21 appropriate mechanism for paying for telehealth is
22 tremendous, and if we were to say, "Well, you know, it's

1 not suited for fee-for-service. It's a population-based
2 thing," that sort of sidesteps the issue because even in,
3 say, an ACO environment, all of the transactions are still
4 being conducted on a fee-for-service basis.
5 And the question of the day is when that claim
6 for a telehealth service comes in, whether it's from an ACO
7 physician or not, how much should Medicare pay for that
8 service? That's the thing that the folks that we respond
9 to on the Hill are dealing with.
10 So I'd like, if we can, to be able to help them
11 on point. It's not to diminish any of the discussion thus
12 far about concerns with the bundling approach that we put
13 on the table or the lack of appropriateness for telehealth
14 in a fee-for-service environment, but if we can do
15 something constructive with respect to this specific
16 question, it would be tremendously well received.
17 DR. CHERNEW: So, if I have this right, we're
18 going to go to --
19 MS. KELLEY: Dana is next.
20 DR. CHERNEW: I have Dana -- for the next three,
21 I have Dana, Jaewon, and Kenny --
22 MS. KELLEY: Yes.

1 DR. CHERNEW: -- are my next three.
2 MS. KELLEY: And then?
3 DR. CHERNEW: And then I have Betty and Cheryl.
4 MS. KELLEY: Correct.
5 DR. CHERNEW: And Lynn at some point. So Lynn
6 after that. But in the interim, we have half an hour,
7 which is good, but this is a long sort of digression, Ledia
8 and Ariel, and you haven't really had a chance to -- I have
9 been trying to read your faces but I am old guy. Do you
10 have anything you want to add, or should we just go around
11 the queue?
12 MR. WINTER: No, this is really helpful to get
13 this guidance, so thank you.
14 DR. CHERNEW: Okay, then Dana.
15 DR. SAFRAN: All right. Well thanks. And, you
16 know, joining others in my appreciation that we're having
17 this conversation and my view that this has very far-
18 reaching implications.
19 I think, you know, the challenge that we're all
20 grappling with is the challenge of threading a needle. How
21 do we sustain access to the value of telehealth without
22 driving up cost? And one of the things that strikes me is

1 kind of the elephant in the room that none of have named so
2 far, is name one other industry where you make a service
3 more efficient and don't lower the price. And that's our
4 problem, is we have figured out how to be freed from the
5 tyranny of the office visit, but we are not willing to
6 reduce the prices of services, even though the cost of
7 delivering them will be lower.

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

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

21 One is, you know -- and Amol will back me up on
22 the literature here -- but I'm pretty sure it's the case

1 that chronic condition bundles have not shown any evidence
2 of saving money, that some procedural bundles have but that
3 chronic illness bundles, for the most part, have not. And
4 I think that this potentially could change that, and it
5 gives us the opportunity to do the kind of evaluation of
6 impact that we aren't going to be able to do with the
7 available data that you have. So one of the reasons I kind
8 of like the idea of the chronic condition bundles is that
9 it does give the opportunity to very systematically plan
10 and execute some evaluation of the impact of this on
11 access, on quality, on outcomes, and very importantly, on
12 equity. Because it could be one of the important values of
13 telehealth is equity through lowering barriers to access.
14 Let me see if there was anything else I wanted to
15 mention. Nope. I don't think so. That's it. Thank you.
16 MS. KELLEY: Jaewon.
17 DR. RYU: Yes. So just a few points. I agree
18 with a lot of the comments that have already been raised.
19 I think my difficulty with this is that telemedicine has
20 been used in so many different ways. There is a lot -- and
21 we use this word a lot -- "heterogeneity," and I think the
22 reality is there are a lot of babies but also a lot of

1 bathwater in this space. And I think the trick is trying
2 to figure out which one is which.
3 So one of the things that I'm hoping we see in
4 the contractor work, Ledia, that you referenced, is some
5 understanding of where are the situations? What are the
6 scenarios where it is more likely to be replacement versus
7 where are the situations where it is more likely to be
8 duplicative or demand inducing, whatever term you want to
9 use. So I am hoping we can at least get some lens into
10 that.
11 In the meantime I think as far as the
12 recommendations I think on Slide 7, I agree with all of
13 those, whether it is reverting back to the physician fee
14 schedule facility rate, the copays, making sure those are
15 in place, and the other safeguards that were described. I
16 think that makes sense.
17 As far as the bundled proposal, I just don't
18 think it naturally lends itself to that. But if we were to
19 do like a targeted chronic disease sort of approach, I do
20 think that starts making more sense. But I think even that
21 would require a lot of work to try to ensure that it's
22 value-add as opposed to extra utilization.

1 MS. KELLEY: Kenny.
2 MR. KAN: This is great work. In theory, I
3 initially like the bundled payment and extended E&M visit
4 to help lower costs and streamline the administrative
5 burden. In practice, I struggle and share many of Larry's,
6 Amol's, and Stacie's concerns. I really think it is
7 actually very hard to predict when the next visit is, for
8 most docs anyway.
9 I am also concerned about the administrative
10 burden, both to docs and payers, to reprocess the claims.
11 And then gaming, I don't know how frequently this happens,
12 but I really need some kind of access to care on Day 59,
13 and there is a 60-day limit, so what happens if I contact
14 my doc and they say, "Oh, you're not covered." Well, you
15 know, it's possible that they may say, "Oh, I cannot see
16 you on Day 59. I can only see you on Day 61." That
17 probably doesn't happen a lot, but I'm just curious about
18 some of the gaming concerns that Stacie indicated earlier.
19 MS. KELLEY: Betty.
20 DR. RAMBUR: Thank you. This has been a
21 fascinating conversation and fascinating work. Thank you.
22 I have to admit that when I was reading this

1 chapter my first thought was is there a way to deploy the
2 popularity of telehealth as a way to incentivize risk-
3 bearing and move away from fee-for-service, but not that
4 helpful, I guess.
5 But really paralleling Jon's comments, I really
6 appreciated Scott's thought about a trial, Robert's about a
7 rollout, and Greg's comment that it shouldn't be specific
8 to this one in the office, this on telehealth, or whatever.
9 And I would also add provider agnostic. And the reason I
10 say that is particular with chronic condition management.
11 It might really be a social worker or a diabetes educator
12 or something. And so instead of thinking this day, this
13 day, this day, we have this condition and here is what we
14 are going to have, and how do we get reimbursed for it?
15 So I rather liked the bundling idea, and I
16 guess, you know, respectfully, I'm sure it's very
17 difficult. I see Larry talking about the people with the
18 broken ankles that come in. But I do think with certain
19 kinds of conditions we have some sense of what it is going
20 to take.
21 So that's where I'm at. I'm interested to hear
22 more about what you develop. I support the principles on

1 page 7 and also, I'm pretty positive about the population-
2 based measures that you talked about. So thanks.
3 MS. KELLEY: Cheryl.
4 DR. DAMBERG: Thank you. I too share concerns
5 about the potential for overuse and overpayment in this
6 space. It's a tricky landscape. In a perfect world we'd
7 run an experiment here or have access to these population-
8 based data to try to understand where telehealth has been
9 used effectively and efficiently.
10 I also share Dana's concern about this is an
11 opportunity subtly to enhance the delivery of care to
12 certain subpopulations that may have had access problems or
13 a different modality that could be more effective. But how
14 is it that the Medicare program can recoup those gains in
15 efficiencies? And I feel like we really haven't been able
16 to fully consider how best to do that.
17 I think in terms of -- and I'm not going to go
18 into this notion of an episode payment piece, but when I
19 was listening to you describe it I was wondering, do you
20 know what fraction of visits are kind of one-and-done
21 versus they have multiple follow-on events? Because I
22 don't know whether we're talking about 20 percent of all

1 visits tend to have follow-on activity. So I think it
2 would be helpful to have some context there.
3 I do think that it's going to be important to
4 monitor what is going on in this space, whether it is
5 potential for inappropriate use. You know, certainly we
6 can look at low-value care delivery, but I think we suffer
7 from the lack of measures or imperfect measures to be able
8 to measure inappropriate care in this space. And so I
9 think it would be helpful to give some more thought on
10 where the hunting should be, if we're going to try to flag
11 what is inappropriate use.
12 I also wonder what the potential is for
13 misdiagnosis, and is it higher in this environment than,
14 say, an in-person visit? I'm not sure how to measure that.
15 I know the patient safety community has been trying to
16 think of that, how to measure misdiagnosis and how often it
17 happens. I do not know if there is anything we can learn
18 from that community that could be applied here.
19 MS. KELLEY: Lynn.
20 MS. BARR: I just, You know, I want to echo that
21 I don't think the bundle approach is going to be the right
22 approach if the question is what is the fee-for-service

1 approach.

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

13 So I do think that there is a way to structure
14 this more. I'm not a big fan of just cutting the facility
15 fees because I don't think that ends up like solving the
16 problem. And I think we're going to overpay and there's
17 going to be lots of fraud. And so the beneficiary protects
18 us with the copay, and the ACO protects us if there is no
19 copay, and that's a way that we can get at this and give
20 broad access to people, but then at a provider level make a
21 decision on whether or not they would have to pay that
22 copay. Does that make sense?

1 DR. CHERNEW: Let me think. Let's go back to the
2 facility fee part. There's an issue about cost-sharing,
3 which we haven't discussed very much today, which actually
4 requires, I think, a lot more attention, because the
5 logistics of collecting cost-sharing on telehealth visits
6 is complicated in a range of ways, and we haven't had that
7 discussion. So I'm not even sure I know how we're going to
8 work through that part.
9 The APM stuff is fine, but there are a lot of
10 places outside of the APM world now that we are really
11 talking about.
12 So the question in my mind for what makes sense
13 is not -- I'll be super clear where I am -- I would never
14 have thought that anything on the facility fee solves our
15 problem. I think the solutions are bigger than in some
16 ways what we have been asked, per Jim's comment.
17 So the question that I didn't understand from
18 your comment is are you saying -- I'm going to ask you a
19 very narrow question. In a world in which moving forward
20 we are paying for telehealth under fee-for-service, would
21 you have (a) the facility fees but what they are in the
22 public health emergency, which it depends on the site you

1 go to, (b) have the facility fees at the non-facility rate
2 regardless of where you are, which I think is where the
3 MedPAC recommendation has historically been, or have © a
4 third, possibly lower facility fee to at least do some
5 balancing of things?
6 MS. BARR: I would bill them a monthly fee, like
7 chronic care management, that gives them access to
8 telehealth. There is no facility fee.
9 DR. CHERNEW: I'm not sure what billing them
10 means. I'm sorry.
11 MS. BARR: So in chronic care management you pay
12 $40, $50 a month.
13 DR. CHERNEW: Yeah, but what do you do for a
14 specialist who is providing telehealth services for
15 something?
16 MS. BARR: You pay for it on a monthly basis.
17 You say, "I want telehealth services with you. I'm willing
18 to pay the copay." Or you say to me, "You need telehealth
19 services. I know you can't afford it. We can waive your
20 copay."
21 DR. CHERNEW: So I am just trying to -- this is
22 like a Round 1 question. I

1 MS. BARR: -- your CCM framework.
2 DR. CHERNEW: I'm checking the clock.
3 MS. BARR: Right.
4 DR. CHERNEW: We are going to have to finish this
5 probably offline, but let me just say, if I understand
6 correctly that is a beneficiary signs up for telehealth
7 service and is charged a copay for doing that. That is
8 different than how the provider gets paid in that context.
9 MS. BARR: With a provider. I signed up with
10 you.
11 DR. CHERNEW: Yeah, I understand. You're a
12 patient. I'm a cardiologist. You sign up for me.
13 MS. BARR: Just like CCM.
14 DR. CHERNEW: That's right. I know that you
15 would be charged under your model. I'm not sure what that
16 means about how I would get paid for it.
17 MS. BARR: So you get the fee every month. Just
18 like CCM, you get the $50 a month. I pay the copay.
19 DR. CHERNEW: Okay. So we are not going to have
20 the time. This is neither the time nor the venue to sort
21 all the details of that, but I do think it's important to
22 at least get a version of that on the record in the public

1 meeting. So in that sense thank you.
2 Dana, I think that was the end of the queue. Are
3 we right. So I'm going to pause for a second to see if
4 anyone else --
5 [No response.]
6 DR. CHERNEW: Okay. So this is the type of
7 conversation that is why you sign up to be on MedPAC. So
8 this could have just been a recruiting session for those of
9 you that are like, boy, I wish I was in the room. It's a
10 remarkably challenging conceptual problem. It's an
11 increasingly important problem, in a range of ways. I
12 think the work in the chapter that you guys did, Ariel and
13 Ledia, was outstanding. The judge is how good the
14 conservation is after the fact, and the conversation was
15 exceptional.
16 So for the public, please, if you do want to
17 chime in, although you couldn't be here, send comments to
18 meetingcomments@medpac.gov, or go on the website. There's
19 a place where you can give us comments.
20 This is obviously not the last time we are going
21 to focus on this issue. I just want to say one last thing.
22 It didn't come up, that if I would've had a Round 2 comment

1 this would've been my Round 2 comment.
2 In whatever we do, I think we have to be really
3 cognizant of the administrative costs of doing all of this.
4 I think that for a lot of the health care system the
5 documentation and the coding and the administrative stuff
6 is crushing for what people do, and this is an area where -
7 - I very much want to avoid an outcome where we define some
8 codes, and they have to be policed, and you are eligible
9 for this service if you meet these three clinical criteria
10 and are certified by this person, and it is more than 15
11 minutes, and you didn't have, within the past 45 days, a
12 visit to an E&M doctor for a related condition, even though
13 you may have had a visit for three things and one of them
14 was --
15 The regulatory burden of how you do this in a
16 fee-for-service world is crushing, and I think too often we
17 forget the administrative burden that we place on the
18 system that is already administratively complicated. And
19 although Larry is not here, I will try and channel one of
20 Larry's comments, which I think is completely spot-on.
21 However, we deal with some of the payment for physicians,
22 which is obviously important, I think one of the

1 frustrations that I think people in the medical community
2 face, of all types, is just the administrative hassles of
3 just doing their job in a range of ways.
4 And so I just want to say whatever we do here I
5 want to at least try and make sure we don't make that
6 substantially worse. I don't know how to do that, which is
7 why I'm going to say thanks, everybody, and thank you all
8 at home. Send us comments, and we'll keep working on it.
9 So with that we are going to adjourn for the
10 night, and we are going to show up again tomorrow at 9 a.m.
11 We're going to be talking about inpatient psych and Part D
12 data and drug rebates and discounts, two also very
13 important topics.
14 So again, thank you all. Have a safe evening,
15 and come join us tomorrow.
16 [Whereas, at 4:45 p.m., the Commission adjourned,
17 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
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM, FACP
KENNY KAN, CPA, CFA, MAAA
GREGORY POULSON, MBA
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD, MPH, MBA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
SCOTT SARRAN, MD

B&B Reporters
29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541

AGENDA PAGE

Congressional request: Medicare and inpatient psychiatric facility care
- Betty Fout, Ledia Tabor..............................3

Recess...67

Analysis of Part D data on drug rebates and discounts
- Shinobu Suzuki, Tara Hayes, Rachel Schmidt..........67

Adjourn...105

1 P R O C E E D I N G S

2 [9:01 a.m.]

