A Summary of the Medicare Payment Advisory Commission (MedPAC) Virtual Meeting

HIGHLIGHTS FROM THE SEPTEMBER 29-30, 2022, VIRTUAL & IN-PERSON MEETING

PREPARED BY HART HEALTH STRATEGIES, INC.

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Supporting safety-net clinicians

Presentation

Staff presenter: Geoff Gerhardt

Overview

The Commission continues examining safety-net providers, this time focusing on clinicians. In the last cycle, the Commission developed a method for identifying safety-net providers and deciding whether Medicare funds should go towards supporting such providers (see below). This body of work began with a request from the House Ways and Means Committee, which asked the Commission to examine access to care for vulnerable beneficiaries. The Commission explored a number of ways that identifying beneficiaries who have difficulty accessing care including those who live in rural areas and those with multiple chronic conditions. The Commission chose to focus on low income beneficiaries because it found they consistently use more health services and have more challenges accessing care compared to other Medicare beneficiaries. Staff highlighted ongoing concerns that have been raised about the financial stability of providers who serve a high number of low income beneficiaries. Staff noted that large, across the board increases in Medicare payments were not financially viable, therefore the Commission strived to develop a way to target safety-net funding to those serving low-income beneficiaries.

Overview of the Framework

The Commission's framework appeared in the June 2022 Report to the Congress and outlined a two-step process based on the premise that safety net providers should be defined on the characteristics of their patients, rather than the type of facility they are, where they're located, or some other criteria. In the first step of the framework, the goal is to identify safety-net providers; the second step is to decide whether new Medicare funding is warranted to support them.

Step 1: The Commission identifies safety net providers as those who treat a disproportionate share of Medicare beneficiaries who have low incomes and are less profitable than the average beneficiary or the uninsured or those with public insurance that is not materially profitable. The underlying premise of defining safety net providers this way is that providers who treat a disproportionate share of such patients could be financially challenged because their patients cost more to treat, or they receive lower revenues for treating similar patients. These financial challenges could lead to negative outcomes for beneficiaries such as having difficulty accessing care if providers close or choose not to treat certain types of patients.

Step 2: Having identified safety net providers, the second step is deciding whether new Medicare funding is warranted to support these safety net providers. Medicare should only spend additional funds to support safety net providers if three criteria are met: 1) there is a risk of negative effects on beneficiaries without new funding such as trouble accessing care; 2) Medicare is not materially profitable payer in the sector; and, 3) new Medicare funding is only warranted if current Medicare payment adjustments cannot be redesigned to better support safety net providers.

Definition of low-income beneficiaries

MedPAC has defined low-income beneficiaries as those who receive full Medicaid benefits, partial Medicaid benefits (i.e., Medicaid pays for their Medicare premiums or cost sharing through one of the Medicare savings programs), or those eligible for the Part D low income subsidy (LIS). Note that LIS provides assistance with Part D premiums and cost-sharing to beneficiaries who are eligible for full or

partial Medicaid benefits right or have incomes below 150% of the federal poverty level (FPL) and have limited assets.

Description of safety-net clinicians

Staff noted that, in the June report, the Commission applied the safety-net framework to acute care hospitals. Unlike hospitals, physicians and other clinicians do not report costs, so information about their revenues, costs, and profitability is limited, forcing them to make inferences about clinician profitability based on what it knows about revenues for low-income beneficiaries. Clinicians are prohibited from collecting the 20% cost-sharing from beneficiaries who are eligible for full Medicaid benefits and those who are duly enrolled in Medicaid for the qualified Medicare beneficiary program. The Commission also knows that 42 state Medicaid programs make reduced cost-sharing payments or do not make any caution payments for services furnished to many LIS beneficiaries. Staff estimate that the combination of these two policies result in clinicians not collecting $3.6 billion in revenue that they would have received otherwise. Finally, some clinicians are serving a disproportionate number of low income beneficiaries; for example, 15% of clinicians had more than 50% their fee schedule claims associated with LIS beneficiaries.

As noted above, the framework's second-step is to determine whether clinicians should be given enhanced financial support. Surveys indicate that low-income beneficiaries have more difficulty accessing care from clinicians compared to other beneficiaries; for instance, 12% of fully dual-eligible beneficiaries and 18% of partial duals reported having trouble getting needed care, compared to 6% of the non-LIS population. While the Commission cannot measure profitability directly, treating low-income beneficiaries tends to generate less revenue than other Medicare beneficiaries. Since there's no reason to believe that the cost of caring for low-income beneficiaries is less than treating other beneficiaries, the Commission infers that low-income beneficiaries are less profitable and may present financial challenges to clinicians. The final step in the process is to determine whether Medicare already has policies that directly supports safety-net clinicians. Staff noted that the physician fee schedule does have some add-on payments, such as the health professional shortage area (HPSA) bonus, targeted financial support for safety-net clinicians does not currently exist.

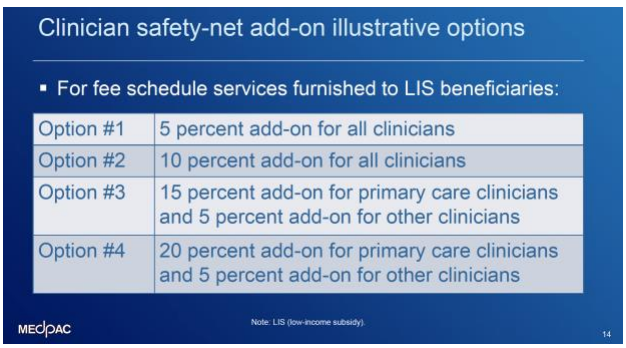
Options for clinician safety-net add-on adjustment

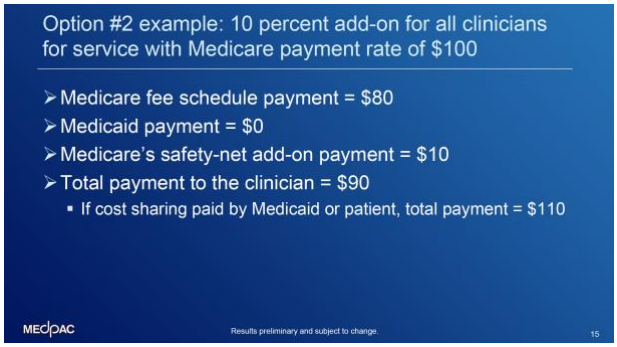
Staff noted that one potential approach to supporting safety-net clinicians is to implement an add-on payment for services that are furnished to LIS beneficiaries and paid under the physician fee schedule (PFS). Under this approach, for each service furnished to an LIS beneficiary, Medicare would calculate an add-on adjustment based on a specified percentage of the PFS payment rate. The uniform payment adjustment would apply to all clinicians, and the aggregate amount of add-on payment for each clinician would vary according to the volume and period of services he or she furnishes to LIS beneficiaries.

