SUBJECT: **SUPPORTING SAFETY-NET CLINICIANS**
DATE: **SEPTEMBER 29, 2022**

Overview:

This session focused on policy options to better support clinicians who act as a safety net for Medicare beneficiaries. The Medicare program strives to ensure access to care for all beneficiaries, yet beneficiaries with low incomes may have more difficulty accessing care. Clinicians who treat high shares of low-income beneficiaries may experience financial strain, which may further undermine access to care and/or impact quality of care. This session reviewed framework developed in the June report to Congress, reviewed the definition of low-income beneficiaries, described safety-net clinicians, and sought to understand adjustment options for clinician safety net add-ons. Commissioners provided feedback on the presentation and voiced their opinion on the direction of future analytical work.

Presentation (link):

MedPAC's Framework:

- Framework (Step 1): Identify safety-net clinicians.
    - Safety-net providers are those who treat a disproportionate share of:
        - Medicare beneficiaries who have low incomes and are less profitable than the average beneficiary, or
        - The uninsured or those with public insurance that is not materially profitable
    - Providers who treat a disproportionate share of such patients could be financially challenged, which could lead to negative outcomes for beneficiaries
- Framework (Step 2): Decide whether new Medicare funding is warranted to support safety-net clinicians.
    - Because Medicare faces substantial challenges, Medicare should only spend additional funds to support safety-net providers if:
        - There is a risk of negative effects on beneficiaries without new funding
        - Medicare is not a materially profitable payer in the sector
        - Current Medicare payment adjustments cannot be redesigned to better support safety-net providers
- MedPAC defines low-income beneficiaries as all LIS beneficiaries who receive:
    - Full Medicaid benefits,
    - Partial Medicaid benefits, or
    - The Part D LIS

Applying the Framework to Clinicians:

- Framework (Step 1): Identify safety-net clinicians.
    - Clinicians do not submit cost reports, so cannot measure profitability directly
    - Clinicians are prohibited from collecting cost-sharing from most LIS beneficiaries
    - Most states do not make cost-sharing payments on behalf of dually eligible beneficiaries
    - Reduces clinician revenue by an estimated $3.6 billion annually
    - Some clinicians serve a disproportionate number of low-income beneficiaries
- Framework (Step 2): Decide whether new Medicare funding is warranted to support safety-net clinicians.

    - LIS beneficiaries report having more difficulty accessing clinician care
    - Cannot measure profitability directly, but clinicians tend to receive less revenue when treating low-income beneficiaries
    - Targeted financial support for safety-net clinicians does not exist in the physician fee schedule

Clinical Safety-Net Add-On Payment:

- Potential clinician safety-net add-on payment
    - For physician fee schedule services furnished to LIS beneficiaries, Medicare would make add-on payments based on a percentage of full rules
    - Add-on payments could vary on two dimensions (percentage of the add-on and whether the percentage varies by type of clinician)
    - The cost of add-on payments would be funded by new spending
- For fee schedule services furnished to LIS beneficiaries:
    - Option #1 – 5% add-on for all clinicians
    - Option #2 – 10% add-on for all clinicians
    - Option #3 – 15% add-on for primary care clinicians and 5% add-on for other clinicians
    - Option #4 – 20% add-on for primary care clinicians and 5% add-on for other clinicians
- Policy and operational issues
    - Magnitude of the safety-net add-on; add-on adjustment needs to be large enough to address issues faced by safety net providers, but needs to be fiscally responsible
    - Different add-on adjustments for different types of clinicians; primary care may need more assistance.
    - Total payments may exceed the fee schedule payment rate; if capped at the fee schedule this could reduce the effectiveness of the safety-net policy
- Clinician safety-net payments and Medicare Advantage (MA)
    - LIS beneficiaries enrolled in MA report having more difficulty accessing care than non-LIS beneficiaries
    - Could apply a similar add-on payment for clinician services in MA
    - Little is known about MA cost-sharing payments for dually eligible enrollees, so it is difficult to quantify differences in clinician revenue for LIS beneficiaries

Questions for Commissioners:

- Should staff continue to develop clinical safety-net policy?
- What is the appropriate magnitude of safety-net add-on?
- Should certain types of clinicians receive a higher add-on?
- Should total payments be permitted to exceed the allowed payment amount?
- How should safety-net payments apply to LIS beneficiaries enrolled in MA?

Discussion:

Overall, all Commissioners were supportive of this work and acknowledged the importance of the discussion. While the group had various opinions on the four options, they collectively disliked Option #1.

Jonathan Jeffery asked a clarifying question about the differences between primary care physicians and non-primary care physicians, citing variable averages. Staff responded that there is a lot of variability, but the way this policy is set up, the add-on payment would correspond with how much of the revenue is for LIS beneficiaries. Those at the top scale would get more add-on payments.

Lynn Barr highlighted the difference between rural and urban areas, mentioning that there was a recommendation in the June chapter to not consider rural health centers and federally qualified health centers (FQHCs) because they are paid more than the physician fee schedule. Staff shared that the thinking is FQHCs generally get paid at a higher rate, so there is not quite as much need. The clinicians are paid on a piecemeal basis and while there might be an argument for extending payment to them, the staff wanted to initially focus on safety net clinicians because the payments tend to be lower and there are more dollars to reallocate.

Lynn Barr asked how the data of LIS beneficiaries are compiled. She noted that if someone is disabled, they are not automatically enrolled in MA. Staff explained that more people are eligible for MA than the number of people who are enrolled.