3 DR. CHERNEW: Hi, everybody, and welcome to our
4 Friday morning MedPAC session. We have two great topics
5 today -- inpatient psych and Part D drugs. We're going to
6 start with inpatient psych, and I am going to turn it over
7 to Betty and Ledia.

8 DR. FOUT: Great. Thank you.

9 Just as a reminder, there's a PDF of the slide
10 available from the webinar's control panel on the right
11 side of your screen.

12 And before I start, I just wanted to thank our
13 colleagues, Jamila Torain, who is not here, and Corinna
14 Cline, for their excellent work and contributions to this
15 work.

16 In this presentation, as part of a response to a
17 congressional request, we discuss inpatient psychiatric
18 facility services under Medicare.

19 In January 2022, the Chairman of the Committee on
20 Ways and Means requested that the Commission conduct an
21 analysis of mental health services in the Medicare program.
22 The request has three components.

1 First is to update the Commission's prior work on
2 trends and issues in inpatient psychiatric care for
3 beneficiaries. This includes examining access to care,
4 quality of care, Medicare payments and provider costs, and
5 information on beneficiaries reaching the 190-day lifetime
6 limit on care received from freestanding psychiatric
7 hospitals.
8 Second is to describe the utilization of
9 outpatient mental health services, including tele-mental
10 health services, and the characteristics of beneficiaries
11 using them.
12 And, third, to the extent possible, is to
13 describe the use of mental health services by beneficiaries
14 enrolled in Medicare Advantage.
15 In this presentation, we address the first and
16 third component as it relates to inpatient psychiatric
17 services, and we anticipate the findings will result in an
18 informational chapter in the June 2023 report to Congress.
19 The Commission will not be making recommendations on
20 payment updates for psychiatric hospitals during this
21 cycle.
22 Beneficiaries experiencing an urgent, acute

1 mental health, or substance use crisis may be treated in
2 inpatient psychiatric facilities, or IPFs. These
3 facilities can be standalone psychiatric hospitals, or what
4 we are calling "freestanding IPFs," or distinct part units
5 of an acute care hospital, or what we call "hospital-based
6 IPFs."
7 To be admitted to an IPF, patients generally must
8 be considered a risk to themselves or to others. IPFs
9 provide 24-hour care in a structured, intensive, and secure
10 setting. Among other treatments, patients may receive
11 individual and group therapy, psychosocial rehabilitation,
12 drug therapy in the form of psychotropic medications, and
13 electroconvulsive therapy.
14 The goal of IPF care is to stabilize the
15 individual's condition and enable safe return to the
16 community.
17 As is the case for general acute care hospitals,
18 IPF stays are covered under Medicare Part A. Services from
19 physicians and other clinicians received during the stay
20 are covered by Part B.
21 Medicare reimburses IPFs for the inpatient care
22 they provide to fee-for-service beneficiaries through the

1 IPF prospective payment system, or PPS, which was first
2 implemented in 2005. To determine the payment for an IPF
3 stay, a base per diem rate is set and updated annually.
4 The per diem base rate is then adjusted for
5 geographic, patient, and facility factors. Geographic
6 factors includes the wage index, cost of living adjustments
7 for certain states, and rural location of the IPF if it
8 applies. Patient factors include age, principal diagnosis,
9 presence of certain comorbidities, use of electroconvulsive
10 therapy, and length of stay, with the per diem for each
11 additional day decreasing with longer stays. Facility
12 adjustors include teaching status and presence of an
13 emergency department.
14 There is an outlier policy for stays that have
15 extraordinarily high costs, drawn from 2 percent of total
16 payments. Medicare makes an outlier payment when the total
17 cost for a stay exceeds the total payment plus the fixed-
18 loss amount, adjusted by facility factors.
19 In 2019, there were 1,542 IPFs for which a
20 Medicare fee-for-service beneficiary had at least one stay.
21 Over 230,000 beneficiaries had nearly 350,000 stays, and
22 the Medicare program spent $3.9 billion on these stays.

1 The volume of IPF services and Medicare program
2 sending was substantially lower in 2020 due to the COVID-19
3 public health emergency.
4 To the extent possible, analyses in this
5 presentation include 2020 data as it is the most recently
6 available data. However, we recognize that 2020 is an
7 anomalous year, and for some analyses, like those for
8 Medicare margins, we use only 2019 data for now but plan to
9 include data through 2021 when available.
10 In the next few slides, we review the
11 characteristics of beneficiaries admitted to an IPF using
12 data from 2020, but we know that the patterns were similar
13 in prior years.
14 Medicare beneficiaries admitted to IPFs are among
15 the most vulnerable and costly.
16 In these charts, the top green bars represent
17 Medicare fee-for-service beneficiaries with at least one
18 IPF stay in the year. The bottom red bars represent all
19 other Medicare fee-for-services beneficiaries.
20 The chart on the left shows that beneficiaries
21 admitted to IPFs are much more likely to be low income or
22 be disabled compared to other beneficiaries.

1 On the right, we show that Medicare Part A and B
2 spending per beneficiary for those with an IPF stay was
3 nearly four times higher than all other beneficiaries.
4 Medicare Part D prescription drug spending for those who
5 had an IPF stay was twice as much as other beneficiaries.
6 In addition, beneficiaries with IPF stays also
7 had higher risk scores, greater prevalence of certain
8 chronic conditions, were younger, and were more likely to
9 be Black compared to other fee-for-service beneficiaries.
10 Beneficiaries admitted to IPFs are assigned to 1
11 of 17 psychiatric Medicare-severity diagnostic related
12 groups, or MS-DRGs, which are based on the principal
13 diagnosis of the stay.
14 The MS-DRG system does not differentiate well
15 among Medicare beneficiaries using IPFs.
16 As shown in the upper right blue wedges of this
17 pie, nearly 75 percent of stays were assigned to the
18 psychosis MS-DRG in 2020. The psychosis MS-DRG is a broad
19 category that is split between patients with a principal
20 diagnoses of mood disorders, such as bipolar disorder and
21 major depression, and non-mood psychotic disorders, such as
22 schizophrenia.

1 The remaining stays composed only 26 percent of
2 the total, as shown in the lower left green wedge. The MS-
3 DRGs for these stays are grouped and listed on the slide.
4 The most common were organic disturbances which were 7
5 percent of stays and alcohol or drug dependency at 6
6 percent of stays.
7 While there are 17 psychiatric MS-DRGs, some are
8 very rarely used. The top seven MS-DRGs accounted for 96
9 percent of all IPF stays.
10 We update the Commission's prior analyses on IPFs
11 related to access to care, quality of care, and Medicare
12 payments and provider costs. We examine access to care by
13 looking at supply and capacity of IPFs and the volume of
14 services used by Medicare beneficiaries.
15 Next, we discussed quality of care measures
16 available through the IPF quality reporting program.
17 Then, lastly, we examine Medicare payments under
18 the IPF PPS and IPFs' costs of providing care to Medicare
19 fee-for-service beneficiaries. This includes presenting
20 aggregate Medicare margins for IPF PPS services and
21 discussing issues related to payment accuracy.
22 This chart depicts the number of IPFs serving

1 Medicare fee-for-service beneficiaries from 2016 to 2020 by
2 IPF type and ownership.
3 As shown in the left-most bars, the most common
4 type of IPFs are hospital-based nonprofit IPFs. Though
5 this number has been declining, they remain about 40
6 percent of the total.
7 In contrast, the number of freestanding for-
8 profit IPFs are increasing, as shown with the white circle,
9 and now represent about 20 percent of the total.
10 Freestanding government IPFs, shown in the right-
11 most bars, were the predominant form of psychiatric
12 hospitals in the 1960s and '70s but now are a small share
13 of the total at about 10 percent.
14 There was an overall annual decline in the number
15 of IPFs from 2016 to 2020 of about 1 percent. However,
16 because freestanding IPFs tend to be large, the overall
17 number of inpatient psychiatric beds actually slightly
18 increased over the same time period.
19 This table shows the annual changes between 2016
20 and 2019 and then between 2019 and 2020. There was a steep
21 decline in utilization due to the start of COVID-19. The
22 number of IPF stays decreased by 16.2 percent between 2019

1 and 2020. However, the decline, to a lesser extent at 5.1
2 percent, was already occurring prior to 2020.
3 We found that average length of stays have
4 increased during this time, possibly indicating a change in
5 the mix of Medicare beneficiaries who are using IPFs. The
6 increase in length of stay likely contributed to the
7 increase in Medicare payment per stay, observed in the last
8 row of the table.
9 Although the total number of IPF beds have been
10 stable in recent years and overall utilization of IPFs has
11 declined, there have been reports of shortages and wait-
12 lists for IPF beds. This has been exacerbated by COVID-19.
13 We did find high occupancy rates among
14 freestanding government IPFs, as shown in the top green
15 line on this chart. These IPFs frequently function as
16 providers of last resort, serving patients with severe
17 mental illness who are difficult to place in other
18 facilities. The high occupancy rate for these hospitals
19 suggests that access to inpatient psychiatric services for
20 some of the sickest beneficiaries may be inadequate in some
21 areas.
22 The occupancy rate across all other psychiatric

1 hospitals was 71 percent in 2019 and 72 percent in 2020,
2 both lower than the occupancy rates from 2016 to 2018,
3 indicating some capacity available. However, as a point of
4 comparison, the occupancy rates across short-term acute
5 care hospitals was 65 percent in 2019.
6 The Commission has previously reported on the
7 incompleteness of the Medicare Advantage encounter data,
8 though there have been improvements over time. In this
9 analysis, we combined the MA encounter data with claims
10 data to identify MA enrollees admitted to IPFs in 2019,
11 which is the most recent year of available encounter data.
12 We believe that the combined data are sufficient for
13 broadly comparing the MA and fee-for-service beneficiaries
14 receiving IPF services.
15 We identified approximately 120,000 MA enrollees
16 admitted to IPFs in 2019. This represented 0.5 percent of
17 the MA population. In comparison, we found 0.7 percent of
18 the fee-for-service population were admitted to IPFs.
19 The demographic characteristics of MA enrollees
20 using IPF services were generally similar to those of fee-
21 for-service beneficiaries admitted to IPFs, with any
22 differences mirroring the differences between the two

1 populations.

2 When comparing the principal diagnosis for the
3 IPF stay, we found that MA enrollees admitted to IPFs had a
4 higher percentage of mood disorders and a lower percentage
5 of schizophrenia compared to fee-for-service beneficiaries
6 admitted to IPFs.

7 Under Medicare, coverage of treatment in
8 freestanding psychiatric hospitals is subject to a lifetime
9 limit of 190 days, after which beneficiaries are
10 responsible for all costs.

11 This provision was enacted in 1965 with the
12 implementation of Medicare when a majority of inpatient
13 psychiatric care was provided by government freestanding
14 facilities.

15 The 190-day limit does not apply to hospital-
16 based units, which compose 60 percent of IPF stays, and may
17 therefore affect the type of facilities from which some
18 beneficiaries seek care and possibly disrupt patient care
19 when beneficiaries reach the limit during a stay.

20 For the cohort of beneficiaries with Medicare
21 fee-for-service sometime during 2019, we examined
22 admissions to IPFs from the time of their initial Medicare

1 enrollment through July 2022, and we found that 722,000 of
2 these beneficiaries had used at least one day in a
3 freestanding IPF, and 35,000 had exhausted all 190 days.
4 We found an additional 9,000 beneficiaries were within 15
5 days of reaching the limit. In future work, we plan to do
6 additional analyses to examine the characteristics of
7 beneficiaries reaching or close to reaching the limit.
8 I'll now switch to quality of care.
9 In summary, we found that data on the quality of
10 care provided by IPFs are limited.
11 The Medicare program currently has an IPF pay-
12 for-reporting quality program that includes 14 measures, of
13 which the vast majority are process measures.
14 Providers report results in aggregate for each
15 IPF, meaning they report numerator and denominator values
16 based on their own administrative and clinical data.
17 As IPFs begin to report patient-level quality
18 results beginning in 2023, CMS and others will be able to
19 better assess the quality of care provided by IPFs.
20 The program does include one claims-based outcome
21 measure, a 30-day, all-cause, unplanned readmission
22 following psychiatric hospitalization, which measures the

1 impact an IPF has on care during the stay and at discharge
2 to prevent patients returning to a hospital. The national
3 mean for the measure is about 20 percent.
4 We calculated Medicare margins for IPF services
5 by comparing payments made under the IPF PPS to providers'
6 costs for their Medicare fee-for-service patients.
7 Overall, IPFs' margins have decreased over time. In 2019,
8 the Medicare margin among all non-government IPFs was
9 negative 2 percent, down from 0.9 percent in 2016, but we
10 do note that these numbers are preliminary and may change.
11 As shown in the chart on the right, IPF Medicare
12 margin varied widely by the type of IPF. In 2019, the
13 aggregate Medicare margin among freestanding for-profit
14 IPFs was 25 percent, as shown in the top solid white line,
15 compared with negative 23 percent among hospital-based
16 nonprofit IPFs, as shown in the bottom red dotted line.
17 The high positive margin among freestanding for-profit IPFs
18 was driven by low costs among these facilities.
19 In the next few slides, we discuss gaps in
20 available information that affect payment accuracy or the
21 ability of the payment system to accurately capture costs
22 and classify patients.