The envisioned add-on payments could vary on two dimensions: 1) the percent used to calculate the add-on, and 2) whether the add-on adjustment would be based on a single percentage for all clinicians or whether they should be higher for primary care clinicians compared to non-primary care.

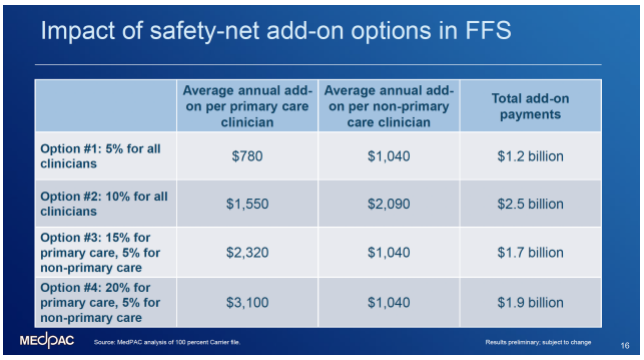
Because the PFS does not have existing bonuses or add-ons for safety-net clinicians that could be repurposed, the framework calls for safety-net add-on payments to be funded with new Medicare dollars and not-implemented in a budget-neutral manner.

Slides 14 and 15 (below) illustrates options for add-on adjustments along with an example of how the add-on payment would be applied (under Option 2).





Slide 16 (below) shows the impact of the safety-net add-on options under each option, noting it would vary based on the number of LIS beneficiaries treated and the services they were provided.



There are several policy and operational issues raised by the proposed safety-net add-on adjustment. One issue is how large the adjustment should be. Because the 20% cost-sharing doesn't get paid for many low-income beneficiaries, a 20% add-on seems like a natural limit for the adjustment. A smaller adjustment would be less costly, but may not be as effective in addressing financial challenges faced by some clinicians. Another issue is whether to apply a flat add-on to all clinicians or by specialty. Staff noted that average total compensation for primary care clinicians is lower than most specialists, and they tend to serve a higher proportion of low-income beneficiaries. However, some specialties have a relatively high portion of claims from LIS beneficiaries, and low-income beneficiaries report having difficulty accessing specialty care. Another key issue is whether total payments, including the safety-net add-on, should be permitted to exceed the PFS full payment rate. Given state- and beneficiary-level variation in cost-sharing policies, capping total payments could be administratively complex.

Finally, the Commission needs to consider whether and how a safety-net clinician policy would be applied to Medicare Advantage (MA). Like their fee-for-service (FFS) counterparts, LIS beneficiaries enrolled in MA report having more difficulty accessing clinician services than non-LIS enrollees. CMS could use the same basic methodology discussed above to make similar add-on payments to clinicians in MA, provided the plan submits accurate encounter records for clinician services. In order to ensure clinicians', receive the full benefit of any add-on adjustment, aggregate payments would be made directly to providers instead of going to the MA plan. Unlike the add-on payments in FFS, it is assumed the safety-net add-on would not be included in MA benchmarks. That being said, it's not clear how treating MA beneficiaries with lower income affects clinician revenue. While it can be asserted that treating FFS beneficiaries with low-income generates less revenue for clinicians because of restrictions on cost-sharing, there is a lack of reliable information about how MA plans deal with cost-sharing for dually-eligible enrollees.

Staff then presented a series of questions for commissioners to consider and discuss.

Commission Discussion

Clarifying questions

Commissioner Jaffrey asked for more granular information on the impact of the safety-net add-on options in FFS, with a focus on the various specialties. Staff noted there is a lot of variability, but referred Commissioners to the draft chapter for available breakdowns. As a follow-up, ***Commissioner Casalino*** asked for the annual mean add-on amount per clinician by quintile, which staff will provide in the next session. ***Commissioner Gelb-Safran*** also wanted to have a better sense of the percentage revenue clinicians are missing out on at the clinician/individual level. Staff noted it is highly variable and based on the factors noted above (e.g., specialty, services delivered, number of low-income beneficiaries treated). The impact table shows the average. ***Commissioner Poulsen's*** data team (@ Intermountain Healthcare) found that the most any of their clinicians would receive is about 6%.

Commissioner Barr was concerned about excluding rural clinics and FQHCs. Staff noted these providers are already paid at a higher rate, so they are not in as much need, but it is something that could be considered. She also pointed out that many LIS eligible beneficiaries do not enroll in key programs, which could have a negative impact. Staff noted this is always a concern, but the numbers are very, very small. She is worried that there isn't something specifically targeted to the beneficiary, but rather a payment to clinicians. ***Vice Chair Navathe*** clarified that the policy considers beneficiaries that are LIS-eligible, not necessarily LIS-enrolled. He also wondered about how clinician setting may have an impact, noting that some specialties are hospital-based. Staff hadn't looked at that, but it is something they can do.

Commissioner Dusetzina asked about the Inflation Reduction Act (IRA) and how that would change who is impacted. Staff will look at how the law may impact the grouping.

Commissioner Damberg didn't see a reference to the fact that Medicare providers additional payments to the D-SNP plans, and wondered if they would also be getting additional payments. Staff will look at what would happen with D-SNPs as best as possible, but notes the payments contemplated here would go directly to clinicians.

Policy Comments

To kick off round two of the discussion, Chair Chernew urged the Commissioners to state their support for one of the four options. Commissioner support is organized by option below.

No option selected: Commissioner Kan supports the work overall, but has not formed an opinion on any of the options. He appreciates break between primary and specialty care, but is concerned about the MA issues, the issues raised by Commissioner Navathe regarding setting of care and potential for double payments, and the issues about how it would be implemented based on state policies.