Lynn Barr highlighted that about 29% of LIS beneficiaries suffer from delayed care due to cost. She asked if the Commissioners should be thinking about that in this policy. Staff noted that this policy does not address the cost of care for the beneficiary, it is focused on the clinician's perspective.

Amol Navathe clarified that there is no conditionality with Part D enrollment when defining LIS. Staff confirmed that is correct but mentioned that most beneficiaries are dually enrolled.

Marjorie Ginsburg highlighted two sets of issues: LIS-eligible beneficiaries may need more care and attention than the physician fee schedule allows, and augmenting payments may lead to states being less attentive to paying their "fair share." She disagrees with the tentative language about LIS being less profitable. Staff noted that unlike hospitals with cost reports, there is not that information available for clinicians, so other data points like revenue must be used.

Cheryl Damberg noted that she didn't see any reference to Medicare providing additional payments to Dual Eligible Special Needs Plans (D-SNPs) and asked how much of those payments will trickle to physicians.

Marjorie Ginsburg asked if there is any other policy that always Medicare to pay physicians directly, instead of through the plan. Staff responded that to their knowledge, this does not exist, but there is an analog in Part A where Medicare makes payments directly to teaching hospitals that reflect the volume of Medicare Advantage beneficiaries.

Lynn Barr supports Option #3 citing the importance of acknowledging the issue of not getting copays. She also noted this applies to rural health clinics, which use cost-based reimbursement.

Michael Chernow highlighted that the goal of the meeting is not to solve for rural beneficiaries and urged Commissioners to stay within the bounds of safety net clinicians. Staff agreed and highlighted that the rationale for the framework included mitigating financial vulnerability at the provider level, so providers who serve vulnerable populations can continue to do so.

Jonathan Jaffery mentioned that he favors Option #4 but asked if this is providing enough support to clinicians that care for LIS and addressing disparities.

Stacie Dusetzina shared that she favors Option #3 and is interested in hearing more thoughts on the Medicare Advantage question.

Jaewon Ryu is in favor of continuing to develop this area of work.

Amol Navathe noted that it would be helpful to see distributions of each option.

Gregory Poulsen highlighted that equity should be addressed in the policy. He also noted that he disagrees with becoming involved in the Medicare Advantage provider space. He is in favor of Option #2.

Betty Rambur is in favor of Option #4, noting that primary care is underinvested.

Kenny Kan is in favor of Option #2.

Dana Safran shared that she is not in favor of connecting this policy to Medicare Advantage.

Cheryl Damberg is in support of the extra payment going to the physician. She noted that with taking the allowed payment amounts, parity is achieved, but asked if there should be more done. She asked about setting up a cap on how much it could exceed. She is in support of Option #3.

David Grabowski is in favor of Option #4 and mentioned he appreciates the emphasis on primary care but agrees with Greg's comment on Medicare Advantage.

Marjorie Ginsburg is in favor of Option #3 of #4 but favors #3 more.

SUBJECT: MANDATED REPORT: EVALUATION OF A PROTOTYPE DESIGN FOR A POST-ACUTE CARE PROSPECTIVE PAYMENT SYSTEM
DATE: SEPTEMBER 29, 2022

Overview:

MedPAC is required to submit a report analyzing the potential impact of the Department of Health and Human Services' proposed uniform prospective payment system (PPS) for four types of post-acute care (PAC) providers in June 2023. MedPAC members generally agreed with the proposed approach for the review, and the details of HHS's model will be discussed during the November meeting.

Presentation (link):

Background:

- Patients served in home health agencies (HHA), skilled nursing facilities (SNF), inpatient rehabilitation facilities, and long-term care hospitals (LTCH) have similar conditions and comorbidities, but Medicare payments for the providers are substantially different.
- The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 required MedPAC and HHS to explore the development of PPS based on patient characteristics for these PAC providers, uniform patient assessments, and quality measures.
- MedPAC created a report in 2016 that demonstrated that the development of a PAC PPS could be feasible given available data and potential budget impacts.
- In July 2022 HHS designed a prototype PAC PPS, which MedPAC will analyze in detail during the November 2022 meeting.

Additional Implementation Considerations:

- Changes in payments for SNFs, HHA, and LTCH may have moved them away from rehabilitation care and towards more medically complex care.
- COVID-19 impacted providers costs, staffing, and service delivery and shifted beneficiaries' use of different PAC settings. MedPAC anticipates that some of these changes will continue after the end of the pandemic.
- Other alternative payment models in use are shifting PAC use to lower-cost settings and shorter stays.

Challenges to Implementation:

- Alignment of regulatory requirements, particularly for staffing, so all providers face similar operational costs.
- Poor quality of patient function data using current assessment tools.
- Strategies to address anomalous data from years impacted by COVID-19.

HHS Prototype Design:

- Base rate adjusted by case-mix group assignment, comorbidities, rural location, and setting where the patient was treated.

HHS discusses using updated data, pairing PPS with a value-based purchasing program, regulatory alignment and aligned cost sharing.

Next Steps:

- November 2022: review analysis of HHS's prototype, based on:
  - Accuracy and equity of payments
  - Ability to explain cost variation across stays
  - Estimated impacts on providers
- March 2023: outline additional diagnostics for the Centers for Medicare and Medicaid Services (CMS) to complete as it updates the prototype with more recent data and review the draft MedPAC report
- April 2023: final review of MedPAC report and vote on recommendations

Discussion:

Lynn Barr asked if the quality elements of the PPS plan could be expanded to include swing beds, which are prevalent in rural areas. She also noted that the HHA recommendations were not aligned with rural states' experiences in struggling to find providers. This may be masked by overutilization in Texas and Oklahoma.