1 First, administrative data may not be sufficient
2 to capture the variation in per diem costs related to
3 differences in patient severity. As shown earlier, nearly
4 three-quarters of IPF patients fall within the same
5 psychiatric MS-DRG, demonstrating the difficulty in using
6 MS-DRGs to differentiate the costs of IPF patients.
7 Earlier studies have found that activities of
8 daily living deficits, serious danger to self or others,
9 and involuntary admission to be important cost drivers, but
10 they are not available on administrative data. Including
11 these and other elements that significantly affect IPF
12 routine nursing and staff time could improve the accuracy
13 of Medicare payments, but doing so would require IPFs to
14 submit additional information about their patients.
15 Second, we found gaps in the reporting of a
16 portion of IPFs' costs. IPFs' costs for caring for
17 Medicare beneficiaries consist of routine and ancillary
18 costs, which are reported to CMS.
19 Daily routine costs include costs for staffing
20 and room and board, which are typically provided to all
21 patients, and the reporting of these costs generally do not
22 vary across patients admitted to an IPF.

1 In contrast, ancillary costs are for specific
2 services, such as prescription drugs and laboratory
3 services, which are the most commonly used, and can vary
4 for each beneficiary and stay. Charges for ancillary
5 services are recorded on the claim and provide a source of
6 cost information that varies by the patient.
7 Hospitals must apportion costs for Medicare
8 patients to each ancillary department unless they have an
9 all-inclusive rate or no-cost structure. For all-inclusive
10 rate IPFs, ancillary services are not reported separately.
11 An all-inclusive rate designation is common among
12 government IPFs.
13 For IPFs that do not have an all-inclusive rate,
14 CMS requires the submission of costs for ancillary services
15 and actually began to specifically enforce this in 2017 and
16 2018 by rejecting cost reports without this information.
17 However, we have observed poor reporting of
18 ancillary services by some IPFs.
19 First, we found a growing number of IPFs
20 designating themselves as all-inclusive-rate providers that
21 do not report ancillary services separately. The growth
22 was concentrated among freestanding for-profit IPFs. As

1 shown in the figure on the right, from 2016 to 2019, the
2 percent of these IPFs designating as all-inclusive-rate
3 hospitals grew from 21 to 64 percent. We did not observe
4 similar changes in designation among other types of IPFs.
5 Second, charges for ancillary services were
6 missing among some IPFs that are required to report them.
7 Most notably, 43 percent of stays at non-all-inclusive-rate
8 freestanding for-profit IPFs did not include any reported
9 prescription drug charges. In contrast, nearly all stays
10 at hospital-based IPFs reported prescription drug charges.
11 Overall, we found that 32 percent of stays in
12 2019 did not have any associated prescription drug
13 ancillary charges. Any updates to IPF PPS adjustments,
14 which have not been done since implementation, will need to
15 address the lacking ancillary services, though how they
16 would be addressed would differ depending on the reason for
17 why they are lacking; that is, whether the data are missing
18 or truly zeros.
19 In summary, we found the supply of IPFs to have
20 remained relatively steady over time while utilization
21 declined. Occupancy rates were high for freestanding
22 government IPFs but showed some spare capacity for other

1 types of IPFs.

2 We found some concerning trends and identified
3 gaps where additional information is needed to assess the
4 quality of IPF care and accuracy of Medicare payments. We
5 emphasize the need for urgency in filling these
6 informational gaps, given that Medicare beneficiaries using
7 IPFs are among the most vulnerable and high risk.

8 As next steps, we plan to update these analyses
9 using data through 2021 in the coming months. We also plan
10 to conduct telephone interviews with IPFs in the fall. A
11 future presentation will cover analyses of outpatient
12 behavioral health care under Medicare.

13 We anticipate this work will form a chapter in
14 the June 2023 report to the Congress.

15 And for discussion today, we would like
16 Commissioners to comment on whether any clarifications or
17 further investigations needed for this particular paper and
18 whether there is any additional guidance for us to consider
19 in putting together the June 2023 chapter.

20 Thank you.

21 DR. CHERNEW: Needless to say, issues related to
22 behavioral and mental health are increasingly important

1 across the board, and I don't know anyone involved in the
2 health care sector that's not spending a lot of time
3 worrying about a range of psychiatric issues. And so I'm
4 really happy that we're looking into this.
5 I'll probably say something a little bit more
6 when we transition from Round 1 to Round 2, but now we'll
7 just start with Round 1. So, Dana?
8 MS. KELLEY: Jonathan.
9 DR. JAFFERY: Great. Thanks. So thank you.
10 It's a fabulous chapter and a presentation. Amen to Mike's
11 comments. You know, it's just pretty sobering to think
12 about how little I actually understand about some of these
13 issues five years into MedPAC, and so I'm really excited
14 we're looking at this, and I'll have some thoughts in Round
15 2 as well.
16 Just two questions for now. Can you say a little
17 bit more about the 190-day policy limit? I get that that
18 happened in 1965, but it's been a long time. Is there a
19 rationale now? Is there anything analogous to that? Do we
20 do anything like that anywhere else in Medicare? That's my
21 first question. I have one other after that.
22 DR. FOUT: I will just mention that there is the

1 60-day reserve days for all inpatient care hospital. But
2 that is very different from this, and there have been
3 definitely calls to change this policy, but it was enacted
4 at the time when it applied to all psychiatric hospitals
5 evenly. But, I mean, it's a common theme in the literature
6 and articles about -- yeah.
7 DR. MATHEWS: Jonathan, one thing to add to that,
8 in addition to the lifetime reserve days that Betty just
9 mentioned, there is a limit on Medicare-covered inpatient
10 days during a spell of illness as well. So there is an
11 analogue there.
12 DR. JAFFERY: Gotcha. But there's no limit on
13 numbers of spells of illness?
14 DR. MATHEWS: Pardon?
15 DR. JAFFERY: There's not a -- you can have
16 multiple spells of illness.
17 DR. MATHEWS: Correct. Correct.
18 DR. JAFFERY: If you have your eighth heart
19 attack, nobody says, "Sorry."
20 Okay. Second question, and I'll come back to
21 some of my thoughts on that in Round 2. But if you go to
22 Slide 7 for a second, I don't know if you have any

1 information about this, and, again, this might be something
2 in Round 2 I'll suggest. But were you able to or have you
3 looked at repeat stays for individuals for the same MS-DRG?
4 And I'm not just thinking about a 30-day readmission,
5 because these are longstanding problems for people, right?
6 So did somebody -- were they admitted for, you know, a mood
7 disorder and then had another admission -- it could be any
8 period of time, but seeing if people are having repeated
9 stays for that?
10 DR. FOUT: That's a good question. We haven't
11 looked within MS-DRG, but we could.
12 DR. JAFFERY: That's it for now. Thanks.
13 MS. KELLEY: Lynn.
14 MS. BARR: Great chapter. I'm really excited
15 we're digging into this, and, you know, I have a lot of
16 compassion for the beneficiaries that are in these
17 institutions.
18 A question about the data so I'm trying to
19 understand. Is utilization declining, you know, for
20 organic reasons, or is this tied to the economy? And
21 because you were starting in 2016 where the economy is
22 booming and, you know, you would think that that might have

1 a dampening effect on mental illness, is it -- do you have
2 data going back to 2000? Can you give us a better picture
3 of, you know, are we going to need more beds as the
4 recession increases, et cetera?
5 DR. FOUT: We have looked back to like 2011 and
6 maybe even prior to the beginning of the PPS, 2004. It has
7 been declining kind of consistently.
8 MS. BARR: It is a consistent decline?
9 DR. FOUT: Yeah.
10 MS. BARR: Any thoughts about why?
11 DR. FOUT: It's a great question.
12 MS. BARR: It's really interesting, because
13 certainly mental illness is not a flat thing.
14 DR. FOUT: Right.
15 MS. BARR: So I'm very curious about that. I'm
16 curious, too, about the profitability of the for-profit
17 IPFs. That seems a little concerning and possibly looks
18 like, you know, somebody's getting very creative and
19 entrepreneurial out there. And I was wondering who owns
20 these IPFs, you know, and is there -- do they have a
21 different patient profile? I'm particularly concerned
22 about how they're converting to, you know, an all-inclusive

1 rate and at that time their profitability is going up and
2 the drugs being reported are going down? And I'm, like,
3 what is going on there? So what are your thoughts there?
4 DR. FOUT: Yeah, all those are very similar
5 questions we had. There is a table in the chapter that
6 shows beneficiary characteristics by IPF type and
7 ownership, so you can see there are some differences in the
8 types of patients served by these different IPFs.
9 MS. BARR: Did that change in the last -- I was
10 wondering if you could look at just the for-profit IPF. Is
11 there something -- like, I mean, because there could be an
12 opportunity for us to create policy to block whatever the
13 heck is going on there -- right? -- if we understood it
14 really well. So if we could dig in more on what's
15 happening in that space.
16 DR. CHERNEW: So, yeah, I mean, some could be --
17 I agree, some could be a case-mix issue; some could be a
18 care delivery pattern issue, right, which --
19 MS. BARR: Right, but it's not happening to
20 everybody else, and so like they --
21 DR. CHERNEW: No; I understand.
22 MS. BARR: They've clearly identified an

1 opportunity.

2 DR. CHERNEW: I'll take that as [off microphone.]

3 I think that summarizes, Betty, where you are.

4 MS. KELLEY: Amol.

5 DR. NAVATHE: Thanks. Really an excellent

6 chapter, I think. I think you did a very systematic job of

7 covering a lot of the different dimensions here. I have

8 three questions. Hopefully it will be fairly short.

9 The first one, I promise I'm not trying to be

10 cheeky here. I'm actually earnestly curious. We talk

11 about the occupancy rates, and in some sense, I was kind of

12 wondering what is a healthy occupancy rate. Like, what

13 would we think is good? Because we cite on Slide 11 71

14 percent or so is low, 84 percent is high. Then we talk

15 about the short-term acute-care hospitals, and they're even

16 lower. And so just because we're using these adjectives of

17 low and high, I was curious, do we have some kind of

18 internal barometer of what we should be seeing in this

19 sector? And how do we determine that?

20 DR. FOUT: That's a good question, Amol. That's

21 why we put the occupancy rates from acute-care hospitals on

22 there as kind of comparator. Whether we have a barometer,

1 I mean, I'm not sure. I can definitely look into that.
2 But, yeah, I think some of those highs and lows are
3 somewhat subjective. And, remember, they're aggregates,
4 too, so it does not mean that it's that at every single
5 IPF.
6 DR. NAVATHE: Right. Okay. Thanks. That's
7 helpful.
8 The second question I had is on page 17 of the
9 reading materials, in a couple of paragraphs you sort of
10 describe the distribution across the different sectors,
11 like for-profit, nonprofit, government freestanding, which
12 is hospital, and then also just the total beds. And I
13 think the general trend on the total beds, for example, was
14 slight increase but generally stable. And what I was
15 curious there is do we have a sense of what's happening
16 across markets? I mean, you just mentioned, for example,
17 that occupancy rates are going to vary by different
18 facilities, which totally makes sense.
19 When we look at it at the market level or the
20 geographic area level, do we see that there's some places
21 where there's greater for-profit, freestanding entry and so
22 the number of beds there is going up; whereas, in other

1 markets maybe we don't see that, and there's some closures,
2 and we're actually seeing it going down? Is there a lot of
3 geographic variation? I'm most interested in the total
4 beds, but also curious about the composition.
5 DR. FOUT: Like just between urban and rural, I
6 think the patterns are pretty similar. They're trending in
7 the same direction for urban versus rural. We haven't
8 looked in specific markets.
9 DR. NAVATHE: Okay. Thank you. And then the
10 third question -- and I apologize if this was in the
11 reading materials and I missed it. I did try to look for
12 it. But can you just clarify for us how an IPF designates
13 the all-inclusive conversion and whether there's
14 requirements associated with that or what that process
15 looks like?
16 DR. FOUT: So our understanding is that -- I
17 mean, the all-inclusive rate designation, a lot of the
18 hospitals have them, the government ones, had them for a
19 very long time. And our understanding is that you aren't
20 really supposed to switch from an all-inclusive rate --
21 sorry, from having a non-all-inclusive rate, meaning you
22 have all the structure and the accounting structure to

1 allocate your costs to the different departments to an all-
2 inclusive rate meaning you don't anymore. But we're seeing
3 it on the cost reports, and that is a question that we've
4 had, and we know that others have seen this and are looking
5 into that as well with the processes for designating that.
6 But, I mean, I will note that we're looking at
7 the cost reports -- kind of a checkmark on the cost report
8 designating its all-inclusive rate. It might all this
9 happened later and they changed, so we're going to continue
10 to look at that. But we have the same question: What is
11 the process for this?
12 DR. NAVATHE: Okay. So I guess the related
13 follow-up question there is the reading material implied
14 that there are facilities that are switching from non-
15 inclusive to all-inclusive, so it does look like there's --
16 you kind of mentioned in your first part of your response
17 that in some sense it may have been kind of a legacy
18 designation and not necessarily intended from there to be
19 switching across that. But that being said, there is
20 switching going across that. Is that something that we
21 have a sense of the quantification? And if not, is that
22 something that we can do?

1 DR. FOUT: You mean the quantification of how
2 many have switched or --
3 DR. NAVATHE: Yeah, over time --
4 DR. FOUT: Yes, and some of that is in the paper.
5 It has increased in 2017 and 2018, which also coincided
6 with when CMS really issued some transmittals and edits to
7 the cost reports where they were going to reject it if they
8 did not contain ancillary charges. So that happened about
9 the same time.
10 DR. NAVATHE: Great. Thanks.
11 MS. KELLEY: Greg.
12 MR. POULSEN: This is an incredibly specific
13 question, and I apologize if we don't know the answer to
14 it. On the 190 days, I understand the difference between
15 inpatient hospital-based facilities and others. What I
16 didn't understand either in the reading or this -- and I
17 couldn't find a quick answer to it -- is do days in a
18 hospital-based IPF contribute to the 190?
19 DR. FOUT: They do not.
20 MR. POULSEN: They do not. So if you had 180
21 days in an inpatient -- or, sorry, a hospital-based
22 inpatient facility, that would still not contribute; you'd

1 still have 190 days to count.

2 DR. FOUT: That's right.

3 MR. POULSEN: Thanks. That's, like I said, very

4 specific, but interesting.

5 MS. KELLEY: Marge.

6 MS. GINSBURG: Interesting work, and we have a

7 lot more to go, but that's very exciting.

8 On Slide 13, you mentioned that 35,000

9 beneficiaries have exhausted their 190 days. I was curious

10 if we knew anything more about what happens to them. Do

11 they stay there and get billed privately? Do they stay

12 there and the facility eats it? Do they get transferred to

13 a government facility? What happens to those that reach

14 their limit? Do we know anything at all about that?

15 DR. FOUT: Yeah, that's a good question, and I

16 think it will be part of our future analyses, looking at

17 that. We got that data very recently, so we haven't really

18 been able to dig in. But those are things that are on the

19 top of our mind, too.