Option #1: No commissioner support.

Option #2: ***Vice Chair Navathe*** echoed the support for this work and the overall approach. He said the Commission should be mindful that that it is making these adjustments in the context of also pursuing adjustments in the hospital safety-net sector, and pointed out that MedPAC and other peer-review literature supports that the access gap observed most is for duals in the outpatient setting (i.e., that is

ambulatory care, particularly for specialists). He encouraged the Commission to "target the targeting" and suggested breaking out the billings for outpatient care to see where the funds would make the most difference (e.g., for low-income beneficiaries to be able to access specialty care in an office setting vs. hospital setting). In the context of MA, he supports payments going directly to clinicians. He encouraged staff to show the distribution of each of the four options across clinicians based on the share of LIS beneficiaries. He said a small share of clinicians take care of a disproportionate number of low-income beneficiaries, and felt it would be good to have this data to ensure the add-in will yield meaningful deltas for revenue for a particular practice or particular condition. He said it would also help to see the distribution to inform which option the Commission should ultimately select. He believes this will vary by setting and could influence the specialty piece. While he supports option 3, he really prefers option 2, to the extent it can be oriented around setting. He believes this would naturally accrue more for primary care because primary care is not doing a lot of facility-based care.

Commissioner Poulsen reiterated that his data team found that the highest add-on for his group would be 6%, but it tapered off pretty quickly. He agreed with the points made by Commissioner Ryu about the difficulty of caring for low-income patients, and pointed out it is not just about the reimbursement. He noted there are inequities between practitioner types, but isn't sure this policy would address that. The focus should be on equity of payment for differing populations, not specialties. He also doesn't want to differentiate based on state policies. Last, he feels strongly that the add-on payment should not be provided in the MA sector. He would rather see MA plans be required to pass on some of their capitated payments to providers vs. another add-on. He prefers option #2.

Commissioner Cherry supports the body of work and favors option #2. He appreciates the rationale for primary care taking priority, but notes the Commission should not underestimate the need for specialty care in the LIS population. He believes a more equitable approach is appropriate, as 5% is too low. Regarding MA, he supports this, as well as direct payments to clinicians. He suggested this could be a way to encourage encounter data collection.

Option #3: *Commissioner Barr* is wildly enthusiastic about this chapter and work, but concerned about rural facilities and said they should also get an add-on adjustment. FQHCs can secure grants to help with uncompensated care, but RHCs just have another fee schedule. RHCs also need this support. She is also concerned about beneficiaries and would like to consider an alternative option that would provide support to both patients and clinicians. *Chair Chernew* and *Executive Director Mathews* clarified that the policy here is aimed at clinicians and ensuring their ability to continuing as a point of access to care for low-income beneficiaries, and the question of beneficiary assistance would be a separate work steam.

Commissioner Dusetzina strongly supports this body of work and felt option #3 made the most sense. She is also interested in hearing more on the MA question, but supported the payments directly to clinicians.

Commissioner Ryu supports this body of work, and supports option #3 and #4, but favors #3. He highlighted the higher cost associated with taking care of the low-income population, which is also important to focus on vs. simply the co-payment piece. He noted that many of these patients require longer visits and additional staff (e.g., social workers) and staff time (e.g., staff coordinating with social services and supports). He urged the Commission to consider who qualifies as primary care, given some specialists are truly delivering primary care (e.g., cardiology, nephrology) and suggested developing some criteria for this. As for the MA issue, he is also in favor of providing the funds directly to the clinicians. He agreed that total payments should be permitted to exceed the allowed amounts.

Commissioner Gelb-Safran is not sure what problem is being solved by this policy, but depending on what that is, it would inform which option she could ultimately support. If she had to choose and option, she prefers option #3 because of the differential for primary care. She wants to front load payments or give differential bonus for clinicians with an emphasis on those with higher social determinants of health (SDOH), including LIS patients. She is undecided on MA, but struck by the points made by ***Commissioner Poulsen.*** She remains leery overall and not sure how much good this policy would actually do.

Commissioner Damberg supports the work and building out the safety-net clinician policy, and favors option #3. She wondered if the payment should be higher as simply achieve parity may not be appropriate if the patients are more difficult to care for. She shared similar concerns of ***Vice Chair Navathe*** and ***Commissioner Gelb-Safran***. She also wondered if there should be some sort of a cap.

Commissioner Ginsburg supported option #3. She is concerned about giving MA more money given they have not provided enough data.

Option #4: *Commissioner Jaffrey* noted support for the work and continuing to develop the policy options. The complexities around "lesser-than" policies in the states are valid, but he supports that total payments could be higher than the allowed amount. He favors the direct payments to providers, given concerns about what would happen if those funds were given to MA plans. He supports options #3 and #4 because there is a differential between primary and specialty care, but leans more toward option #4. He thinks these payments will help primary care to prepare for population-based and value-based payments.

Commissioner Rambur fully supports this work and believes option #4 sends the right message, which is that primary care should be prioritized. She would appreciate a breakdown of the impact by type of clinician (e.g., nurse practitioners).

Commissioner Grabowski enthusiastic about this body of work and appreciates option #4 noting that primary care needs to be emphasized, and the dollars need to be meaningful. He does wonder if this will be enough, and suggested some modeling. He is concerned about the "lesser-off" policies in the states, and how it impacts care and physician behavior, at least in the nursing home setting. He suggested pulling back on the MA piece based on ***Commissioner Poulsen's*** comments.

Commissioner Sarran supports the work and felt all the options would achieve value, but seemed to favor option #3 since it was less costly and supported primary care. He supports total payments exceeding the allowing amount. On MA, he leaned against this. He said MA does a lousy job aligning provider incentives given they mostly pay on a fee-for-service basis, and he feels that MA is already overpaid. He also said that by including MA, regardless of whether the payments went directly to clinicians or not, the plans are likely to lower their contracted rates noting some of their providers are getting this add-on payment.

Commissioner Casalino favored option #4, but wants to see the quintiles. He strongly agrees with ***Commissioner Ryu's*** comments.

Commissioner Riley strongly supports the work and supports option #4. He said primary care has been undervalued too long.