Dr. Carter agreed to consider discussing requirements for rural swing bed providers but noted their analysis would not be able to evaluate if the PPS model would improve rural access.

Dr. David Grabowski asked if the functional assessments are completed in the hospitalization or in the PAC setting.

Dr. Carter responded that most of the data is collected from the PAC and supplemented with hospital data as relevant.

Dr. Robert Cherry asked for clarification on whether the challenge related to accurately measuring functional status was due to the availability of the information or based on the model used to assess the patient.

Dr. Carter responded that some data is missing and that the recorded data may be inaccurate, particularly when there are payment incentives to rate a patient's function lower to access higher rates. He also noted that the measures used across settings are consistent, but the data overall may be biased.

Dr. Amol Navathe asked why the setting type was incorporated into HHS' model if the goal is to move towards uniform payment.

Dr. Carter noted this would be discussed more next month, and that it may have been included as a predictor of the cost of care.

Dr. Kenny Kan expressed his support for the plan and asked for additional information on how the model performs when back-tested and if there is flexibility to account for possible impacts of long COVID.

Dr. David Graboski noted that the goal of this effort is to reduce inefficiencies and distortions caused by paying for costs in settings with similar patient mixes. The new model will help sort individuals into settings that best meet their needs, but an alternative payment model may better help address the problem of low-value PAC. Additionally, harmonizing regulations, cost sharing, and quality measures across settings will be beneficial, regardless of the final PPS recommendations. However, he cautions that because HHA relies on family supports, we need to account for social factors in the model to ensure it does not result in distortions for individuals without those supports. Finally, he noted that initial evaluations of patient characteristic-based payments to SNFs showed that after implementation there was a notable spike in up-coding and cautioned that MedPAC will need to ensure that PAC coding used in PPS needs to be accurate.

Mr. Poulsen expressed concern that it will be difficult to meaningfully capture different patient characteristics, including family support and social considerations. He was also concerned that the group is setting HHA apart from the other PAC settings, when technological advances could soon feasibly support higher acuity patients in lower cost HHA PAC. Instead, the model should consider the individual's total clinical and social needs and find the most effective and cost-effective setting that meets those needs.

Dr. Scott Sarran noted that PAC settings were established with rigid business models to deliver specific benefits, rather than improving beneficiary outcomes. In developing the PAC PPS, MedPAC has the opportunity to implement outcome-based payment methods to improve communication, coordination, and services for beneficiaries.

Dr. Cherry noted that while initial models will need to rely on current patient characteristics, further research is needed on their related functional outcomes to inform and refine the payment model in the future.

Dr. Grabowski and Dr. Safran agreed. **Dr. Safran** also noted that further investigation into functional outcomes may be beyond the scope of this immediate report but would benefit from additional engagement with experts to help facilitate the transition to value-based payments.

Dr. Navathe stated that he would request additional information on the reliability of functional assessment data to support MedPAC's recommendation on the model.

Dr. Cheryl Damberg recommended the committee consider implementing additional auditing of functional assessment data or exploring opportunities to incorporate electronic health record data to determine if the individual is in the most appropriate setting.

Dr. Betty Rambur noted that many agencies' largest expense was staffing and that while HHA has the lowest costs, that may be partially driven by lower salaries. Given current workforce shortages, and the value of care provided by HHA, Medicare may need to reconsider if the lower HHA costs are still appropriate.

SUBJECT: NURSING FACILITY STAFFING
DATE: SEPTEMBER 29, 2022

Overview:

Recognizing the ongoing workforce challenges facing the healthcare industry generally and particularly for nursing facilities, MedPAC reviewed nursing facility (NF) staffing requirements set by federal and state governments, how the Centers for Medicare and Medicaid Services (CMS) collects staffing data from the facilities and analyzed staffing trends through the COVID-19 public health emergency. MedPAC plans to continue analyzing this staffing data and exploring how it relates to overall facility costs, patient access, and other trends.

Presentation (link):

Background:

- About 1.2 million people work in 15,000 nursing facilities in the U.S., serving a resident population that is mostly Medicare eligible.
- Federal Medicare and Medicaid NF staffing standards were established under the 1987 Nursing Home Reform Act, and have not been updated since, however, 38 states and D.C. have set a variety of additional standards.
    - 11 states have wage pass-throughs directing a portion of Medicaid rate to staff wages and benefits
    - 32 states and D.C. have cost-based payment policies that tie a portion of Medicaid rates to allowable direct care costs
    - 16 states have value-based payment programs with staffing measures
- CMS reported in 2001 that residents in NF with staffing below critical levels were at significantly higher risk of experiencing quality of care problems but did not update federal staffing requirements based on these findings.
- CMS is currently studying the level and type of staffing needed to ensure safety and quality care in NF with Payroll-Based Journal (PBJ) data reviews, site visits, and literature reviews. They plan to propose a new minimum standard within one year.