20 MS. KELLEY: David.

21 DR. GRABOWSKI: Great. Thanks. This is really

22 super work. I wanted to ask about Slide 14. It reads,

1 "Quality of care: Data provided by IPFs is limited." I
2 feel like this is like an evergreen heading for MedPAC.
3 "Quality of care: Data provided by [blank] is limited,"
4 and insert your provider there. Ledia, I think you've used
5 this template before.
6 [Laughter.]
7 DR. GRABOWSKI: I wanted to ask specifically
8 about how do we improve the measure set, and my reading of
9 the chapter was that we have these chart-based measures,
10 and they're provider-reported, and we don't sort of trust
11 those. And then there's these outcomes-based measures like
12 hospitalizations, mortality is coming in terms of new
13 measures. Are these -- the third bullet there, "providers
14 must report patient-level results," is that the chart? And
15 if not, like, where do we go, Ledia, to kind of get better
16 measures here?
17 MS. TABOR: I think it's two things. One is I
18 think the -- so the beginning of next summer -- it was
19 voluntary this summer -- IPFs will have to report basically
20 the chart information below the numerators and denominators
21 that they've been report now. So I think it's going to add
22 some validity to what's being reported. So I think that's

1 going to be a huge step.

2 And then I think there are opportunities to
3 develop more outcomes measures, which CMS has said in the
4 proposed rulemaking that they're working on, like the
5 mortality measures, I think there are some patient-reported
6 outcome measures, which are important. I know many
7 Commissioners have supported it in the past. I think
8 there's also patient experience measures.

9 I've heard from an IPF that we did a site visit
10 with over the past years that they used HCAHPS. So I think
11 it's not uncommon for IPFs to already be doing some kind of
12 patient experience, but to have it be required and reported
13 so that could be publicly reported I think would be
14 valuable.

15 DR. GRABOWSKI: Just as a quick follow-on, I
16 really like potentially the patient-reported outcomes,
17 experience, maybe family -- there are a lot of possible
18 measures there. And I don't know if this is a fair
19 question or not, but are hospitalizations and mortality
20 good -- do we know that they're good measures for this
21 population? Like, how do we think about them? I know
22 they're sort of the go-to's here, but are those the first

1 measures I would want to look at with an IPF?
2 MS. TABOR: I think readmissions has value, and,
3 I mean, I don't -- I think we see differentiation across
4 facilities on it, and the readmission rates are higher than
5 they are for acute-care hospitals, for example, so I think
6 it shows there's definitely opportunities for improvement.
7 I guess as CMS continues to develop the measures
8 on mortality, it could be that there's no variation, it's
9 not reliable, you know, kind of all those things. But I
10 can't kind of say without looking at the data results. But
11 I think conceptually it's interesting.
12 DR. CHERNEW: Yeah, I just want to jump in and
13 say one point on this which is relevant. This whole
14 discussion is very facility-focused, what's happening in
15 IPFs. It's not very patient-focused, and as was pointed
16 out, these patients may go to other types of hospitals and
17 get other types of care. So there's a version of quality
18 measure what's happening in the IPF, but there's also a
19 version of quality of care what's happening to people, and
20 I hear across several of these clarifying questions that
21 basic concern, which is sort of -- we're concerned about
22 the people, and we're now in a conversation about one type

1 of facility that deals with them. So I think that's a
2 theme that will come back, but certainly in the quality
3 measure set issue, it's particularly relevant because --
4 for a range of other things.
5 I'm sorry. I didn't mean to jump in. Were you
6 done, David?
7 DR. GRABOWSKI: Yes.
8 DR. CHERNEW: Okay. Dana.
9 MS. KELLEY: Scott.
10 DR. SARRAN: Yeah, somewhat expanding off of
11 David and Mike's comments, I'm just so struck by the
12 discordance between, on one hand, all the sort of troubling
13 hints and reasons we would want to know more -- right? --
14 the whole for-profit freestanding piece, you know, which I
15 think generates a lot of immediate concerns, the
16 vulnerability of the population, the impacts on quality of
17 life, and the obvious -- and people have known this for
18 umpteen years -- need to think long term about outcomes.
19 This is not seeing whether somebody's hip replacement was
20 successful 30 days out. This is what's happening in their
21 lives 180 and 360 days out. So we've got all that on the
22 one hand; then on the other hand, all the things you report

1 that suggest CMS has not taken, at least until very
2 recently, the need for reasonable diligence with outcomes
3 very seriously. And, in fact, they may be backing off by
4 allowing these hospitals to go, you know, the route of all-
5 inclusive and, therefore, having less robust granular data.
6 So my question is: Do we have any insights into
7 why CMS has not been more rigorous in this space about
8 looking at outcomes? It just feels like something -- like
9 they've decided for some reason not to pursue it seriously.
10 MS. TABOR: I can say for the quality piece -- a
11 very hard question. I think we're challenged across the
12 Medicare program to look at outcomes because of things that
13 we talked about yesterday, like data limitations and how do
14 you track a patient kind of outside of the data that we
15 have. I don't know if anybody has something to add.
16 DR. CHERNEW: [Off microphone.]
17 MS. KELLEY: Mic.
18 DR. CHERNEW: Here's my interpretation of that
19 answer, Ledia. Tell me if I'm right. It's a very hard
20 thing to do, and we don't know exactly why they've decided
21 to put more or less resources into doing it. That might
22 not be that clarifying, and that might lead to a Round 2

1 comment, but at least in the clarifying sense, the answer
2 is it's hard for us to say something about the motivations
3 of CMS in what is an admittedly difficult area. Is that --
4 MS. TABOR: That's perfect. Thank you, Mike.
5 DR. CHERNEW: I'm sorry.
6 MS. TABOR: No, that was good.
7 DR. CHERNEW: I'm looking to see where Scott is
8 in Round 2.
9 [Laughter.]
10 DR. CHERNEW: I can see he has a Round 2 face.
11 It's a face I'm learning to recognize.
12 [Laughter.]
13 MS. KELLEY: Cheryl.
14 DR. DAMBERG: I'm going to pile onto the measure
15 conversation. I wholeheartedly agree with everything David
16 pointed out. I think I'm sort of struggling with two
17 things. So I recognize there's sort of a shortage of the
18 types of measures we might want related to outcomes, but I
19 always sort of feel like there's kind of a lack of
20 precision when we sort of throw out the term "outcomes"
21 without sort of saying what exactly we would sort of want
22 to signal to Congress or CMS that they should be focused on

1 measuring. So I don't know whether there's any work we can
2 do to, you know, add a little bit more precision in that
3 space.
4 But I wondered, because I think you have sort of
5 this near-term charge of being able to try to assess
6 quality and quality differences, are there other claims-
7 based measures that you could be looking at? I don't think
8 I saw ED utilization on there because to me that would
9 maybe signal that something's going awry. And I did see
10 that there was, you know, medication continuation within
11 the 30-day period, but I'm assuming that these patients are
12 on longer-term medications, and whether we want to look
13 out, you know, 90 days, six months, really understand what
14 that profile looks like, you know, to try to manage their
15 conditions in an ambulatory space or in the home space.
16 And then, you know, potentially looking at whether there's
17 sort of excess ambulatory care utilization sort of in some
18 time period.
19 MS. TABOR: Those are good ideas. We can take it
20 back.
21 MS. KELLEY: Jaewon.
22 DR. RYU: Yeah, I had two questions, one of them

1 also on the 190-day phenomenon. So we talked a little bit
2 about what happens to the beneficiary. What happens to the
3 facility? So if someone needs to be admitted, they have
4 already exhausted the 190 lifetime limit. Does that just
5 become uncompensated care then for the facility that admits
6 them?
7 DR. FOUT: That's our understanding from
8 conversations we've had.
9 DR. RYU: Okay. And there are no alternate kind
10 of sources of funding, whether it is state or other?
11 DR. FOUT: I mean, that is possible. I don't
12 know about that.
13 DR. RYU: And then the other question was around
14 ER use. I think it is a significant setting where a decent
15 amount of this care gets delivered. Is that envisioned to
16 be part of the later meeting outpatient chapter or is that
17 going to be covered in this hospital chapter?
18 DR. FOUT: It wouldn't be covered in this
19 chapter, but you mean going to the ER?
20 DR. RYU: Just to understand it more.
21 DR. FOUT: Yeah, about ER use?
22 DR. RYU: Yeah.

1 DR. FOUT: Yeah. That's a good point. It could
2 be in this chapter, yeah.
3 MS. KELLEY: Kenny.
4 MR. KAN: This is great work, very rich data.
5 On page 10, Slide 10, I'm really surprised by the
6 fact that the unique beneficiaries, that's just a big jump
7 of 18 percent, and then the Medicare spend, you know, only
8 went down by 13 percent, suggesting that could be an acuity
9 issue possibly. So I know that this report will be
10 refreshed with 2020 and 2021 data, so a couple of things is
11 I'd be very curious to see what is the impact of COVID over
12 time, as we learn more about this.
13 And also, I'm wondering, on page 10, can we show
14 how this varies between for-profit, nonprofit, and
15 government, the statistics here? That would be very
16 helpful. Thank you.
17 MS. KELLEY: Wayne.
18 DR. RILEY: Thank you, Betty and Ledia, for this
19 very sobering analysis of a very tough issue that continues
20 to perplex a lot of us in terms of psychiatric resources
21 for Medicare beneficiaries.
22 Going back to Slide 6, you point out that the

1 beneficiaries who tend to be the most affected, vis-à-vis
2 the IPFs, are Black beneficiaries. Can we assume by
3 inference then that they are a significant portion of that
4 30-plus percent who have exceeded the cap? Do we have any
5 specific data on that because I would flag it as another
6 dimension of health disparity.
7 DR. FOUT: That's a great point and we will look
8 into that when we dig into the 190-day limit.
9 DR. CHERNEW: That is the end of Round 1.
10 MS. KELLEY: No, I have two more actually. Lynn,
11 go ahead.
12 MS. BARR: Just continuing on the quality
13 recommendations, following on Cheryl. I'd be interested in
14 seeing whether or not they actually saw a therapist, you
15 know, got some ambulatory care, so it's not about overuse
16 of inappropriate ambulatory care but actually that would be
17 a good clean space measure.
18 And it seems to me like the outcomes that we're
19 really looking for is that people can live a reasonable
20 life. So do they have a home? I mean, so there are ways
21 of looking at that as well. Thank you.
22 MS. KELLEY: Okay. And I have two round 1

1 questions from Larry. The first is, can you say a bit more
2 about the advantages and disadvantages of moving to all-
3 inclusive status and about the advantages and disadvantages
4 of not reporting ancillary costs, even when the hospital is
5 not all-inclusive?
6 DR. FOUT: Those are good questions and I think
7 we're going to get some better answers for those when we do
8 interviews with IPFs in the fall.
9 MS. KELLEY: Okay. And his other question is,
10 can an IPF refuse to admit a patient, assuming the IPF
11 doesn't have its own ED?
12 DR. FOUT: Yes. If they don't have an ED, they
13 can refuse a patient.
14 DR. NAVATHE: Because EMTALA doesn't apply then.
15 MS. KELLEY: Okay. That's the end of Round 1.
16 DR. CHERNEW: Okay. That was a pretty
17 comprehensive Round 1, and I have a reasonable sense, I
18 think, of where people are going. I'm going to summarize
19 it. We have a bunch of Round 2 so I'll summarize it
20 quickly.
21 There is a ton of enthusiasm and there are a lot
22 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

1 doing that. Right now the chapter that we're going to
2 present is likely going to be an informational chapter, but
3 we certainly are open to sort of figuring more and which
4 directions, depending on how the conversation is about to
5 go.
6 Jim?
7 DR. MATHEWS: I would agree with that. Given the
8 very expansive nature of what we've been asked to do here,
9 it is going to be a full-time job for Betty and Ledia, and
10 Ledia has many full-time jobs at this point, simply to
11 comply with the terms of the request. And in the course of
12 this work we no doubt will identify policy issues that
13 warrant some attention, and we can take those into
14 consideration for future work if there is interest among
15 the Commissioners in doing so.
16 But I think the drill for this cycle is going to
17 be report out what we have been asked to do, and to the
18 extent things warrant further analysis it is going to be a
19 next cycle kind of thing.
20 MS. KELLEY: Okay. Round 2. Jonathan is first.
21 DR. JAFFERY: Great. Thanks, and I appreciate,
22 Mike and Jim, that set-up. This has been great to dig into

1 this conversation. Clearly, as Mike said, there's a lot of
2 enthusiasm. We all acknowledge and understand the growing
3 recognition of the need for paying attention to mental
4 illness, that the fact that we all had questions about this
5 190-day limit policy that seems kind of crazy right now but
6 in 1965 probably made a lot of sense to people. I think it
7 really speaks to the fact that we have come a long way, but
8 we have a lot to go.
9 And so I'll try and focus some comments about
10 things that I think could push us down towards work that we
11 could do this cycle that might address the mandated report
12 but also speak to maybe things we could do in subsequent
13 cycles. And I don't approach this thinking about it like a
14 December discussion at all.
15 I'm really glad that part of the plan for this
16 cycle is to look at some of the use for outpatient
17 behavioral health services because as you know and as
18 people have already commented on, this is not just an acute
19 episode issue for people who are coming in with a need and
20 being taken care of in X number of days in an inpatient
21 facility.
22 This is really about a spectrum of care that

1 spans inpatient and outpatient therapy, and many of these
2 conditions that are treated actually, in fact, have that
3 spectrum of inpatient hospitalization to intensive
4 outpatient, and then individualized outpatient. So
5 understanding those patterns of use for beneficiaries is
6 going to be extremely important for us to understand, are
7 people getting needs met.
8 As we think about the capacity issue, it is very
9 difficult to think about what the right goals are in some
10 senses, and I think about are our treatment regimens even
11 adequate. So, you know, there are evidence-based
12 approaches to certain things. For example, a substance use
13 disorder, we know that 90 days treatment -- and again, this
14 is not an inpatient treatment. It is a spectrum of
15 inpatient and intensive outpatient and whatnot, depending
16 on individualized needs -- has much better outcomes than
17 shorter treatment regimens. And yet a lot of coverage for
18 people in the commercial and in other worlds limits things
19 to 28 days.
20 And so understanding what people are actually
21 getting and then what the outcomes are, and as Scott
22 mentioned, this is not a 30-day, are people ambulating