Mandated report: Evaluation of a prototype design for a post-acute care prospective payment system

Presentation

Carol Carter

Overview

The *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014* required uniform patient assessment items and quality measures and reports on a post-acute care (PAC) prospective payment system (PPS) design. The law required three reports on a unified PAC PPS: a MedPAC report submitted in June 2016, a Secretary of the U.S. Department of Health and Human Services (HHS) report submitted in July 2022, and the MedPAC report due June 30, 2023. The designs must span the four PAC settings and base payments on patient characteristics, not the setting where the care was furnished.

Staff reviewed MedPAC's work on a unified payment system, which spans six years, and the design features of a PAC PPS, which were discussed in MedPAC's June 2016 and June 2018 reports. They explained how the PAC PPS design was evaluated and the implementation issues identified in MedPAC's June 2017, 2018, and 2019 reports. In its early work, MedPAC noted that a value incentive payment (VIP) program should accompany the implementation of a PAC PPS. In response to two additional congressional mandates on value incentive programs, MedPAC discussed a skilled nursing facility (SNF) value-based purchasing program in its June 2021 report, and a PAC value incentive program in its March 2022 report.

Changes in the PAC landscape may shape the design and impacts of a PAC PPS, including PPSs for SNFs and home health agencies (HHA), and new criteria for long-term care hospital (LTCH) payments. COVID-19 impacted providers' costs, staffing, and service provision, as well as beneficiaries' use of PAC and their severity of illness. The expansion of alternative payment models (APMs) illustrates the potential to shift PAC use to lower cost-settings and to shorten lengths of stays.

Challenges to implementing a unified PAC PPS include aligning regulatory requirements for a new PAC provider, accurately measuring the functional status of patients, and addressing anomalies in data from years with large COVID-19 effects on providers and patients. Despite these challenges, rationales for a PAC PPS remain. Providers' responses to the new HHA and SNF PPSs are consistent with those that would occur with a new PAC PPS. Staff work showed that an accurate PAC PPS is feasible using existing uniform data. The brunt of COVID-19 impacts on providers can be dampened by using a relatively recent year of data and periodic revisions.

The Secretary's report on a unified PAC PPS estimates the model accuracy and impacts on payments to providers. It does not include recommendations or policy options but includes discussions of quality measures and a value-based purchasing program, regulatory alignment, and aligning cost sharing. Staff reviewed their planned analyses of the Secretary's prototype design and impacts (to be presented in November 2022). In March, MedPAC will consider the draft report and recommendation. The final discussion of the draft report and a vote will take place in April. The chapter will be included in MedPAC's June 2023 report.

Commission Discussion

Clarifying Questions

Commissioners asked a variety of clarifying questions, including:

- ***Commissioner Barr*** asked whether swing beds were considered in elements other than payment (quality reporting, for example). Medicare pays a ridiculous amount for this care. She was also struck by the disconnect between the rural perception of HHA access and MedPAC's perception of HHA access. Staff responded that they could think about including a discussion of requirements for rural swing bed providers. They can also think about how to include a perspective of whether a payment system redesign would improve rural equity/access. ***Executive Director Matthews*** reminded Commissioner Barr about prior work by the commission on access to care in rural areas. Across the sectors examined, MedPAC found comparable levels of utilization across all gradations of rurality, until frontier areas. At that point, utilization tails off. That led the commission to conclude that there is not, in the aggregate, a problem with rural beneficiaries accessing HHAs. ***Commissioner Barr*** argued that this is an issue of averaging – there are people in places like Texas, for example, that are overutilizing HHA services, while other rural areas face access issues.

- ***Commissioner Grabowski*** confirmed that coding (to determine functional status) is done in the prior hospitalization setting. Staff explained that some of the information is taken from claims data or during the PAC stay. They used hospital data to assess measures of severity. There is some information from hospital claims, but the majority of HHA services do not have a hospital stay associated with them.

- ***Commissioner Cherry*** asked for clarification about the challenges in measuring the functional status of patients. Is the problem incomplete data? Or is it a problem with the model for assessing functional status? Staff responded both – there is missing data, but there also may be inaccuracies in how function is recorded, particularly when function is used for payment.

- ***Commissioner Navathe:*** Do you have any sense of why setting is even considered if we are trying to get to a unified PPS? Staff responded that the model was trying to accurately predict costs of care. Including the setting as an indicator helps with that. ***Chair Chernew*** noted the tension in what MedPAC is doing – trying to accurately predict costs, vs. adjusting for how the payment system impacts the cost. Staff added that this will be discussed more in November. ***Commissioner Kan*** would like to better understand this dynamic. He is curious if there is any impact of long COVID – perhaps the model should be flexible to account for this.

Policy Discussion

Commissioners expressed their general support for the direction of this work. Much of the discussion centered around the lack of reliability for the data used to determine functional status/patient severity. There was also agreement around the idea that a unified PAC PPS is a move in the right direction but should not be the ultimate destination.

Commissioner Grabowski: The problem we are trying to solve is that Medicare is paying a different rate for similar patients across four PAC settings. So, a unified PPS is a step in the right direction, but he hopes a unified PPS is not the destination (as it is still based on fee-for-service (FFS)). A unified PPS will not curb

low value PAC. Beyond harmonizing payments, there is value in harmonizing cost sharing and quality measures. HHAs have always been the challenge from the perspective of a unified PAC PPS. They are noninstitutional and rely often on family caregivers as a complement. He expressed support of the HHA adjuster.

Commissioner Poulson expressed concern that it may be difficult to tease out different patient characteristics. The coding that patient severity is based on is so variable that it may not catch all the information in a meaningful way. He is troubled by the idea of the uniqueness of HHAs and that it could result in not fully embracing the totality of a unified PAC PPS. To say that HHAs is different because they cost less troubles him – we need to find a mechanism that is more embracing and allow organizations to find the most cost-effective setting that meets a patient's needs.

Commissioner Cherry commented on the methodology used and the dependency on patient-related characteristics given the lack of data on functional outcomes. This may work from a population health perspective, but it could be lost in translation at the level of an individual patient stay. It is necessary to understand what we are getting for what we are paying, so those functional outcomes are critical. Outcomes need to be a mandatory report out at the end of the day.