Collection of NF Staffing Data:

- The Certification and Survey Provider Enhanced Reporting (CASPER) system was initially used to collect self-reported staffing data from NF; however, studies have found this data to be non-representative.
- The Affordable Care Act (ACA) required CMS to use PBJ and other auditable data to collect information on NF staffing.
    - PBJ includes daily, paid nursing staff hours by staffing category
    - May not include unpaid hours worked for salaried staff
    - Does not reflect the intensity of workload, which notably increased during COVID-19
- CMS publicly reports on PBJ data on Care Compare
    - Also used in star ratings, state survey process (i.e. investigations of staffing)

  - FY 2023 Skilled Nursing Facility (SNF) final rule adopted PBJ staffing measure in value-based purchasing (VBP) for SNFs in FY 2026

MedPAC Analysis of PBJ Data 2019 – 2021:

- Total nursing staff hours and resident days declined during COVID-19, and by the end of 2021 had not returned to pre-pandemic levels.
- Nurse aide staff hours per resident were relatively stable, with some decline at end of 2021
- Use of contract staff nearly tripled from 2019 to 2021, with the largest growth for CNAs and LPNs
  - Impact on sector-wide cost data as contractors are more expensive
- MedPAC will continue to analyze PBJ data and look for additional trends, facility-level variation, access to NFs by staffing level, and staffing level's relationship with facility costs and margins.

Discussion:

Dr. Stacie Dusetzina asked how unpaid sick time, which is more common for lower-level workers, impacts the observed trends and if the downturn could be attributed to individuals leaving the workforce or going on unpaid sick leave.

Ms. Linehane replied that the PBJ data only includes paid staff hours and cannot distinguish between working hours and paid time off. She also noted that other research has shown that there are staffing declines immediately after a COVID outbreak in a facility, which could potentially be due to workers taking sick leave.

Mr. Kenny Kan asked if future analysis could incorporate variations in minimum staffing requirements by facility.

Dr. Mathews noted that MedPAC is not currently capable of making determinations about minimum staffing requirements, but that these analyses could help inform CMS' development of new standards.

Dr. Jonathan Jaffery recommended future analysis incorporate state payment and other policies that would also impact NF staffing levels before MedPAC considers making any federal recommendations.

Ms. Linehan agreed that a qualitative description of relative state policies could be considered in future research.

Dr. Scott Sarran asked if MedPAC could use this data in relation to acuity, outcome measures, or source state data on Medicaid per diem payments to see how staffing correlates with payments and results in outcomes.

Ms. Linehan noted that CMS is currently assessing the relationship between staffing and quality measures and that MedPAC recently reviewed NF requirements, payment rates, and staffing levels but have not published the analyses yet.

Dr. Chernew also replied that NF staffing is related to funding from Medicare, Medicaid, and private payments and that acknowledging this interplay will be important. However, MedPAC's analyses will primarily focus on Medicare.

Dr. Cheryl Damberg asked if it would be possible to link PBJ staffing and acuity data. **Ms. Linehan** agreed it would be possible.

Dr. Betty Rambur asked if the PBJ data incorporate geriatric nurse practitioners that are in-house full or part-time.

Ms. Linehan replied that this is not included in nursing staffing data, and also noted there are additional therapy staffing data that MedPAC has not yet analyzed.

Dr. David Grabowski commented that he believes CMS underweights staffing data in the star ratings because prior data was so poor and that he would support a MedPAC recommendation urging CMS to weigh those measures more heavily. He noted that the staffing and resident day graph does not fully convey the crisis faced by NF due to COVID-19 because it does not illustrate how case mix has intensified and staff burden has increased. He cautioned that the Biden Administration minimum staffing standard is good in a vacuum, but he is concerned about how much additional funding is going to be needed to support the new standards. Finally, he mentioned research showing that in parts of the country with higher immigration, they have better NF staffing levels and better quality care. Therefore policies that impact immigration will also impact NF staffing levels.

Dr. Betty Rambur commented that NFs are competing for nursing staff against the entire healthcare market, and for NF to remain competitive employers, Medicare and others will need to reconsider rates and staff salaries. She also suggested that MedPAC recommend funding graduate nurse education funding to prepare geriatric nurse practitioners to work in NFs.

Mr. Greg Poulsen noted that the U.S. is likely going to see a rise of technology to partially replace worker-based care and services in the next few years and that MedPAC's recommendations should look more broadly at ways to address patients' needs.

Dr. Cheryl Damberg is interested in further exploring how staffing levels vary by funding mix for patients and profit margins for NFs.

Dr. Robert Cherry noted that staffing challenges limit access to SNFs on weekends, which creates challenges for hospitals and health systems trying to decompress and reduce lengths of stay. He also noted the importance of reviewing social services and case management services that support patients throughout their NF stay.

Dr. Scott Sarran suggested looking at how staffing relates to Part B provider visits and the penetration of institutional SNPs within an NF.

SUBJECT: **MANDATED REPORT: STUDY ON THE EXPANSION OF TELEHEALTH**

DATE: **SEPTEMBER 29, 2022**

Overview:

Based on the Consolidated Appropriations Act, the Commission must submit a report to address the use of telehealth services, related expenditures, and Medicare payment policy. The Commission discussed alternative payment approaches under the Physician Fee Schedule (PFS) and Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) systems. The presentation and roundtable discussion compared pre-pandemic telehealth coverage to current coverage to consider potential payment models for after the end of the Public Health Emergency (PHE). The Commission emphasized the complexity of paying for telehealth in a fee-for-service (FFS) system and outlined alternative payment models based on bundles and chronic care management. The Commission will release the report in June 2023.