1 after a hip surgery. This is, are people at 6 months, in
2 12 months, and even 18 and 24 months, are they living
3 independently, have they been readmitted for their whatever
4 MS-DRG they had or are they resuming use of a substance.
5 So I think that's going to be really important
6 for us to think about, and it is going to stretch us to
7 think about it in ways that we haven't necessarily had to
8 in other areas.
9 But again, thinking even in terms of this
10 capacity, I guess thinking more about are we looking at the
11 same metrics that we look at in other sectors. And there
12 is a very different kind of supply and demand dynamic going
13 on here.
14 With that I'll just finish up with a couple of
15 ideas for the analysis, and I'm probably just being
16 redundant here, but again, thinking about this in terms of
17 a spectrum, and maybe it's almost an episode of care that
18 includes that outpatient. And I'm not thinking about a
19 payment model here yet in a bundle. I'm thinking about
20 understanding what happens in the course of treatment for
21 somebody.
22 I had talked about repeat stays. Marge had

1 mentioned what happens after the 190-day limit. That is
2 going to be a really important thing for us to understand.
3 Thirty-five or 45,000 people who are at that or exceed it
4 or are close to it, are they coming back in? And that's
5 obviously a huge cost and quality issue.
6 So I'll leave it at that, but I'm very excited
7 about this. I think it's long overdue, clearly, and I
8 appreciate you guys putting all this effort into it. Thank
9 you.
10 MS. KELLEY: Stacie.
11 DR. DUSETZINA: Thanks very much. I will echo
12 Jonathan's comments. I think this is a great and sobering
13 chapter, and I'm glad we're looking into it. I appreciate
14 Mike and Jim's comments too about scope and thinking about
15 what it is we've been asked to do and what we could do.
16 Although I think that everyone has very nicely
17 raised the days limit and how old that policy is and how
18 much things have changed, I think the report already starts
19 to highlight that. I think it will do even more than that
20 in the next iterations.
21 And it might be nice if we could make a strong
22 statement of some kind, even if it's not a recommendation,

1 that this needs to probably be revisited if that's where
2 the data lead us.
3 But thank you so much for this work. I think
4 it's absolutely incredible and very important.
5 MS. KELLEY: Robert.
6 DR. CHERRY: Yes, thank you. I really do
7 appreciate the team digging into this analysis. It's
8 really a very worthwhile discussion, very important work,
9 and thanks to Mike and Jim for kind of level-setting what
10 the objectives are here, that this is really informational
11 and hopefully will set the stage for future work in future
12 cycles.
13 I had two broad-based comments. One is I guess a
14 recurring theme about sort of the lack of data. And I
15 would say that for this particular space it is rather
16 disappointing that we don't have the data capture that is
17 really necessary.
18 I would argue that just simply reporting out
19 numerator-denominator information is insufficient and
20 rudimentary from a quality perspective. You know, during
21 my day job I would say that one of the things that I'm
22 challenged with, and I think others are as well, with

1 regards to improving the quality of care within inpatient
2 psychiatric facilities, is the need for risk adjustment
3 models. And so just the numerator-denominator question
4 doesn't really get to it because you really want to
5 understand adjusted length of stay, adjustments with
6 regards to readmissions, and it's very difficult to do that
7 without the risk adjustment models.
8 So I would say in the informational report I
9 would strongly encourage that that is a need, that the data
10 capture is very important here. Certainly for acute care
11 hospitals there's enough data, enough risk adjustment
12 models that despite the challenge with data capture we've
13 been able to move quality and safety efforts along. I
14 think within mental health that there is a great deal of
15 opportunity to improve the measurement sets here, even for
16 things like the use of restraints. You know, there are
17 certain diagnostic categories where restraints are utilized
18 at a higher rate than others, and it's helpful to
19 understand the differences.
20 I would also say that the DRG model is sort of
21 insufficient for risk adjustment models because there are
22 many different types of diagnostic categories within that.

1 So having 74 percent of the patients just lumped into a
2 single DRG, that doesn't present the granularity that is
3 necessary for risk adjustment models. So I would strongly
4 really advocate for that.
5 The second thing, I think many of us found the
6 190-day lifetime limit and the 35,000 beneficiaries that
7 have exceeded that limit to be a rather interesting
8 measure. I think for me personally it triggered the fact
9 that we're very much focused on psychiatric facilities and
10 we're not thinking, I think, enough about preventative
11 services as well.
12 Looking back at the ask by the House Ways and
13 Means Committee it appears that they also want us to look
14 at other outpatient services as well. And I really hate to
15 add onto the work, because I know this is an enormous
16 undertaking in terms of the informational report. But I do
17 think that it's important in order to understand
18 psychiatric facilities that we understand the entirety of
19 the mental health delivery system that exists.
20 And by that the report really doesn't mention
21 residential treatment centers. Some specialize in adults.
22 Some specialize in pediatrics. Some specialize in eating

1 disorders. Some specialize in addiction services. But
2 understanding county by county whether inpatient
3 psychiatric facilities exist and what are the resources
4 available in terms of residential treatment facilities
5 could be important in understanding how to transition
6 individuals back into the community successfully without
7 readmissions and other impacts.
8 The same is also true for partial hospitalization
9 programs, where they get the intensive resources of daytime
10 hospital services but allowed to go home or even back to
11 some sort of community group setting during the overnight
12 hours.
13 Intensive outpatient treatment services is also
14 not mentioned in the report, and this could be very helpful
15 for individuals that have dual diagnosis outside of mental
16 health in order to keep them within the community.
17 And some counties do have mobile crisis units as
18 well so that they can present with a few crisis at the
19 scene, help with the escalation procedures, decide
20 appropriate triage of the individuals.
21 And so I think understanding all of these
22 different models that exist within a community can help us

1 understand how those that are suffering from mental health
2 are actually expertly managed within their communities.
3 And so another important sort of quality measure
4 is disposition. So if they don't have the breadth of
5 services, like the ones that I mentioned, then you are
6 going to have an increase in readmissions, ED visits, and
7 unfortunately, suicide attempts or actual suicides.
8 And so I think that we have to look at the whole
9 model holistically and not just tease out the inpatient
10 facilities.
11 Otherwise, this has really been just a great
12 attempt to take a very difficult issue and try to wrap your
13 mind around, and I'm looking forward to future iterations
14 of the work.
15 MS. KELLEY: Greg.
16 MR. POULSEN: I would add to the compliments
17 regarding the great work. This is worthy of the hard work
18 that's gone into it.
19 I agree with everything that Robert said, which
20 is going to seem awkward when I'm about to do something you
21 said none, and don't just look at numerators and
22 denominators.

1 But in this case some work that we did a few
2 years ago, I think it was 2015 and 2016, we looked at
3 people who had gone to an emergency room, about a million
4 people, was the group that we looked at, that had gone to
5 an emergency room for a mental health condition, an acute
6 mental health condition, and had subsequently been admitted
7 to one of these type of hospitals.
8 So I think -- I was trying to remember this, but
9 I think it was for hospital-based IPFs. Those would all be
10 not, not for profit, nine freestanding IPFs that were for-
11 profit and one freestanding IPF that was not for profit.
12 And then we looked at the 180-day, within 180-day
13 time, the number who would have then gone back to an ER for
14 an acute mental health need or been readmitted, one of the
15 two, either of the two.
16 And what we saw was, I think, deeply troubling.
17 It impacted what we did with our panels, but what we saw
18 was more than a 3:1 variation between -- based on which
19 facility they had gone to, whether they were likely to be
20 readmitted or to end up in an ED with an acute episode
21 again. And, you know, 3 or almost 4:1 difference in
22 outcomes for a different type of condition, a readmission

1 for, you know, fill in the blank. And I think we'd be
2 stunned by that, but sadly, we weren't stunned by it when
3 it was those mental health numbers.
4 And I think that what you all found, looking at
5 the -- at least what appears to be a lack of interventions
6 and ancillary services and drug use and other things within
7 those admissions, within the admission structure, I think
8 may be indicative of that.
9 So my thought would simply be to say we should
10 not underestimate the magnitude of the quality differences
11 that exist, and it is well worth looking into that more
12 deeply because more than 3:1 if, in fact, our experience is
13 representative of the country is a remarkable variation,
14 and yet we're spending very similar amounts between those
15 places but potentially getting a wildly different value for
16 it, so thanks.
17 MS. KELLEY: Betty.
18 DR. RAMBUR: Thank you so much for this fabulous
19 and sobering work, and I really appreciate the comments of
20 the staff as well as the Commissioners.
21 I just want to make a few points. My major
22 comments were actually addressed largely in Round 1 with

1 the issues of the quality reporting that's summarized on
2 page 41 that David, Scott, Cheryl, Lynn, Greg, and others
3 have talked about.
4 I certainly support the exploration of the whole
5 continuum that's been brought up by Robert and Jon,
6 particularly, but I wanted to understand something that
7 Kenny said sort of in passing in Round 1 is the differences
8 between the different types.
9 I mean, the magnitude of the profitability in
10 one's group versus the other really brings to me questions
11 about what are the staffing ratios, what's the turnover,
12 what's the skill mix. So just like in our previous
13 conversations, I think it's really important, to the extent
14 that it's possible without being too laborious, think about
15 what's happening within that facility, you know, at the
16 working service.
17 The other thing I just wanted to comment,
18 something that David said very briefly, I do think some
19 measures that are used in other settings are applicable
20 here, but others -- for example, the family experience, I
21 think, is profoundly important in this particular setting,
22 and how that can be captured would be very valuable.

1 Thank you so much for this fabulous work, and I
2 look forward to our continuing efforts.
3 MS. KELLEY: Scott.
4 DR. SARRAN: So, in terms of the context, Mike
5 and Jim, that you set up, I wonder if what we should do is
6 just call out that, as we tried to put together an
7 informational chapter, we have some glaring holes in that.
8 I've thought about my short list of what I would
9 -- my suggestion what we'd prioritize and include in that.
10 First, that we need more granular data, and I would
11 prioritize among that that we are seriously concerned by
12 the all-inclusive hospitals and the way that that makes
13 some of the data, the key data opaque and embrace that as a
14 concern.
15 And then the lumping of the mood and non-mood
16 psychosis just clinically strikes me as that's just dumping
17 two things that may be completely different into one
18 bucket, and that's at a minimum worth some exploration.
19 Then the second overall thing I'd suggest we
20 raise is that we need to think about this in a much more
21 patient-centric, beneficiary-centric fashion, and that's
22 come up in the comments. And the ways I would

1 operationalize that would be that risk adjustment. This is
2 a space that cries out for risk adjustment, inclusive of
3 it, at a minimum social determinants of health and at a
4 minimum dual diagnoses, and those would be my top priority
5 stuff for risk adjustment.
6 And then that we need to capture over time a much
7 more lengthy time period, the full range of inpatient and
8 outpatient services. That would be my short list of what
9 we tee up in the -- "Hey, we tried to do a good job of
10 this, but we're missing some stuff that we need."
11 MS. KELLEY: Jaewon.
12 DR. RYU: Yeah, a few points. And I agree with
13 Scott's framing. I think that's about right, and I agree
14 with a lot of Robert's comments. That's where I struggle
15 as well. I think this is an area that's tough to confine
16 because it spills over into so many other areas.
17 And I think the interplay between some of these
18 settings is important to at least note, if not dig into the
19 extent feasible. The categories I thought were, yes,
20 inpatient, but also how it interplays with the outpatient
21 availability of services. And I think you're going to get
22 to that in the future meetings section, but I think there

1 is a correlation. Subpar access on the outpatient side,
2 I'm pretty sure that's got a spillover effect on increasing
3 inpatient need and demand.
4 But I think we should also make sure we don't
5 lose sight of the emergency room because I think most ERs
6 across the country, a good portion of psychiatric care is
7 actually delivered there, and it doesn't really show up as
8 an actual admission. Admission rights may be south of 10
9 percent, but an awful lot of folks may even be boarding for
10 multiple days, where functionally it resembles an
11 admission. So I think it's important to understand that.
12 The other is I think this impacts the work that
13 we had yesterday with safety net and LIS. If you look at
14 your Slide 6 -- I think it was Slide 6 -- on this deck, it
15 had LIS significantly more likely to be admitted inpatient
16 for psychiatric disorders, and I think there is a
17 connection point there that might be worth calling out.
18 A couple other points. On Slide 11, the
19 occupancy rates do suggest that there's some availability.
20 It would be helpful to understand that because, again, if
21 you go to most ERs across the country, you'll see handfuls
22 of patients boarding in the ER waiting for placement for an

1 inpatient psych bed, and those two things seem to be a
2 disconnect that I can't reconcile.
3 And then the last point is around digging in on
4 why the for-profits have higher Medicare margins. I just
5 don't understand exactly what that might be due to even
6 within a given category. So, within the freestanding,
7 their margins are significantly higher. It would just be
8 helpful to understand why we believe that's true.
9 MS. KELLEY: Cheryl.
10 DR. DAMBERG: This is excellent work, and I
11 applaud the staff for all of your effort in this regard.
12 Very illuminating.
13 It's clear from the comments of the Commissioners
14 that there's, you know, more that we want to know and try
15 to unpack, and I recognize we probably won't be able to get
16 it all done in this particular chapter. And so I think it
17 would be good to spotlight the areas where we'd like to see
18 more work done.
19 You know, I'm in total agreement with Scott's
20 framing, and I think sort of the real challenge that others
21 have spotlighted is, you know, this isn't just about the
22 inpatient admission. This is about comprehensive care

1 over, say, course of a year in trying to understand sort of
2 the trajectories that these patients are on and how they
3 get managed in trying to get to what I would call a much
4 better integrated delivery system for managing mental
5 health care.

6 I guess in terms of some of the things, as data
7 permits, I would add to the list of unpacking. I do think
8 it would be helpful to try to break down any of these
9 statistics, particularly on the quality measurement side,
10 by, say, duals, non-duals, race and ethnicity, and so on,
11 again, to the extent that you can do that.

12 And I am also interested in trying to understand
13 the relationship between these profit margins and quality
14 performance, and I think it starts to channel some of what
15 Betty's signaling in terms of staffing and other things
16 that may be going on that could affect quality of care.