Commissioner Safran appreciated the timeline and requested its inclusion in future work and for other issues/chapters.

Commissioner Navathe was struck by the challenges in this space. In a perfect world, there would be no overlap across different settings – there would be a perfect matching of patient to level of acuity/setting. He agrees the points made earlier: we are dependent on data we cannot rely on to differentiate between patients (functional assessment measures). How reliable is this data? How practical is the idea of mandatory reporting? How long would it take to validate the data? We do not want the perfect to be the enemy of the good. He also acknowledged that a unified PPS is a stop on the path to an ultimately more APM-like system.

Chair Chernew acknowledged that this issue about case mix adjustment/functional status also plagues how we pay for APMs and Medicare Advantage (MA). That is a whole broader discussion. We should keep trying and go into the task with a lot of humility – this problem cannot be solved with a MedPAC report.

Commissioner Damberg agreed that we are not where we need to be when it comes to the measurement of function – this space needs greater investment to be improved.

Commissioner Rambur commented on the lower cost of home health. The highest costs in this space are from the people doing the work, and their salaries are low. In the current labor situation, will people still be willing to do this work? She noted that many value based payment models are very nurse centric.

Chair Chernew heard a lot of enthusiasm for this work. He noted the tension about whether setting is a de facto case mix adjuster (sometimes? for some patients?). This is a complicated area and commissioners should manage their expectations about what this chapter can achieve.

Nursing facility staffing

Presentation

Kathryn Linehan and Lauren Stubbs

Overview

Staff provided an overview of the session, noting that the material discussed in this session would not be a separate chapter in the March or June 2023 Reports to Congress, but parts may be used as background in future work. Staff noted that they sought feedback and guidance on how data on staffing could inform future work on the healthcare workforce.

Staff began by providing background on skilled nursing facilities (SNFs), noting that they provide short-term skilled nursing care and rehabilitation services. In 2020, SNFs served 1.2 million Medicare fee-for-service (FFS) beneficiaries. 94 percent of SNFs are also certified as nursing facilities (NFs), which provide less-intensive long-term care services that Medicare does not cover.

About 1.2 million people work in SNFs or NFs in the country, with three types of nursing staff providing the most direct care – registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) – and they roughly account for half of a facility's costs. Each level requires separate training and or licensing/certification.

Federal staffing requirements for have been unchanged since 1987, including a requirement for a director of nursing who is an RN, an RN on duty 8 consecutive hours per day for 7 days a week, a licensed nurse (either RN or LPN) on duty 24 hours per day for 7 days a week, and sufficient nursing staff with appropriate competencies and skills to assure safety and well-being.

At the state level, staffing requirements vary, with 38 states and the District of Columbia having stricter minimum staffing requirements than the federal requirements, which studies suggest lead to some quality improvements but also unintended consequences. States have also enacted other policies to encourage staffing, including wage pass-through policies, cost-based payment policies, and value-based payment.

CMS has investigated nursing facility staffing requirements, including in a 2001 Congressionally mandated report and in 2016 rulemaking, but has not changed federal requirements. While CMS previously collected staffing data through the CASPER system, concerns about that system's accuracy led to an Affordable Care Act requirement for CMS to collect better staffing data. In response, CMS now maintains the payroll-based journal system, or PBJ, which collected detailed day-level data for each provider, aggregated by staffing category and separately tracked for employed and contract staff. While the PBJ data are auditable, however, it includes some limitations, including that it may not reflect all staff hours worked and that it does not measure workload intensity.

CMS is studying minimum federal staffing requirements, as noted in the SNF PPS final rule, following an announcement by the White House in early 2022. It will include analysis of PBJ staffing data and patient outcomes, site visits, and literature review. Based on its findings, CMS intends to propose minimum standards for nursing facility staffing within the year.

CMS uses PBJ data in a number of ways. CMS publicly reports staffing measures on Care Compare, and includes measures in the nursing facility star rating staffing domain. CMS also incorporates PBJ data into the state survey process for compliance and investigation purposes. CMS plans to add a staffing measure into the SNF VBP program in 2026.

MedPAC staff conducted analysis of PBJ data from 2019 through 2021, including identifying sector-wide trends in total staffing, total resident days, staffing level and mix changes, and changes in the use of contract staff. Staff analysis showed:

- Reductions in staff hours and resident days that had not recovered to pre-pandemic levels.
- Nurse staff hours per resident day that remained generally consistent, but were slightly lower by the end of 2021
- Nursing facilities' use of contract staff that increased in 2020 and 2021 to 8.4% of staffing hours per resident day (up from 3 percent in Q1 2019)

Staff identified future analysis that could be conducted, including:

- Aggregate sector-wide trends in mix of nursing staff types, use of contract staff, and staff hours per resident day.
- Facility-level variation in mix of nursing staff types, use of contract staff, and staff hours per resident day.
- Beneficiaries' access to SNFs by staffing level.
- The relationship between facilities' staffing levels, costs, and margins.

Staff sought input from the Commission on future work that could be undertaken using the PBJ data, including in its payment adequacy analysis and other research on the nursing facility workforce.

Commission Discussion

Commissioners generally noted enthusiasm for the availability of the PBJ data and the additional insight it could offer and encouraged further analysis of the data. Additional comments addressed the following:

Minimum staffing requirements

- ***Commissioner Kan*** asked if future work could include minimum staffing requirements that vary by facility. Staff noted that they are looking for direction from the Commission. ***Executive Director Mathews*** did not anticipate focusing on minimum staffing requirements, but noted that this is an area that CMS is exploring. MedPAC analysis could inform CMS' development of new standards.
- ***Commissioner Grabowski*** suggested caution around minimum staffing requirements, noting the need for new dollars (from Medicare or Medicaid), as well as the need for transparency in how facilities use their funds.
- ***Commissioner Rambur*** noted that she has limited support for minimum staffing requirements. She noted it was a regulatory solution to a market problem. She suggested the need to increase payment for nurses.

Interaction between State Policy and Medicare policy

- ***Commissioner Jaffery*** asked what other information might be available at the state level, noting the variation in state policies. He questioned whether federal recommendations would be possible. Staff noted that they could look at state-level policies and could – at the least –

qualitatively describe policies. Staff suggested state policies would be "unignorable," even though MedPAC does not typically look at state-level policies.