Presentation (link):

- Background:
  - The telehealth report due June 2023 must cover the use of telehealth services, Medicare expenditures on telehealth, Medicare payment policy for telehealth services and alternative approaches under the PFS and the FQHCs and RHCs payment systems, and the impact of expanded coverage on access to care and quality.
  - Prior to the PHE, telehealth coverage was flexible in Medicare Advantage and two-sided ACOs but limited under PFS. Use of telehealth services was very low.
  - At the start of the PHE, Medicare temporarily expanded coverage to allow telehealth services for beneficiaries originating in their homes, payment for over 140 additional telehealth services, and PFS rate is the same as in-person service.
- Policy Options for Post-PHE Telehealth:
  - **Option 1:** Medicare should continue certain telehealth expansions for a limited duration (e.g., pay for specific services regardless of location, cover telehealth services that show clinical benefit)
  - **Rationale 1:** Allow policymakers to gather more evidence about the impact of telehealth on access, quality, and cost.
  - **Option 2:** Medicare should return to paying the PFS's facility rate for telehealth services. Providers should not be allowed to reduce or waive cost-sharing for those services.
- Mandated Report:
  - The telehealth report will use pre-pandemic data, surveys, and focus groups to understand if beneficiaries having access to multiple modes of care impacts, quality outcomes, access, and cost.
- Alternative Approaches to Paying for Telehealth Services Under PFS:
  - Problems with paying separately for each telehealth service (difficult to price, administrative burden)
  - Option: bundle telehealth services into a larger unit of payment
  - Precedence includes monthly payments to cover outpatient dialysis-related physician services for ESRD patients and the global surgical policy
- Alternative Approaches to Paying for FQHC and RHC Telehealth Services after the PHE:
  - During the PHE, FQHCs and RHCs could bill Medicare for services as the distant site and were paid based on PFS rates.

Alternative approach: Pay them a rate based on PFS rates for telehealth instead of their standard rates.

- For Commission Discussion:
  - Plan for analyzing changes in telehealth volume and spending, and impact of telehealth on access and quality
  - Alternative approach to paying for telehealth services
  - Alternative approach to paying for telehealth services billed by FQHCs and RHCs

Discussion:

David Grabowski asked a question about the population-based measures used in the report on slide 11. Staff responded that it's a measure of both access and quality for those with chronic conditions and acute care.

Michael Chernew followed up and asked whether the report compares people using telehealth and those not using telehealth. Staff answered that the measures are population-based but they plan to look at markets with high telehealth intensity instead of low.

Dana Gelb Safran asked for clarification on the use of claims data. Staff explained that they use claims data that are population-based and talk to patients and clinicians.

Lynn Barr asked about the impact of global payments and the number of patients that had follow-ups prior to global payments. Staff responded that there isn't data to look at that because the fee schedule has always had built-in global surgical codes. If there were codes that switched from 10 to 90 days, you could exploit that. But we don't have a lot of data on these procedures. **Lynn Barr** followed up with a question on the impact of PHE in telehealth on traditional telehealth. Staff stated that they can investigate that further and you still see it being provided in rural areas with seeing originating site claims. When you look at 2021 data, we'll keep an eye on that to see if rural areas and originating site claim changed.

Larry Casalino stated that you can't tell if there are going to be additional telehealth visits until after the initial visits. All visits would need to be billed 30 days later. Staff explained that if the clinicians know they are going to see the patient first in person with no telehealth, they can go ahead and bill that code or decide to wait. There is also a process to submit an amended code.

Lynn Barr asked about the adoption rate of virtual check-ins and stated that some physicians did not want to do virtual check-ins due to the cost of billing. Staff responded that it increased a lot from 2019 to 2020, and they will track it in 2021. CMS introduced a code that pays more for longer check-ins in 2022.

Cheryl Damberg stated that CMS is starting to track audio-only versus video telehealth services in 2023. How is the report going to account for the change? Staff explained that there are certain E&M services that have separate claims codes but some data they won't be able to tell until 2023 when CMS implements the code modifier.

Amol Navathe expressed concern about the suitability of the payment system with an episode or bundled structure. He stated there is ideally an accountability structure that comes with a degree of freedom. In the general FFS system, we don't have an accountability system. We will hit a cliff at some point which is

concerning from a design perspective. If we compare the surgical/professional services and dialysis bundle, telehealth services feel more like the surgical side. He suggested it makes more sense to think about a telehealth-only bundle that can be triggered with the first telehealth visit.

Larry Casalino suggested that MedPAC give recommendations for telehealth companies that only provide telehealth services v. brick-and-mortar providers. He explained that telehealth companies have lower costs, and Medicare shouldn't pay the same for both. Brick-and-mortar providers can provide ancillary services and make referrals for services that are different from telehealth-only companies.

Lynn Barr stated that in provider-based rural health clinics, it's a nightmare to carve out issues like this and make it work from a financial perspective. If MedPAC's policy prevents access, it's a bad policy. Why do we care whether Medicare pays them this and then cost-based reimburses them for other services? She expressed dislike of cost-based reimbursed RHCs having this structure. She recommended a design that is similar to a chronic care management program where there is a monthly fee. She stated that most patients would prefer to receive telehealth services from their brick-and-mortar provider than a telehealth-only company.

Stacie Dusetzina emphasized that we must make sure Medicare doesn't over or underpay. She asked about how people use telehealth - is it prior to face-to-face encounters or to avoid face-to-face visits? How people access these services impacts bundling. She stated that we need to be intentional about how service use has changed over time. Is there learning going on between beneficiaries about services we don't do well under telehealth? Avoidable hospital use is a good outcome to look at but we're missing an opportunity for avoiding face-to-face visits. Is there flexibility around E&M code options? She expressed concern that with bundling everyone might start to overpay for services that they don't ultimately receive.

Jonathan Jaffery stated that one of the challenges is that this analysis could be informing alternative payment plans and expressed concern about the alternative payment plan for a bundle. Is telehealth an add-on or is it the main reason/service? It becomes substitutable for in-person. What is the problem we are trying to solve? He pointed out that slide 13 shows problems with paying separately for telehealth services – those are problems with FFS. We're talking about population-based payments. Can people in APMs use telehealth with more flexibility?