17 MS. KELLEY: David?

18 DR. GRABOWSKI: Great. Thanks again for this
19 really important work.

20 Scott, I also appreciated your framing of kind of
21 identifying those glaring holes. I would point to three.
22 The first, I just want to double down on Jonathan's comment

1 around the 190-day limit and just that being outdated, and
2 we need to really rethink that and given sort of the
3 context today.
4 The second is Robert's point about IPFs being
5 kind of part of a bigger continuum, and that's so
6 important. And I'm glad you raised that, Robert, and I
7 think it's hard to view this chapter in this broader
8 context.
9 The third comment is really one a lot of us
10 touched on, and that's quality. And I think we could
11 really double-down here in the chapter of suggesting better
12 data, better measures, better risk adjustment, as it came
13 up with Robert and others.
14 This idea of a patient experience, family
15 experience measures, once again, I think are so central
16 here.
17 I think there's an opportunity here to signal to
18 CMS and to the Congress kind of what sets of measures would
19 really work for this population.
20 Thanks again for this great work.
21 MS. KELLEY: Amol.
22 DR. NAVATHE: Thanks, Ledia and Betty.

1 So, obviously, a super important population and
2 great work that you're doing here.
3 Largely speaking, I'll keep my comments pretty
4 quick and high level because I think they're largely
5 echoing what other folks have already said.
6 I think one point, the Round 1 question I'd ask,
7 it would be helpful to understand something about the
8 geographic variation in these trends. I suspect it could
9 vary, but maybe it doesn't.
10 I think, as many have pointed out, it would be
11 helpful to understand the type of care, the case mix, the
12 types of patients, et cetera, scope of service at the for-
13 profit and the freestanding.
14 I agree with Jonathan, David, Scott, Robert, and
15 so the whole group about quality, about the 190-day piece.
16 I think one thing that's helpful to think about, I think,
17 as a framing in some sense around the system of care and
18 the fact that there is an outpatient system that's related
19 to inpatient is almost thinking a little bit conceptually
20 about what is the analogy here to an ambulatory care-
21 sensitive condition type of admission, because I think
22 that's kind of the spirit of where we want to get in terms

1 of thinking about what the outpatient sector should look
2 like and how that relationship is.
3 In part, understanding that we have -- being with
4 constraints, I'm not forcefully suggesting this, but I
5 wonder if we look at the commercial sector and/or the
6 Medicaid-only sector, if that would help us understand a
7 little bit more of what's happening here in terms of some
8 of the interface and some of the dynamics.
9 But thank you very much for the work, and I agree
10 really wholeheartedly with the other Commissioners'
11 comments.
12 MS. KELLEY: Okay. I have a Round 2 comments
13 from Larry.
14 Two points. First, for clinicians in ambulatory
15 care, getting timely and useful psychiatric help for
16 Medicare patients with serious psychiatric problems seems
17 almost hopeless.
18 Second, Robert is right. For the seriously
19 mentally ill, various types of care in the community apart
20 from direct clinical care from a mental health professional
21 are incredibly important. So we can't really address the
22 problem without understanding these, which as Robert said

1 are quite different from and go way beyond 1:1 clinical
2 care. But I recognize that getting into these other
3 services would be an enormously difficult task, but at
4 least we should flag this area significantly in the report.
5 There isn't a great deal an ambulatory mental
6 health clinician can do for a homeless person with
7 interacting medical and social needs. And he also adds it
8 will be particularly important to get a sense of the extent
9 of cherry-picking that's going on in the for-profits.
10 And, lastly, I have Lynn with a Round 2 comment.
11 MS. BARR: Thank you. I really support this
12 work, and you guys got a tremendous start to it.
13 I think that as we think about -- I've got to
14 find my note here -- about the capacity issue, I think
15 there is something here. I hear it all the time: "I can't
16 find beds." And if we look at the profitability of the
17 nonprofit hospitals -- we're shocked by the profitability
18 of the for-profit IPFs. We should be equally shocked at
19 the negative 20 percent margin of the nonprofit hospitals.
20 Those are safety-net hospitals that have set up these
21 facilities because there's no place else for these patients
22 to go. So they're taking it -- I mean, basically, a 20

1 percent hit on behalf of this population.

2 And I wonder when we talk about available beds,

3 are we talking about staffed beds, or are we just talking

4 about beds? So we have a number of beds in a cost report,

5 but we don't know how many nurses there are, right? And

6 with staffing, the issue it is, you know, I could see how

7 for-profit hospitals are going to be more inclined to admit

8 patients that require less staffing, right, and that's

9 going to increase the burden on our nonprofit.

10 So I think it's really important for us to

11 understand the true capacity issues. We're pretty high on

12 bed utilization there, and it would seem obvious to me that

13 that 20 percent is not actually available, and so I'd like

14 to see a little bit more understanding of that.

15 I don't know how much we can do on this, but

16 maybe this is several years of work for the Commission.

17 Thank you.

18 DR. CHERNEW: Several years of important work.

19 Sometimes when we have these sessions, Jim and I

20 go back to debrief, and we're trying to balance different

21 Commissioner views on things and figure out how we're going

22 to thread the needle, and I think you could see some of

1 that in certain things yesterday. This is actually not one
2 of those cases.
3 We had a really rich discussion of unbelievable
4 agreement, both in terms of the enthusiasm and I think the
5 substance.
6 So I think that, Betty, you did a terrific job.
7 Ledia, great job. There's obviously a lot of nodding heads
8 here, and so I look forward to where we go with this. We
9 will figure that out. There's obviously a lot of places,
10 and there's constraints of what we can do, but I think we
11 should just go with "thank you." I think all those themes
12 that you've heard resonated quite well, so we're good.
13 We have -- [speaking off mic].
14 We're going to take a five-minute break. My
15 camera might even still be off. I apologize for those of
16 you -- no one actually ever cares about seeing me, so
17 that's fine.
18 [Laughter.]
19 DR. CHERNEW: I was, in fact, here for all of
20 those of you that were wondering why my camera was off.
21 But we are going to take a five-minute break,
22 which I think is good, and we'll transition -- that just

1 makes is smoother, and we'll transition to Part D drug
2 stuff.
3 And, again, thanks a lot.
4 [Recess.]
5 DR. CHERNEW: Hi, everybody. We are back.
6 Thanks for joining us. We are going to jump into the issue
7 of Part D drugs and rebates. I am not going to take much
8 more time for the intro. I am going to turn it over to
9 Tara, Shinobu, and Rachel, and, Tara, I think you're
10 starting. Go ahead.
11 MS. HAYES: Thank you.
12 Good morning. In this session, we will describe
13 our team's continued work looking at proprietary pricing
14 data on Part D drug rebates and discounts that Congress
15 recently made available to the Commission. This follows
16 presentations we made in October 2021 and this past April,
17 and this work may become part of a chapter in the
18 Commission's June 2023 report to the Congress.
19 Before we get started, we'd like to thank Corinna
20 Cline for her help with this work. As a reminder to the
21 audience, you can download a PDF version of these slides in
22 the handouts section of the control panel at the right-hand

1 side of your screen.

2 In 2020, the sum of all Part D spending at the

3 pharmacy -- what we refer to as "gross spending" -- was

4 nearly $200 billion. However, drug manufacturers and

5 pharmacies provided mandated and negotiated price

6 concessions, and net spending was about one-third lower.

7 The light green part of the bar in this chart is the amount

8 that Part D requires brand manufacturers to provide for

9 prescriptions in the coverage-gap phase of the benefit

10 (about 6 percent of gross spending). The last portion

11 (other DIR) is mostly fees paid by pharmacies to plans

12 after the point of sale.

13 But the data we're focusing on now are the

14 rebates negotiated between plan sponsors' PBMs and drug

15 manufacturers, which represent 22 percent of gross

16 spending, as of 2020, and reduce plans' costs of providing

17 pharmacy benefits.

18 You've seen this slide of a simple pharmacy

19 transaction before. When a beneficiary fills a

20 prescription, she pays the pharmacy her cost sharing and

21 the pharmacy bills her plan sponsor and its PBM for an

22 amount they've agreed upon ahead of time.

1 After the prescription has been filled, if the
2 plan sponsor has a rebate contract with the drug's
3 manufacturer, the sponsor's PBM collects a rebate. The
4 sponsor and PBM may also pay or collect a fee from network
5 pharmacies based on contingent payment agreements, referred
6 to as "pharmacy DIR." (Though, as of 2023, CMS is putting
7 in place a rule that may lead to less pharmacy DIR.)
8 The thing to note here is that the price of a
9 prescription at the point of sale does not reflect final
10 costs to a plan because there are rebates and fees that
11 take place after the transaction.
12 There are some inherent tradeoffs to bear in mind
13 about how plan sponsors use DIR. First, note that because
14 there are price concessions against the cost of providing
15 Part D benefits, CMS keeps a portion of DIR to reflect the
16 fact that Medicare pays a lot in reinsurance -- 80 percent
17 of the cost of prescriptions filled in the catastrophic
18 phase. Plan sponsors typically use the remaining DIR to
19 keep their premiums lower than they would be otherwise.
20 Lower premiums benefit every enrollee in the plan, as well
21 as Medicare because the program subsidizes enrollee
22 premiums.

1 However, there are tradeoffs. Part D plans
2 charge coinsurance for prescriptions in certain phases of
3 the benefit and for specialty-tier drugs. Because that
4 coinsurance is a percentage of the price at the pharmacy
5 before rebates, it's a higher amount of cost sharing that
6 the beneficiary has to pay, or that Medicare pays on behalf
7 of low-income enrollees. Sometimes that amount can be
8 greater than plans' net cost for the drug. Further, higher
9 cost sharing moves beneficiaries more quickly into the
10 catastrophic phase of the benefit where Medicare pays 80
11 percent of the costs.
12 MS. SUZUKI: Factors that explain the rapid
13 growth in DIR include certain features of Part D that
14 provide incentives for plan sponsors to maximize rebates.
15 Competition for enrollees has turned plans' focus
16 on keeping premiums low. Changes in law and patterns of
17 drug use have reduced sponsors' share of financial risk.
18 The figure on the right shows that in 2007, plans were at
19 risk for 75 percent of the basic benefit costs. By 2020,
20 that share had declined to 37 percent. The flip side of
21 that is that Medicare and, therefore, taxpayers are at risk
22 for over 60 percent of the benefit costs.

1 Not all drugs receive rebates, and rebates aren't
2 uniform across drug classes. To get a better understanding
3 of circumstances around the use of rebates, we examined
4 three drug classes as case studies: asthma and COPD
5 medications, insulin, and TNF inhibitors for autoimmune
6 conditions. Later in this presentation, Tara will discuss
7 one of the case studies in more detail.
8 At a high level, for all three classes we found a
9 high degree of competition among brands, but little or no
10 generic entry. Gross prices at the pharmacy grew, and
11 competition played out through rebates on somewhat
12 different trajectories. Asthma drugs and insulin had
13 larger rebates in percentage terms than TNF inhibitors,
14 which may be due to their larger patient populations, a
15 lower price point, or greater number of competing products
16 than TNF inhibitors.
17 At the same time, consolidation among plan
18 sponsors and vertical integration of the largest sponsors
19 with PBMs have given those organizations bargaining
20 leverage to negotiate more DIR.
21 In our analysis of the 2020 DIR data, we examined
22 30 brand name drugs selected from 10 categories of drugs

1 with a varying degree of competition among brand name
2 products shown on the slide.
3 These categories were selected from drug classes
4 with very different rebates. Average rebate ranged from
5 less than 10 percent for antineoplastics to more than 50
6 percent for diabetic therapies.
7 Because rebates are not attached to specific
8 claims, our analysis used the average dollar amount per
9 standardized prescription calculated for each product for
10 each plan.
11 Rebates can vary due to many factors, but we
12 wanted to quickly go over how differences in organizational
13 structure could affect variation we observe in the DIR
14 data. For example, large sponsors use their own PBMs while
15 many smaller sponsors use PBMs owned by large sponsors.
16 In this hypothetical setting, we have one large
17 plan sponsor (sponsor A) that operates its own plans and
18 serves as the PBM for other plan sponsors through its PBM
19 XYZ.
20 In this example, PBM XYZ administers multiple
21 formularies -- one for sponsor A and two each for the other
22 two smaller sponsors.

1 A PBM could leverage their market share and
2 negotiate across all of their Part D clients. For some
3 products, the PBM may customize their rebate negotiation
4 for each sponsor. Alternatively, because formularies are
5 key to rebate negotiations, there may be a separate
6 negotiation for each formulary.
7 But plan sponsors must report DIR at the
8 individual plan level, which requires sponsors to allocate
9 the DIR across their individual plans. So, at the most
10 granular level, we looked at how rebates varied across
11 plans. But in addition, we tried to organize the data
12 analysis at levels of aggregation that were more likely to
13 be reflective of the actual rebate negotiation.
14 First, and maybe not surprisingly, we found that
15 rebates received for the same product can vary widely.
16 Among the six largest plan sponsors, the median
17 rebate for one product differed by as much as two and a
18 half times.
19 We also found that rebates for a given product
20 can vary widely even among plans operated by the same
21 sponsor.
22 Large sponsors tend to use multiple formularies,

1 often to distinguish between basic and enhanced benefits,
2 or to tailor benefits to specific populations, such as LIS
3 enrollees.
4 In general, manufacturers pay larger rebates for
5 a formulary position that gives them advantage over their
6 competition in winning market share.
7 Given the importance of formularies in rebate
8 negotiations, the use of different formularies could
9 explain why rebates sometimes vary widely even among same
10 sponsor's plans.
11 When we compared rebates for a given product
12 among plans that used the same formulary, we found that
13 plans using the same formulary tended to receive similar
14 rebates, but we also found instances where large
15 differences remained.
16 The extent of the variation differed across plan
17 sponsors, individual formularies, and by product.
18 This means that, in some cases, the net-of-rebate
19 cost of a given product may vary widely even among plans
20 using the same formulary. And this also has implications
21 for cost sharing paid by beneficiaries and Medicare on
22 behalf of LIS enrollees, which we'll discuss next.