- *Commissioner Sarran* asked about data on Medicaid per-diem payments. State payment data may be more difficult to obtain. MACPAC has done some preliminary analysis, which can be shared. *Commissioner Sarran* suggested the need to shine a light on these relationships.
- *Chair Chernew* noted the challenge of recognizing the impact of Medicaid policy and making a connection to recommendations for the Medicare program. MedPAC will need to stay in its own lane. *Commissioner Sarran* indicated that there is a legitimate interest in Medicaid funding policy because Medicare beneficiaries live in the facilities and their safety is affected. *Chair Chernew* acknowledged that concern. He also noted that in some cases, payers pay more than Medicare and that help the Medicare program. As the Commission goes through staffing data, MedPAC will have to acknowledge how the situation is affected by funding, but will have to consider its own purview.
- *Chair Chernew* noted that if there is a challenge with staffing in SNFs, there is a question as to what extent is that a MedPAC problem. It affects Medicare beneficiaries, so it is a concern, but it also affects MedPAC's payment adequacy recommendations. This analysis will give insight into an area where there was not much before.

Potential areas for future exploration

- *Commissioner Sarran* asked about whether the staffing data could be matched up against measures of acuity and patient outcomes. Staff noted that CMS is looking at some of these exact issues about the relationship between staffing and quality outcomes. *Commissioner Damberg* also suggested using PBJ data alone or in combination with other data to better understand the relationship between staffing and quality of care, including taking into consideration intensity.
- *Commissioner Grabowski* supported the idea of incorporating data into payment adequacy work.
- *Commissioner Grabowski* suggested that MedPAC can further explore the therapy data reported in the PBJ.
- *Commissioner Damberg* expressed interest in understanding the relationship between staffing levels and profit margins.
- *Commissioner Cherry* noted that staffing is a tool for improving safety and quality, as well as a need to ensure access to SNF care. Lack of staff creates access challenges, including on weekends. He suggested that weekend throughput should be considered.
- *Commissioner Cherry* noted the need to address social needs and other services furnished to nursing facility residents besides just nursing.
- *Commissioner Casalino* specified that any study of staffing and quality should account for the three different types of staff, which are different from each other.

Clarifying questions

- *Commissioner Dusetzina* asked whether the PBJ analysis included sick time as well as working time. Staff noted that the time could not be distinguished between the two. Staff also noted that there could have been a reduction in direct care staffing hours with the pandemic.
- *Commissioner Damberg* asked whether there was acuity data. Staff indicated that there was acuity data.
- *Commissioner Rambur* asked whether staffing data include geriatric nurse practitioners. Staff indicated that they do not. There is also therapy staffing data that are not included.

Additional topics

- ***Commissioner Grabowski*** suggested that CMS underweights staffing data on Care Compare. He noted interest in recommending that to CMS.
- ***Commissioner Grabowski*** noted the need to take care when looking at trends in staffing versus trends in residents. All the data available suggests that patients are more high-acuity today than they were in the past so constant staffing levels per resident may be misleading.
- ***Commissioner Grabowski*** suggested working on the tone regarding Medicaid wage pass-through policies. Studies suggest these policies lead to better wages and staffing when they are implemented. He noted that the challenge is that there is leakage, which has led to questions regarding whether the policies do what they were intended to do.
- ***Commissioner Grabowski*** noted that parts of the country with increases in immigration have better staff nursing and quality. Limits to immigration will limit staff. This may be outside of MedPAC's purview.
- ***Commissioner Rambur*** suggested that nursing facilities should be places that everyone would want to work at and also where everyone would want to receive treatment. As such, policies should reflect such a goal.
- ***Commissioner Rambur*** noted that SNFs and nursing homes compete for the same staff.
- ***Commissioner Rambur*** suggested that a portion of savings from value-based care models should go back to nurses.
- ***Commissioner Rambur*** suggested graduate nursing education funding could go to nursing homes.
- ***Commissioner Poulsen*** suggested that the current landscape is one that will change with the use of new technologies. He suggested considering factors beyond just human staffing that could better support residents. He noted some of this transition may fall short regarding social needs, but that there could also be lessons learned from experiences during the COVID-19 PHE. This look at technology could address some of the issues around staffing shortages and staffing expense.

In closing, ***Chair Chernew*** emphasized the relationship between staffing and quality. He acknowledged Commissioner Poulsen's comments regarding technology. He also raised the need to consider contract nurses in the analysis. He suggested that the more that the Commission can understand about the facilities, the more they can consider a range of potential follow-up action.

Mandated report: Study on the expansion of telehealth

Presentation

Ledia Tabor and Ariel Winter

Overview

The Consolidated Appropriations Act 2022 required a report to Congress to be submitted by June 2023. The report was required to include five elements:

- Information on the use of telehealth services
- Medicare expenditures on telehealth
- Medicare payment policy for telehealth services and alternative approaches under the Physician Fee Schedule (PFS) and the payment systems for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- The impact of expanded telehealth coverage on access to care and quality
- Other areas determined appropriate by the Commission

Before the PHE, coverage of telehealth was flexible in Medicare Advantage, two-sided accountable care organizations (ACOs), and other payment systems, but coverage was limited under the PFS, where Medicare paid for a limited set of services provided in certain settings in rural areas, with some exceptions. Use of telehealth was low, reflecting less than 1 percent of PFS spending in 2019.

At the start of the PHE, to allow beneficiaries to maintain access to care, Medicare temporarily expanded coverage of telehealth services. Medicare expanded telehealth to beneficiaries in rural and urban areas, including to patients in their homes, added a number of services to the Medicare telehealth services list and allowed audio-only interaction for certain services, and began paying services at a higher non-facility rate, as if the services were furnished in person. Prior to the PHE, the PFS paid for telehealth at the lower facility rate.

In the March 2021 Report to the Congress, the Commission provided a policy option for post-PHE telehealth to continue certain telehealth expansions for a limited time (e.g., ongoing telehealth coverage regardless of location, ongoing telehealth coverage of selected services with potential for clinical benefit, and provision of certain services via audio-only interaction), but also to revert to some other pre-pandemic policies (facility rate payment and no waiver of cost sharing) and to incorporate additional safeguards to protect against unnecessary spending and potential fraud.