Greg Poulsen stated that telehealth has unbelievable potential value. It can be safer. When appropriate, it is incredibly satisfying to patients and their families. We might underestimate the way that it can lead to full system redesign. The systems that have done that have all been prepaid. However, the fear of abuse is very legitimate. It makes it significantly easier to do. To the extent that we must fall short of the all-inclusive bundle and capitation of prepayment, bundles and chronic disease management models could be a place because it is the closest to capitation. My view is that we would be agnostic on whether telehealth services are the place to do that. We wouldn't penalize.

Robert Cherry stated that these solutions are difficult to implement and operationalize. Palliative care is a great use case. Doctors meet with different family members, but it doesn't neatly meet the definition of a first appointment. For diabetes care, it could be an in-person visit, and then three telehealth visits. You might not have the data because the goal is to reduce the long-term chance of heart disease. Instead of universally considering E&M codes, it is helpful to consider specific diseases.

Michael Chernew emphasized that Congress is asking the Commission how to pay for telehealth in an FFS world which leads to a different response than what the Commission has been discussing. He stated that telehealth reimbursement would work if they paid completely differently. He explained another approach is a lower facility pay and then a chronic care PCP.

Greg Poulsen asked to what extent is it appropriate for the Commission to say that telehealth is not well suited for FFS.

Michael Chernew responded that they can describe the complexity of shoehorning telehealth into FFS. He stated that it is difficult to narrow the scope of the request. There are concerns with each different payment model. The Commission needs to come up with an option that is less complicated than what they discussed. There are a lot of issues where bundling with E&M is problematic. If you're going to stay in an FFS world, you're going to have to do something on the monitoring side to make it work.

Dana Gelb Safran asked how we sustain access to telehealth without driving up the cost. She explained that part of what the paper needs to get across is that it's another reason to move aggressively towards alternative payment models. Chronic condition bundles have not shown any evidence of saving money. We won't be able to evaluate the impact with the current data. There is an opportunity to plan and execute quality and equity.

Jaewon Ryu explained that the difficulty is that telehealth has been used in a lot of ways. We need to understand duplicative v. replacement services and ensure that these services bring added value as opposed to extra utilization.

Kenny Ka expressed support for bundled payments in theory, but in practice, it is difficult to predict when there will be the next patient visit.

Betty Rambur explained that there is a way to leverage the popularity of telehealth to spur the move away from FFS.

Cheryl Damberg shared concerns about overuse and overpayment. Do you know what fractions of services are one-and-done or require follow-up appointments? She asked about the potential impact of misdiagnosis.

Lynn Barr stated that the bundle approach will not be the right approach and that APMs should be able to waive copays on chronic care management. She expressed concern over cutting facility fees due to potential waste and fraud.

Michael Chernew highlighted the issue of cost sharing. There are a lot of APM-related issues that they did not address. He expressed caution about overburdening providers with administrative fees.

SUBJECT: CONGRESSIONAL REQUEST: MEDICARE AND INPATIENT PSYCHIATRIC FACILITY CARE
DATE: SEPTEMBER 30, 2022

Overview:

This session provides an update to the Commission's prior analysis on Inpatient Psychiatric Facilities (IRF) given that beneficiaries are reaching the 190-day lifetime limit and describes the use of mental health services by Medicare Advantage enrollees.

Presentation (link):

- Background:
  - Inpatient psychiatric facility (IPF) services
    - Beneficiaries experiencing an urgent mental health or substance use-related crisis with a goal of stabilizing a beneficiary's condition (provided in freestanding psychiatric hospitals or distinct units in acute care hospitals)
    - IPF stays are covered by Medicare Part A, while physician services are covered by Part B
- IPFs are paid through a prospective payment system (PPS)
  - Utilizes per diem base rate with various adjustments of characteristics including geographic, patient, and facility-related factors
    - Medicare program spent $3.9 billion on these stays in 2019, and $3.4 million in 2020 (shown on Slide 5, IPF summary, FY 2019 and FY 2020), therefore beneficiaries using IPFs have been designated as being among the most vulnerable and costly (having greater risk scores, greater prevalence of chronic conditions, were younger, and more likely to be Black compared with other fee-for-service (FFS) beneficiaries) (refer to graphs on Slide 6)
    - A majority of IPF stays were grouped in 1 of 17 MS-DRGs, FY 2020, with 74% of stays in psychosis
- Updating Commission's Prior Analysis on IPFs: Access to Care
  - From 2016-2020, there was a decline in IPFs, but growth in freestanding for-profit IPFs
    - Most common type is hospital-based nonprofit IPFs, however recently freestanding for-profit IPFs are emerging (approximately 10%)
    - While the number of patients in psychiatric facilities increased during that period (from 2016-2019), there has been a steep decline in utilization due to COVID-19 (from 2019-2020)
    - Increase in length of stay between 2016-2019 contributed to an increase in Medicare payment per stay (from 2.8% to 6.4%)
- Updating Commission's Prior Analysis on IPFs: Quality of Care
  - Inpatient Psychiatric Facility Quality Reporting (IPFQR) program focuses predominantly on process measures
    - One outcome measure: 30-day all-cause unplanned readmission following psychiatric hospitalization (national mean for this measure is 20%)
- Updating Commission's Prior Analysis on IPFs: Medicare Payments and Provider Costs
  - There was a wide variation in aggregate Medicare margins for IPF PPS services in 2019 (25% (for freestanding for-profit) vs -23% (for hospital-based non-profit))
- Next Steps:

- Describe the use of outpatient mental health services including tele-mental health
- Continue describing the use of mental health services by Medicare Advantage enrollees

Discussion:

Betty Fout and **Ledia Tabor** began the discussion by asking for questions and feedback on their presentation.