1 For products with relatively high rebates, cost
2 sharing can be a much higher share of the plans' costs than
3 the amount suggested by the benefit design.
4 For the six largest plan sponsors, average cost
5 sharing for some products often exceeded 50 percent of
6 plans' costs after accounting for rebates, or net costs.
7 In some cases, cost sharing exceeded plans' total
8 net costs, meaning that, in those instances: plans did not
9 incur any benefit costs for these prescriptions, and
10 beneficiaries and Medicare's low-income subsidy paid more
11 than the total cost of the drug.
12 In many instances, the highest cost sharing
13 involved LIS enrollees, where Medicare paid most of the
14 cost sharing.
15 MS. HAYES: Now we will focus on some of our
16 findings related to asthma products, a class in which
17 rebates are estimated to have grown substantially, from
18 roughly 30 percent in 2016 to between 40 and 49 percent in
19 2020.
20 The findings presented here provide a snapshot of
21 some of the variation Shinobu discussed.
22 First, some background. While inhalers have been

1 widely available for decades, brand name products continue
2 to dominate the market. Over the past 70 years, many new
3 types of inhalers have been introduced, and there are now
4 hundreds of drug-device combinations to treat respiratory
5 diseases. In six of the ten subclasses of asthma products,
6 however, brand name products accounted for 75 percent or
7 more of Part D claims in that class in 2020.
8 There are two key regulatory hurdles that have
9 slowed generic entry in the asthma market. First, inhalers
10 are drug-device combination products which makes it more
11 difficult for generics to gain approval since both the drug
12 and delivery mechanism must undergo regulatory approval.
13 Further, manufacturers of combination products
14 can patent both the drug and device, increasing
15 opportunities to extend their market exclusivities.
16 A study found that among the 62 inhalers approved
17 between 1986 and 2020, there was a median of more than 8
18 patents per inhaler, and 53 of these 62 products were brand
19 name rather than generic.
20 The lack of generic competition in the market has
21 significant cost implications for the Medicare program and
22 beneficiaries. Let's consider one subclass: SMART

1 therapies (or single maintenance and reliever therapies),
2 which is arguably the most competitive. SMART therapies
3 combine a quick-acting inhaled corticosteroid with a long-
4 acting beta agonist. This chart shows products from this
5 class in 2020, plotting each product's price relative to
6 its share of total claims. Three of the top four asthma
7 medicines in Part D by gross sales were SMART therapies.
8 Each of these products had gross sales over $1
9 billion that year and had been on the market between 7 and
10 20 years. Generics have only recently come to market, and
11 all but one of these generics are authorized generics.
12 Notice that the generics, grouped in the bottom
13 left, have much lower costs but very little market share.
14 Despite this direct competition, gross spending
15 per claim for each branded product has increased at an
16 average annual growth rate of roughly 8 percent over the
17 past decade. This growth in prices indicates list prices
18 are not the basis for competition among these products. It
19 appears, instead, the competition has taken the form of
20 post-sale rebates, which are now some of the largest among
21 all drug classes in Part D.
22 Formulary coverage decisions by plan sponsors

1 also suggest rebates are driving competition. An outside
2 study examining coverage and costs for inhaler products
3 across seven subclasses in Part D found nearly all plans in
4 2015 covered at least one product in all classes, though
5 the product with the lowest total point-of-sale cost did
6 not always have the highest rate of coverage, as shown
7 here. In the chart, the bars show the average monthly cost
8 at the pharmacy for various asthma products in different
9 subclasses, with the gray portion showing beneficiary out-
10 of-pocket costs and the blue, the cost to insurers. The
11 lines mark the share of plans covering each product on
12 their formulary. Notice that plans were much more likely
13 to cover Proair, with 92 percent of plans covering, than
14 Ventolin, which just 56 percent covered, despite Proair
15 costing insurers twice as much as Ventolin on average,
16 before rebates.
17 The same was true among inhaled corticosteroids:
18 QVAR had the highest coverage rate despite the other four
19 products in that class having lower point-of-sale costs for
20 the insurer.
21 While we cannot know for sure why a plan sponsor
22 would be more likely to cover a product with a higher cost

1 to them, one plausible explanation is that such products
2 are providing insurers with post-sale rebates to offset the
3 additional cost.
4 As Shinobu noted earlier, when plan sponsors
5 prefer products with high rebates, cost sharing can make up
6 a larger share of the drug's net costs.
7 This graph shows, for the six largest plan
8 sponsors, enrollee cost sharing for a SMART therapy product
9 as a share of plans' costs net of manufacturer rebates.
10 Plan sponsors A through F are arrayed in no particular
11 order. Each vertical line reflects the distribution of
12 cost sharing across all plans offered by each sponsor.
13 For example, median cost sharing across plans
14 operated by sponsor A was 32 percent (denoted by the orange
15 square) that is 32 percent of net costs, compared with 48
16 percent for enrollees in a plan at the 90th percentile of
17 the distribution.
18 For every other case shown here, median cost
19 sharing was greater than 50 percent of the plan's net
20 costs. The yellow dotted line shows where costs sharing
21 exceeds 100 percent. As you can see, many sponsors had
22 some plans with cost sharing above the yellow line. For

1 example, plan sponsor B had plans with cost sharing that
2 was 168 percent of its net cost of the drug.
3 As Shinobu noted earlier, in these instances,
4 plans would bear no cost for that product and may even earn
5 a profit when it is purchased. We found similar patterns
6 for other products.
7 Our initial analysis of the DIR data found wide
8 variation in manufacturer rebates obtained by plans,
9 including among plans using the same formulary.
10 For highly rebated drugs, beneficiary cost
11 sharing can exceed plans' net costs.
12 Our case studies illustrate that what contributes
13 to large rebates may vary widely across drug classes and
14 products and likely evolves over time. Because of
15 differences in how plan sponsors are organized and
16 differences in the market dynamics of specific drug
17 classes, it is hard to predict what we might expect each
18 plan sponsor to receive in rebates.
19 We would be remiss, however, to not acknowledge
20 the fact that the landscape is changing and the drug
21 pricing environment will be very different in a few years
22 given the recent passage of the Inflation Reduction Act.

1 This law included a redesign of the Part D benefit that
2 will cap beneficiary out-of-pocket costs, increase insurer
3 liability, reduce Medicare reinsurance, and change the
4 amount owed by drug manufacturers in mandatory discounts.
5 The law also included inflation penalties which
6 will require drug manufacturers to pay rebates to the
7 Medicare program for any growth in prices faster than the
8 rate of inflation.
9 Additionally, the law provides new authority for
10 the Secretary of Health and Human Services to negotiate
11 prices for some drugs.
12 Each of these changes are likely to affect
13 manufacturers' pricing decisions which will impact the
14 availability and size of rebates. Our DIR analysis will
15 provide a baseline for evaluating how these major policy
16 changes affect rebates.
17 For our next presentation, we plan to analyze
18 data from other years to better understand the relationship
19 between rebates and changes in the competitive dynamics of
20 a product class. We also plan to examine rebates for drugs
21 affected by specific policies such as protected classes or
22 specialty-tier drugs. In all of our work, we will continue

1 to focus on understanding the potential implications for
2 beneficiaries and Medicare program spending.
3 In your discussion, aside from any questions, of
4 course, we would like to hear other ideas for analysis of
5 the DIR data.
6 And now we'll turn it back over to Mike.
7 DR. CHERNEW: Great. Before we do Round 1, I
8 think Jim wants to say something.
9 DR. MATHEWS: Yes. Just to clarify for the
10 audience who's tuning in to this presentation, Slide 14
11 presents some product-specific information on rebates, and
12 I just want to say out loud that here we are citing an
13 external health services research study. We are not
14 reporting out this information on the basis of the DIR data
15 that we have where we are subject to very, very stringent
16 limitations on the degree to which we can report out drug
17 manufacturer specific rebate arrangements. So I just need
18 to say that out loud to avoid a lot of phone calls after
19 this meeting.
20 [Laughter.]
21 DR. CHERNEW: Perfect. So, Dana, I'll save my
22 comments, so let's start with the queue.

1 MS. KELLEY: All right. I have Kenny.
2 MR. KAN: I am enthusiastic about the fantastic
3 chapter, which is based on very rich and powerful data, as
4 I know that many of such data are highly proprietary.
5 As a new Commissioner, one of my biggest pleasant
6 surprises is the high quality of the staff and analysis on
7 very complex topics. So regarding this very complex Part D
8 DIR topic, thank you for highlight, on page 17 of the deck,
9 and page 20 of the reading material, that the Inflation
10 Reduction Act could change a lot of this, or may change.
11 I, for one, believe that the Inflation Reduction
12 Act would likely substantially mitigate many of the member
13 cost-sharing and potentially reduced member access
14 implications of the study. For example, when you cap a
15 member out-of-pocket at $2,000, when you basically remove
16 the beneficiary cost-sharing in the catastrophic phase I
17 believe this would substantially mitigate some of the
18 findings. So I would be very curious if that could be
19 highlighted.
20 DR. CHERNEW: Let me emphasize one thing that
21 came up, just as we go through. We are in a little bit of
22 an awkward situation in the following sense, which is we

1 wanted data like this for a long time, we have data like
2 this for a long time. I think it's pretty clear when you
3 look at this data that there were some things going on that
4 we would rather have not been going on. Anyway, and then
5 there's been a policy response, which was highlighted on
6 whatever, Slide 17, the Inflation Reduction Act's policy
7 response.

8 So as was said, we are not going to go forward
9 and try and figure out what policy response should be
10 imposed given the data that we have looked at because there
11 has been a response. So we will be able to continue to
12 monitor this to see what happens, to see how things are
13 working. And there are a bunch of other things we will do.

14 That's just a little bit of a level-setting type
15 thing. So I'm not looking for -- to be clear -- this is
16 our next big Part D thing. And I might add, and I wasn't
17 part of the Commission so I can say this sort of a little
18 bit, some of the things you saw in the Inflation Reduction
19 Act did have some connection to some of the things that
20 MedPAC has been talking about for a long time. So I will
21 just leave that there.

22 Anyway, Kenny, thank you. But yes, I agree. To

1 your basic point about this is data and now we're going to
2 be changing some things, yes.
3 MR. KAN: Mike, great point, and I understand
4 that we are in a little bit of an awkward situation here,
5 But, you know, some very useful career advice I got early
6 on is don't bury the punchline. You know, I'm reading and
7 there's a lot of great data, very rich, and then it's at
8 the end, and then I find out later there's been a policy
9 response, and I'm trying to figure out how I should think
10 about that.
11 MS. KELLEY: I have a Round 1 question from
12 Larry. What is the rationale for rebates? Why not just
13 have competition on prices?
14 [Laughter.]
15 DR. SCHMIDT: Thanks a lot, Larry. I think
16 rebates are kind of a mechanism of price discrimination.
17 So it's the way in which manufacturers are able to kind of
18 figure out the exact willingness to pay of individual
19 payers, individual plan sponsors based on the tools they
20 have for managing and the number of enrollees they have and
21 how they've organized themselves. And it's not the only
22 market that uses price discrimination, but it is very

1 apparent in this one.
2 DR. CHERNEW: There is a considerable amount of,
3 I think, work and interest academically in trying to sort
4 through some of the aspects of this. Because that is
5 certainly true. It is a mechanism of price discrimination.
6 But there are other aspects of things that are going on
7 institutionally in the drug market that contribute to why
8 you would want to do things through a rebate. So for
9 example, some prices, for example, are tied to sort of the
10 gross, and so you might not want to change your gross
11 because of other things that are going on, and go through
12 rebates, and there's a bunch of other things. I don't
13 think we want to go through that particularly now.
14 I think, Dana, Larry was the last Round 1
15 question, which, of course, is interesting because if
16 there's any area where we need clarification, this would be
17 the topic. But I think that's fine. We should probably
18 move on to Round 2.
19 MS. KELLEY: Okay. Kenny, did you have a Round 2
20 comment?
21 MR. KAN: Yes. So there is a material
22 difference, I believe, between a standalone Part D plan

1 and MAPD. So I don't know if the data that the staff
2 looked at would be able to tease this out.
3 A standalone Part D plan would apply formulary
4 and rebate strategies to optimize financial growth and
5 quality outcomes. That may differ from an MAPD plan who
6 are increasingly much more focused on medication adherence
7 and multiple medication synchronization to optimize
8 members' whole health, you know, that will result from less
9 costly and unnecessary future health events, mitigate
10 disparities, and improve star scores.
11 So perhaps for future phases of this work can the
12 staff look into correlation between Part D star scores and
13 medication adherence and DIR economics?
14 MS. KELLEY: Stacie.
15 DR. DUSETZINA: Thank you for a fantastic chapter
16 and presentation. I'm going to start with a couple of just
17 minor comments on the report and then I have an idea for
18 kind of additional analyses that I think would be really
19 helpful.
20 One is just on page 7 in the report. I think
21 there is a little bit of a mixing two concepts, because you
22 talk about the high price of specialty drugs and the gross-

1 to-net price growth. And as you all know there is a lot of
2 variability within the specialty drug space where some
3 don't get rebates. I think teasing those two things apart
4 a little bit more would be really helpful in the chapter.
5 I love that you did with the within and across
6 formulary analysis. As soon as I started reading into it,
7 I was like, oh, could you look at it within formularies or
8 standardizing of the formularies, and then you did. I
9 always love when you anticipate all of my data needs, and
10 it was great.
11 One of the things I did wonder, though, is
12 whether the variation in rebates by the same plan sponsor
13 could be differences in sales volume and getting to some
14 sort of target volume-related discount. So I didn't know
15 if you had the ability to look at like the size of the plan
16 or something like that to get at maybe whether volume was
17 the other piece that was missing when you saw those
18 differences within a plan sponsor.
19 The last kind of broader comment I think is
20 really related to, I don't think you buried the lead with
21 the Inflation Reduction Act, and I don't think it's going
22 to solve all of the problems here. I think it will solve

1 some of the gross-to-net price issue with the prices being
2 limited, the list prices being limited to rate of inflation
3 over time. But we don't know yet whether plans will use
4 copays or co-insurance for that long initial coverage
5 phase. So we know it solves the coverage gap problem.
6 So one of the things that I think would be really
7 helpful, and I think in general would be helpful for this
8 type of information, is how often do plans use copays in
9 these circumstances for drugs that have these large
10 rebates? So especially we see this like egregious data
11 that show that patients are dramatically overpaying
12 relative to their stated cost share, but it would be
13 helpful to know, in the initial coverage phase, what
14 percent, in those cases, use copays. My assumption is many
15 use copays in those phases, which makes this problem less
16 concerning, because we want plans to pick the drug with the
17 biggest rebate and the lowest net price. We just don't
18 want that to harm the beneficiaries.
19 So I think that contextually would help and maybe
20 would help to kind of give us a little bit more information
21 about like do we think that plan sponsors will still have
22 really strong incentives to offer those drugs that copays

1 under the new benefit design in 2025. I certainly hope so,
2 but we just don't know for sure.
3 I think that, going to Kenny's point about the MA
4 versus PDP, that would also be a nice breakdown for those.
5 So are we seeing different behaviors in the offering of
6 high-rebated drugs with copays in the initial phase for MA
7 plans versus PDPs.
8 And I think, in general, if it's possible,
9 especially when looking at these, I always kind of do the
10 same thing. I liked your case studies. I always give
11 insulin as the case study to teach students about rebates
12 and what that means from the consumer's out-of-pocket cost
13 space. But then I follow it up with this is an extreme
14 example because many, many drugs aren't in this high of a
15 rebate category. And I wonder if it's possible to show
16 what percent of brand-name products have rebates that are
17 high enough that patients would be paying more than the
18 plans.
19 So just as a kind of high-level, like how often
20 does this problem happen I think would be nice context for
21 the chapter, so that people don't walk away thinking that
22 this is really representative of all of the behavior of

1 plans and the drugs that they cover.