Congress and CMS have made other changes to Medicare's telehealth policies, including extending flexibilities for 5 months after the PHE, covering tele-behavioral health services at home, and extending the timeframe for covering some services furnished via telehealth until the end of 2023. CMS also included a proposal to require a claims modifier for audio-only services, consistent with a Commission recommendation, in the CY 2023 PFS proposed rule.

For the analysis plan, staff plan to use Medicare claims data to examine volume and spending for telehealth services provided by clinicians, FQHCs, and RHCs. Staff will use data between 2019 and 2021. Staff will assess the telehealth flexibilities on access and quality, but they also noted that the analysis is limited by several factors, including limited use of telehealth before the PHE, concerns about the representativeness of data during the early pandemic days, and technical challenges such as lack of data on lab results or other reported outcomes. Staff are working to test the feasibility of using population based measures, such as ambulatory care sensitive hospitalizations and emergency department visits, to study the impact of telehealth expansions. Staff will provide more details as it finalizes its methodology in future meetings.

In addition to claims analysis, staff will also use additional sources, including review of literature, focus groups with beneficiaries and clinicians, and the annual survey of Medicare beneficiaries and privately insured individuals.

Staff also presented an alternative option for paying for telehealth services under the PFS, consistent with the charge for the mandated report. Staff noted problems with paying separately for telehealth services (e.g., incentives to bill for more services, administrative burden associated with documentation and billing, and difficulty in pricing services). As an alternative, staff suggested an alternative under which telehealth services would be bundled into a larger unit of payment, such that each service would not be billed and paid separately. Staff suggested these bundles could be expanded evaluation and management office and outpatient visit codes that include related telehealth and in-person services provided during a period of time (e.g., 30 days, 60 days, or 90 days). Staff noted that there are

precedents for bundled payments under the PFS, including monthly bundled payment that covers outpatient dialysis-related physician services for ESRD patients, as well as global surgical bundles. However, staff also noted concerns that surgical global procedures appear to be overvalued and noted the importance of monitoring changes in care delivery and adjusting payment rates to reflect changes.

Staff provided an illustration of expanded E/M office/outpatient bundled visit code on slide 15. However, staff noted that several design considerations would need to be addressed. For example:

- Which services to include in expanded E/M codes (E/M visits, in person and telehealth, virtual check-ins, remote evaluation of digital images, no originating site fee). Staff noted that telehealth services not bundled would be paid separately.
- What time period to cover
- How to account for variation in time and resources.
- How to determine payment rates
- How to ensure that payment rates remain accurate over time.

Separately, for FQHCs and RHCs, during the PHE, Medicare temporarily expanded coverage of telehealth services provided by FQHCs and RHCs. While before the PHE, these facilities could only bill as an originating site, during the PHE they could bill for any service payable via telehealth under PFS. The rate paid is less than what Medicare pays for in-person services for these facilities. If telehealth continues to be paid, CMS could pay based on its standard in-person rate, but CMS could also continue to pay based on PFS rates, similar to what is paid during the PHE. That would reflect a lower cost for furnishing services and would align payment/achieve payment parity. However, payment at the PFS rate would likely require a change in statute.

Staff sought feedback from the Commissioners on the draft analytic plan, the alternative bundled approach for paying for PFS telehealth services, and the alternative approach for paying for FQHCs and RHCs. They noted that this work will be included as a chapter in the June 2023 report.

Commission Discussion

Deliberation on the analysis plan

- *Commissioner Grabowski* asked for clarification on population-based measures. Staff indicated it would include the measures used for payment adequacy work, such as ambulatory-sensitive admissions.
- *Chair Chernew* clarified that staff would look at markets with high telehealth intensity and low telehealth intensity.
- *Commissioner Safran* asked whether methods will involve claims. Staff confirmed that they will use claims, along with focus groups, literature review, and beneficiary survey.
- *Commissioner Damberg* asked if staff would be able to track telehealth via modality given the CMS proposal to report on audio-only claims will only go into effect in 2023. Staff noted that there are certain codes for telephone E/M that can be tracked. There are other services that are billed audio only or with video using the same code, so for those codes, it will be difficult to tell until after the 2023 modifier data become available.
- *Vice Chair Navathe* suggested looking at telehealth by primary care versus specialty care.
- *Vice Chair Navathe* suggested looking at the substitutive versus additive nature of telehealth services.
- *Vice Chair Navathe* agreed that the analysis should not seek to pit in-person care against

telehealth.

- *Commissioner Casalino* suggested that MedPAC give attention to telehealth only organizations and whether they should be paid at the same rate as organizations that have brick and mortar locations. He indicated that telehealth only organizations should be paid less as they have lower costs, brick and mortar offices may be harmed, and services offered may vary (e.g., related to referrals and lab services).
- *Commissioner Dusetzina* suggested looking at avoidable face-to-face visits.
- *Commissioner Safran* noted the need to focus on equity impacts, suggesting that one of telehealth's most important impacts could be an improvement in equity. *Commissioner Damberg* agreed with the notion that telehealth has helped to address access issues and equity.
- *Commissioner Ryu* noted that telehealth has been used in many different ways. The trick is to figure out the scenarios where telehealth is more likely to be replacement versus duplicative or demand-inducing.
- *Commissioner Damberg* noted the difficulty in measuring inappropriate care and how to best monitor for inappropriate use.
- *Commissioner Damberg* also asked about the potential for misdiagnosis via telehealth versus in-person care.
- *Commissioner Rambur* was positive about the use of population-based measures.