Jonathan Jaffery asked if Betty could say more about the 190-day policy limit developed in 1965 and if there is rationale now/anything analogous to that policy anywhere in healthcare. **Betty Fout** explained that there is only the 60-day rule for Medicare, which is similar to the 190-day policy limit.

Lynn Barr questioned if utilization is declining for organizational reasons, or if it is tied to the economy. **Betty Fout** responded by explaining that since 2004, utilization has declined consistently. **Lynn Barr** was also curious about the profitability of for-profit IPFs and wanted clarity on who owns these IPFs/if they have a specific patient profile. She also questioned how they are converting to an all-inclusive rate. **Betty Fout** explained that there is a table in the chapter on beneficiary characteristics outlining different patient services.

Amol Navathe asked Betty to clarify the definition of a healthy occupancy rate and if there is an internal barometer of what we should be seeing in this sector. He also asked if we have a sense of what is happening across the markets. More specifically, when looking at the market level, are there some places where there is greater profit in freestanding entry and then closures where we see it going up and down? **Betty Fout** responded by stating that there currently is no internal barometer and there are some differences between urban and rural outcomes.

David Grabowski questioned where to access information/how to report patient-level results starting in 2023. **Betty Fout** explained that IPFs will have to report the chart information below the numerators and denominators for this summer.

Cheryl Damberg explained the importance of signaling Congress or CMS to focus on certain measurements. **Betty Fout** explained that medication continuation within a 30-day period (assuming patients are on longer-term medications) and whether we want to look at 90 days or 6 months, is really what the profile looks at to manage those conditions in ambulatory utilization in home spaces.

Michael Chernew explained that there was tons of enthusiasm and many issues which set the stage for the December discussion. In preparation for Round 2, he explained that one of the things he is trying to sort is how far down the path they want to go regarding this issue of care for patients with psychiatric illnesses.

Jonathan Jaffery explained that there is a growing recognition of the need for such services, given psychiatric patients require a spectrum of care spanning inpatient therapy, outpatient, and individualized therapy. He raises the importance of thinking about what can happen in the treatment course for someone, and what happens after the 190-day limit, which can become a great cost and quality issue.

Stacie Dusetzina explained that we should make a strong statement of some kind, even if it's a recommendation if that's where the data lead us. **Robert Cherry** explained that a recurring theme that is necessary is to understand the differences to improve quality of care through risk adjustment models. He

provided an example showcasing that an increase in readmissions can correlate to higher levels of suicide attempts, therefore, it is very important to look at the model holistically and not just tease out inpatient facilities.

Cheryl Damberg explained that it is clear there is more that we may want to know and unpack, and it may be good to spotlight areas where we want to see more work done. **Cheryl and Scott Sarran** agreed that this isn't just about inpatient admission but is about comprehensive care over the course of the year.

Amol Navathe added the importance of observing geographic differences across trends. One thing that is helpful to think about with the system of care is almost thinking conceptually about the relationship of the outpatient sector. He wondered if looking at the commercial sector/Medicaid-only sector will make us understand this a bit more.

Hope Kim concluded the discussion by stating that they look forward to what the team can do and thanked everyone for their comments.

SUBJECT: **ANALYSIS OF PART D DATA ON DRUG REBATES AND DISCOUNTS**
DATE: **SEPTEMBER 30, 2022**

Overview:

Pharmacy price concessions are what pharmacies pay health plans for dispensing Part D drugs, and they currently account for a third of total Part D spending. This includes manufacturer rebates and direct and indirect remuneration to pharmacy benefit managers (PBMs) and plan sponsors. Consolidation of plan sponsors and PBMs should increase their bargaining power with manufacturer rebates and pharmacy fees, but there are wide variations in formulary drug costs and rebates vertically integrated firms receive. These competitive arrangements and subsequent leverage over rebate size have raised concerns over cases where beneficiaries' median cost sharing exceeds plans' net costs, with beneficiaries and Medicare paying more than the drugs' costs to health plans.

Presentation (link):

Background:

- Mandated and negotiated price concessions made up 33% of Part D spending
- Pharmacy remuneration is composed of direct and indirect remuneration (DIR)
    - Post-sale fees and post-sale rebates from brand drug manufacturers and pharmacies
- How plan sponsors apply their share of DIR has inherent tradeoffs
    - CMS retains a share of DIR to reflect price concessions on Medicare reinsurance payments
    - Plan sponsors usually keep the rest to keep premium growth lower
    - Tradeoffs include higher cost sharing in catastrophic care areas, where Medicaid pays 80% of costs
- Part D has incentives to maximize rebates
    - Private plans compete for enrollees mainly based on premiums
- Other factors have contributed to DIR growth
    - Comments: examined asthma, COPD, insulin medications (drug classes) with large and growing rebates showed strong brand-brand rivalry with limited generic entry
    - Consolidation of plan sponsors and vertical integration with PBMs has increased bargaining power for manufacturer rebates and pharmacy fees (higher DIRs as a result)
- Analysis of 2020 DIR data for 30 brand-name drugs
    - Average rebates ranged from <10% for antineoplastics to >50% for diabetic therapies
- Differences in organizational structure may contribute to DIR variation
    - Plan sponsors may have their own PBM or use other plans' PBMs
    - PBM can leverage market share and negotiate across all their Part D clients via different formularies
    - Plan sponsors must report DIR at the individual plan level
- Analysis of the 2020 DIR data: rebates for same product can vary widely
    - Among six largest plan sponsors, the median rebate ranged as much as 2.5 times
    - Large sponsors tend to use multiple formularies, which can explain why rebates vary among plans operated by the same sponsor
- Plans using the same formulary may face widely divergent costs
    - Plans using the same formulary tended to receive similar rebates, but differences still remain