2 I'm a huge fan of all of you and this work. I'm

3 really excited to see where it's going.

4 MS. KELLEY: Scott.

5 DR. SARRAN: Yeah, excellent and important work.

6 For many years I've been struck by the perverse at least

7 potential of rebates as well as the opacity of them, and

8 I've had the same question in my head for many years that

9 Larry raised, about would the world be better without

10 rebates. But understanding that's not going to be an

11 immediate option I focus in my mind on the other concern

12 which is the opacity of rebates as they exist, and

13 understanding how pharma and PBMs and plans want to

14 maintain that opaque nature under the umbrella of needed

15 proprietary protections so that their idea of the free

16 market works well.

17 You know, I'm just so struck by how the opaque

18 nature, both on one hand inhibits our understanding of how

19 well the market is or isn't working to serve their consumer

20 and the taxpayer, and it's antithetical to the principle of

21 transparency that I think we all believe is important and

22 pretty widespread in its application to understanding how

1 taxpayer money is being spent and how beneficiaries' money
2 is being spent.
3 So I just think there should be some exploration,
4 at least, of the pros and cons of making all rebate data
5 public. I understand it's not simple, but I think it
6 should at least be discussed.
7 MS. KELLEY: Amol.
8 DR. NAVATHE: Thanks. Fantastic work. I think
9 obviously this is very interesting and sometimes
10 provocative data, and I think you've done a very nice job
11 of leading us through it in a systematic form since we
12 received the data.
13 A couple of comments, really a comment and a
14 question in a sense. First off, I like Stacie's comments a
15 lot. I think to some extent there are these very eye-
16 catching pieces of the analysis where we see that there
17 could be net profits to a plan sponsor if a beneficiary
18 uses a particular drug.
19 I think to the extent that it is possible, if we
20 could match it with Part D claims to get a sense of how
21 often this is happening, I think contextualizing this would
22 be really helpful for us to interpret. I think eye-

1 catching is different in some sense than expansive problem,
2 and I think we should try to do our best to understand,
3 understanding that it is obviously the prevailing historic
4 system and some of that might change. But at least in the
5 context that would be very helpful.
6 The second point somewhat relates to Scott's
7 point, which is I think certainly the market economists
8 amongst us would say we want a really well-functioning
9 market here and price transparency, in some sense, is often
10 a feature of a well-functioning market, but it depends on
11 where that price transparency is and how it's influencing
12 choice. And I think there are a number of layers of
13 dynamics here that are somewhat complicated.
14 And so what I am curious about is, in some sense
15 we also have this trend towards this notion of real-time
16 benefit checks where through EHRs we can get access to what
17 the benefit design is and therefore we can then understand
18 what the transparent cost is to the patient at the point of
19 care, or at least at the point of sale.
20 And so this is just an open question, Round 1,
21 Round 2, Round 3 style, which is, from your expertise and
22 your sense, given that the rebates are sitting behind this,

1 is that level of transparency ultimately giving the
2 beneficiary the information that they need, and to some
3 extent the price transparency that Scott is talking about
4 is behind the curtain. It's not transparent. It's behind
5 the curtain. But ultimately the beneficiary may get what
6 they want if we implement this real-time benefit check.
7 And I am just curious if you can comment on that in the
8 context of the dynamics around price transparency.
9 DR. SCHMIDT: So they're not, obviously, not
10 seeing the rebate piece of it, but I wouldn't say that it's
11 not beneficial at all, in the sense that if they are using
12 copays, for example, at least they could be made aware of
13 that. And it gets the bene to the point of being able to
14 say, hopefully with the prescriber right there, you know,
15 "What are my options, at least in terms of my copay?"
16 So I think that's still a beneficial thing. It's
17 not necessarily getting to what is the absolute lowest
18 cost, of course, as you are pointing out.
19 MS. SUZUKI: So one thing we have highlighted in
20 the paper is that manufacturers are giving rebates for a
21 better placement, and that typically means you're on the
22 preferred tier which has copays as Rachel mentioned. And

1 so I think there is some benefit to allowing beneficiaries
2 to see in real time the copay amount rather than the co-
3 insurance amount, which can be much higher than the copay
4 that the plans set for preferred tier.
5 MS. KELLEY: Stacie, did you want to weigh in on
6 this question of transparency?
7 DR. DUSETZINA: Yeah. I just wanted to mention
8 that in the prior report on this we're trying to get a
9 little bit at some of the economic arguments against price
10 transparency that have been brought up forever, which
11 include that some organizations are getting very large and
12 generous rebates that lower the net spending on the program
13 and others are not. And so there is this concern that if
14 you have full price transparency everyone will regress to
15 the mean, or the ones that are getting a good deal will not
16 get a good deal.
17 So some of the initial work that the group did is
18 trying to look at variability in average rebates by plan
19 sponsor and size and things like that, to try and see if we
20 see those types of signals, that there really are very
21 large differences in the negotiations. Because there is so
22 much consolidation over time in the plan sponsors and PBMs

1 there is a big question in my mind of is that actually true
2 or is everybody getting roughly the same deal, in which
3 case transparency would not harm or we would actually have
4 low prices and everybody is getting the same low prices.
5 Just they're not being transparent about it.
6 So I think that was part of what was reflected in
7 the prior set of work, that was in March or June. So I
8 think we're trying to get at some of those longstanding
9 economic arguments against transparency because every
10 effort that has been made for that at all it results in a
11 lot of lawsuits. So there is a lot of fierce arguing
12 against it.
13 DR. CHERNEW: So let me just add, the economics
14 behind this is complicated in a range of ways, and there
15 are both efficiency and equity issues that are playing out
16 here. So very broadly, almost unrelated -- not unrelated
17 but not directly specific to this, price discrimination
18 inherently is not a bad outcome in particular types of
19 markets. And what we're trying to do is we have a market
20 in which manufacturers have exclusivity, and we could
21 debate a whole bunch of things around that.
22 And so the PBMs are a source of competition

1 promoting it, and the process we have allows that to play
2 out, at least in theory. But as is pointed out in the
3 chapter, there are a ton of places where that goes awry
4 that's just frustrating, including what I think we see your
5 examples is the most egregious is where people are actually
6 paying more out of pocket for a drug than the actual net
7 cost of the drug is.
8 And part of what is happening is because of the
9 nature of competition premiums are going down some, and it
10 is being financed in part by targeted beneficiaries that
11 are being charged more in ways that they might have a hard
12 time of sorting out, and there are an enormous number of
13 other, I would argue, administratively complex things --
14 real-time benefit adjudication things, copay card issues,
15 although Medicare can't do copay card issues -- but there
16 are a slew of other things that are happen morning broadly
17 in the prescription drug market that make this complex, to
18 make the economics.
19 But I think our main concern here is to have the
20 data and understand sort of what is going on, and then
21 we'll be able to track this going forward. I think the
22 issue of copays versus co-insurance is a particularly

1 interesting one because of the difficulties in how people
2 shop and how it gives rise to a lot of the underlying
3 problems.
4 We are not in a stage now where I think we are
5 prepared to make particular recommendations about what we
6 will do, in part because we have a law that we just passed
7 and we are going to have to see how that plays out, as
8 Kenney said before. But I think tracking particularly what
9 is happening to individuals and how competition is working
10 in this market is going to be important.
11 And so we get sort of some insight with all of
12 this data, but it's very hard to make normative judgments
13 when you see disparities across things, right, because you
14 have market power on the -- not only do you have market
15 power at every point on that chart. At every point on that
16 chart there is some market power, and then there are
17 vertical connections between all of them. If Bruce Pyenson
18 were here, he would point out that the organizational
19 connections between these groups are very complicated, in
20 both the PDP and the MA market.
21 So I think now we are, again, like in the last
22 session, in sort of a reporting what's going on phase, and

1 will, over time, I think, begin to develop if something
2 more needs to be done. I am sort of where Stacie is, that
3 the Inflation Reduction Act will surely not solve all the
4 problems we think might need to be solved in this space but
5 we are going to have to figure out how that plays, in a
6 bunch of other ways. So for example, we are going to have
7 to see how that plays on innovation of drugs, which has
8 been another sort of topic that we worry about. So there
9 are a lot of puts-and-takes.
10 Sorry. That was longer than I intended it to be.
11 MS. KELLEY: Amol had something on this point?
12 DR. NAVATHE: Yeah. I was simply going to point
13 out, in some sense, that I think what we mean by price
14 transparency may not be interpreted by everybody the same
15 way, and to your point, Mike, I think there is a lot of
16 layers here. And so, if we mean price transparency to the
17 beneficiary, this real-time benefit check kind of tool
18 essentially sort of accomplishes that.
19 And I think it's unclear about advocating in
20 either direction that, given the system that we have and
21 what Stacie was pointing out, that there may be puts and
22 takes in terms of thinking about what across-the-board

1 rebate and price transparency would look like if it were up
2 to the entire system. And it's unclear to me, at least,
3 that beneficiaries, if they know what the rebate is, if
4 that's really going to influence their choice if they're
5 relative to knowing what the price they're going to pay is
6 in a copay setting.
7 So I think it's a nuanced thing, and I think when
8 say price transparency, I think it means very different
9 things to different people, and we should just be aware of
10 that.
11 MS. KELLEY: Cheryl.
12 DR. DAMBERG: I just want to say thank you for
13 this great work. It's just so exciting these data are
14 available and we can start to get greater insights into
15 this space. So that's incredibly welcome.
16 So, Mike, you stole my thunder over there.
17 I just was like -- was reading through this. I
18 just kept going, how come we're not talking about
19 consolidation and sort of all the perverse kind of market
20 incentives that are in play here? And that we really --
21 like this market is not functioning in a way that is
22 delivering value, and so I would hope at some point that

1 the Commission would try to spotlight that more. I don't
2 know whether this -- it's in this particular chapter or a
3 future chapter and what the implications are and what, if
4 anything, policy can do to sort of affect a lot of those
5 perverse incentives that are in this market.
6 DR. CHERNEW: If I'm correct, Dana, Cheryl was
7 the last in the Round 2 queue, and so let me just say a few
8 things, and then I'll try and watch the chat. We'll close
9 up.
10 So I agree with all of that. This is a
11 complicated area because so many of these things are
12 happening outside of MedPAC in the broad environment, and
13 so the sort of ways in which we kind of engage in Part D
14 space, for example, a lot of stuff on the Medicare benefit
15 design issue. In Part B space, you're going to see a lot
16 of stuff on promoting competition. We'll have a whole
17 bunch of Part B work. Some of that could deal with Part D
18 as well. You'll see some of those things, like alternative
19 kind of work, for example, in ASP+6.
20 So there's going to be ways in which we engage.
21 How many of the bigger-picture issues that are dealt with
22 and how the prescription drug market works in this country

1 are kind of beyond where we will really get to, although
2 your point, which I take as reasonable, it is useful to
3 point that out in the context of what's going on here,
4 certainly the consolidation between these different
5 sectors. It is relevant, and so, as Ken said, it has
6 ramifications for MA and certainly for the Part D stuff.
7 So, again, I think here's what I take from this
8 discussion. It's really great that we have this data. We
9 will be able to do things that heretofore we had not been
10 able to do. We have a particular concern with how the
11 beneficiaries are experiencing access to the medications,
12 and I think we would broadly agree that making sure that
13 beneficiaries have access to medications is a sort of core
14 goal to promote quality, I think, in most of the important
15 chronic conditions and areas like cancer and, you know, a
16 bunch of places. The innovations in the drugs that people
17 have access to is crucially important, and making sur that
18 we can maintain that in a fiscally sensible way, I think,
19 is sort of a core goal.
20 So, going forward, I think we're going to
21 continue to monitor this. There's obviously a lot of
22 changes in the market, but changes aren't going to really

1 bite in the near term. It's going to take a while for the
2 new law to really work through to see what's happening. So
3 we will continue to find places where I think -- I've said
4 things like this in the past -- where there's issues
5 particularly in the nooks and crannies of execution on the
6 distribution of things, where we can find a policy way and
7 to improve it, without trying to totally reform how we deal
8 with drug pricing and distribution in this country is
9 probably where our sweet spot is going to be, because
10 there's a lot of things in this space that get talked
11 about. We could use the rest of our time having Stacie go
12 through them.
13 [Laughter.]
14 DR. CHERNEW: That are outside, they're outside.
15 I mean, we're not -- just to be clear, we're not going to
16 talk about a bunch of broad price index regulation. We're
17 not going to talk about a bunch of reimportation things.
18 We're not going to talk -- I mean, there's a bunch of broad
19 issues here that we're not going to get into.
20 We're going to find the places that are
21 particularly Medicare-oriented and try and make sure that
22 we can do the best for the beneficiaries and the program

1 within that kind of lane.

2 So I hope you all continue to be as excited about
3 having the data as we are to see it, and I'm just looking
4 to see. So it looks like I'm going to pause for a second
5 to see if anyone wants to say anything else.

6 [Pause.]

7 DR. CHERNEW: So, for those of you at home, as
8 always, we want to hear your comments on this topic, and
9 you can reach us at MeetingComments@MedPAC.gov or go on to
10 the website and leave us comments, reach out to the staff,
11 to the Commissioners. Again, thank you for a wonderful end
12 of September to bookend the wonderful beginning of
13 September, and again, I think I will thank the staff for
14 all of the work that they did.

15 And, as an aside -- and I was mentioning this to
16 Jim before the meeting -- it may not always be clear how
17 hard it is to run this sort of logistics of all that we
18 have to do in the world that we live in, and actually, I am
19 really amazed at how well -- this is our real -- it's the
20 third meeting we've had in person since I've been chair,
21 public meeting we've had in person since I've been chair,
22 and the logistics of how it's worked have really been

1 really done well. So a special shout out to all the folks
2 that make that part happen, because it seems seamless, but
3 it is not. So, again --
4 [Applause.]
5 DR. CHERNEW: So, with that, broad thanks in a
6 complicated world, everybody, travel safe, and we'll see
7 you in a month. It will seem like two weeks.
8 [Whereupon, at 11:20 a.m., the Commission was
9 adjourned.]
10
11
12
13
14