    - Net-of-rebate cost of a given product variation could affect Medicare cost-sharing levels on beneficiaries
- For drugs with high rebates, cost-sharing can exceed plans' net costs
    - Cost sharing for some products exceeded 50% of plans' net-of-rebate costs
    - In some cases, plans did not incur any benefit costs for these prescriptions
    - In many cases, the highest cost-sharing involved LIS enrollees, which Medicare paid for
- Case study: asthma and COPD medications
    - Rebates are expected to grow substantially, with unique regulatory hurdles that limit generic entry
- Brand-name asthma/COPD products have higher prices but still maintain market share over generics in 2020
    - Gross prices for brand-name products have grown by around 9% annually since 2012
    - Generics have lower costs but very little market share, indicating competition is happening via post-sale rebates versus list prices
- Formulary coverage decisions also suggest competition is not based on point-of-sale price
    - Plan sponsors appeared to be covering more drugs that were more expensive than other generic or branded options
    - Such products are providing insurers with post-sale rebates to offset costs
    - This data is from an external source, not the DIR data that was used for the rest of the analysis
- Cost sharing for asthma/COPD products varies widely across sponsors' plans
    - Median cost sharing often exceeded 50% or even 100% of plans' net costs
    - When cost sharing exceeds plans' net cost, plans bear no cost for the product and may earn a profit on these sales
- Summary of initial findings
    - Wide variation in rebates even among plans using the same formulary
    - For highly rebated drugs, cost-sharing can exceed plans' net costs, leading beneficiaries and Medicare to pay more than drugs' costs to the plans
- Considerations of a changing landscape
    - Under the Inflation Reduction Act:
        - Part D benefit redesign would cap beneficiaries' out-of-pocket costs, increase insurer liabilities, reduce Medicare reinsurance, and change the amount drug manufacturers would provide in mandatory discounts
        - Drug manufacturers will pay rebates to Medicare for any increases in drug prices that are faster than the rate of inflation
        - New authority under HHS to negotiate prices for new drugs
- Next steps and discussion
    - Analyze other data to understand the relationship between rebates and changes in competitive dynamics across product classes
    - Examine rebates for drugs affected by specific policies, such as protected classes or specialty drugs
    - Focus on understanding potential beneficiary and Medicare spending

Discussion:

Mr. Kenny Kan appreciated the inclusion of the IRA's effects on potentially mitigating cost-sharing and drug access issues.

Dr. Michael Chernew noted the value of the DIR data but cautioned against policy recommendations since there has already been some legislative response, saying that he wanted to monitor the landscape.

Dr. Stacie Dusetzina asked why the competition was happening on the grounds of rebates and not list prices. **Ms. Marjorie Ginsburg** responded that rebates are a way to price discriminate and assess the organization and resources plans have at their disposal. **Dr. Chernew** also responded that on top of price discrimination, he mentioned how some prices are tied to growth.

Mr. Kan asked about differences between stand-alone Part D plans, which require plans to optimize formularies and growth, and Medicare Advantage Part D plans, which focus more on medication adherence and optimizing members' holistic health, mitigate disparities. He asked for future work to look at correlations between DIR and holistic health plans.

Dr. Dusetzina appreciated the access analyses within and across formularies and asked if the variation in rebates within the same plan sponsor could be attributed to plans trying to get volume or sales discounts. She also commented on how much the IRA addresses the coverage gap and coinsurance frequency for drugs with large rebates, with future research efforts going to the latter. We want plans to pick the drugs with the lowest price and highest rebates, but not at the cost of the beneficiary. She also seconded Kenny's interest in comparing PDP vs MA plans.

Regarding the insulin case study, she asked for more general data on excess cost-sharing drugs, or how often patients actually overpay for drugs, resulting in plans profiting off of necessary drugs. She also cautioned against extreme examples like insulin.

Dr. Scott Sarran commented on the opacity of rebates and relationships within the pharmaceutical industry. Opacity not only inhibits market efficiency understanding, but it is also antithetical to transparency in understanding how public funds are used to cover healthcare costs. He asked for more cost-benefit analysis on increased transparency.

Dr. Amol Navathe seconded Dr. Dusetzina's concerns about the generalizability of the case study level data. In terms of price transparency being a good indicator of a well-functioning market, he brought up the value of real-time benefit designs where patients can see the true cost at point-of-sale. Would price transparency actually bring about improvements for patients?

Dr. Dusetzina commented that patients were not seeing the benefits of rebates, but they could benefit from being able to interact with prescribers and understanding how much they are paying in coinsurance. She also analyzed the argument against price transparency where, under complete price transparency, every plan would just regress to the mean price and the benefits of economies of scale would be lost for large sponsors. She asked for confirmation on whether that hypothesis is true, if payers are legitimately receiving large discounts, or if prices are standard across the board.

Dr. Michael Chernew reiterated the value of the DIR data, but once again pushed for the committee to monitor the situation in light of legislative action needed to take effect.