Deliberation on the alternative bundled payment approach raised by staff for PFS payment

- *Commissioner Casalino* asked if the standard E/M rate would be paid for all visits, or at what point would it be billed. Staff suggested that that is to be determined. Not necessarily all E/M visits would be included. And physicians would likely bill towards the end of the period to determine the right level at which to bill for the service.
- *Commissioner Casalino* asked if a claim for an ankle sprain would be included in an expanded claim for an initial asthma visit. Staff suggested that this will be another design consideration, noting the different resources required but also the risk of unbundling.
- *Commissioner Casalino* asked whether all E/M visits would be paid at an expanded rate. Staff suggested focusing on office/outpatient visits, and not E/M visits in other settings. It might make sense to consider all office/outpatient E/M visits for the code.
- *Executive Director Mathews* suggested Commissioner Casalino's question may have addressed whether a standalone E/M visit would need to be billed as an expanded visit.
- *Commissioner Barr* noted that many providers refused to do telehealth. How would they be considered under an expanded E/M code? Staff suggested that the lowest level of code could be used for a single in-person visit only. If telehealth were furnished, a higher-level code could be used.
- *Commissioner Casalino* noted the challenge of billing and administrative complexity with a bundled visit. Staff agreed with this challenge and noted that it supported a shorter time period for the bundle. Staff also noted that there is a process for submitting amended claims.
- *Chair Chernew* noted the difficulty in answering clarifying question if there are still design considerations. He noted there were a lot of design issues to consider.
- Several Commissioners raised concerns about or opposition to bundling payment as suggested in the presentation (*Vice Chair Navathe, Commissioners Jaffery, Safran, Ryu, Kan, Barr*).
- *Vice Chair Navathe* raised concerns about the suitability of these services with a bundled structure. A bundle ideally includes a defining triggering event, a start and stop, and an accountability structure. A bundle will inherently include a cliff, which may raise concerns. He suggested the Commission should be careful and consider suitability. He also noted that, to the

extent that there are different levels of care, that undermines the concept of having the episode. He also suggested the contemplated bundle seemed to look a lot more like surgical codes rather than dialysis codes, which should make the Commission more concerned. ***Commissioner Jaffery*** raised concerns about a bundling approach, in line with Vice Chair Navathe.

- ***Vice Chair Navathe*** suggested considering a telehealth-only bundle, triggered by a first telehealth service. However, it will also have the same problems he mentioned above.
- ***Commissioner Dusetzina*** liked the idea of bundling, but worried about potential overbilling and overpayment. She noted that if there is flexibility to correct payment retroactively, that may be difficult from an accounting perspective.
- ***Commissioner Kan*** raised concerns about administrative burden and gaming.

Considerations related to global surgical packages

- ***Commissioner Poulsen*** asked whether global codes capture virtual check-ins. Staff noted that the bundled visit data for global surgical codes were collected starting in 2017. Staff noted that the virtual check-in code was not introduced until 2018 or 2019. But the data collection focused on E/M visits, not virtual check-ins. Commissioner Poulsen noted that virtual services may already have been replacing in-person visits for the global codes.
- ***Commissioner Barr*** asked whether patients had more follow-up visits before global surgical payment and whether that dropped off. Staff suggested that there is not good data to answer that question. Global surgical codes were always built in from the beginning of the Resource-based Relative Value Scale. There could potentially be information on codes that switch global periods. However, there is little data on services provided during the global period.

Telehealth payment for FQHCs and RHCs

- ***Commissioner Kan*** asked how rural FQHCs and RHCs are paid for telehealth services. Staff noted that they are paid at the PFS rate for telehealth services, regardless of location.
- ***Commissioner Barr*** asked what the impact of PHE was on traditional telehealth, with rural beneficiaries and originating sites. Staff indicated that this could be investigated. However, since most telehealth visits were furnished while beneficiaries were at home, originating site claims went down significantly during the PHE.
- ***Commissioner Barr*** noted limited uptake of telehealth in rural communities and significant barriers. Provider-based RHCs that are cost-based reimbursed have a very difficult time carving out services like this. She noted that if the policy prevents access, it is a bad policy. A policy could create a barrier to care for cost-based reimbursement. She was not supportive of cost-based facilities having additional requirements. She noted that FQHCs are not cost-based reimbursed, so she does not feel as strongly about them.

Concerns about expanded availability of telehealth and preference for limiting use of telehealth in alternative payment models

- ***Commissioner Ginsburg*** noted the need to be careful about going forward or the Medicare program may be facing a financial disaster and poor-quality care.
- ***Vice Chair Navathe*** suggested layering in flexibility aligned with APM participation, to align design elements with a system that could potentially work.
- ***Commissioner Casalino*** noted a recent article by Chair Chernew and colleagues on telehealth considerations in Millbank Quarterly. It lays out a conceptual map for thinking about telehealth and could be incorporated into the Report to Congress. He noted the issue is extremely important and likely to move quickly. ***Chair Chernew*** noted that the report could be considered

an argument for why telehealth would not work in FFS.

- *Commissioner Dusetzina* acknowledged the benefits of telehealth, but also the risk of gaming and inaccurate payment. She noted that many times telehealth services are used to avoid a face-to-face visit. Additionally, she noted that in cases, telehealth visits do lead to in-person visits, which might require reduction of payment for initial telehealth visits.
- *Commissioner Jaffery* agreed that greater clarity was needed about how telehealth services are used. He asked what is the problem that needs to be solved. He noted that the problems noted in the presentation regarding billing and payment for telehealth are generally problems not just with telehealth, but with FFS more broadly. He suggested that there was a need to move towards population-based payments. He supported providing APMs more flexibility to use telehealth.
- *Commissioner Sarran* suggested piloting the bundle with two or three chronic conditions. That might be a way of taking off the table concerns about waste, fraud, and administratively complexity. He suggested the pilot could even offer a $0 copay to take away barriers to care for patients with these conditions.
- *Commissioner Poulsen* agreed with Commissioner Jaffery and Sarran. Telehealth offers good value and other benefits (e.g., greater safety), and when done appropriately is satisfying for patients. Some pre-paid systems have been successful at incorporating telehealth into care. Fear of abuse is legitimate.
- *Commissioner Poulsen* liked the idea of looking at some bundles, per Commissioner Sarran's suggestion. He suggested being agnostic regarding use of telehealth versus other care modalities. Some systems may be willing to share information and analytics.
- *Commissioner Cherry* noted the challenge of operationalizing payment changes. He suggested that palliative care was a great example of how telehealth could be used. It could be used with multiple disciplines in the same visit, and with family members across the country, but it may not follow typical patterns for first visits. Similarly, dermatology is another use case that may not well follow the bundled approach. There might be some value in following patients for a longer period of time, for example. Diabetes care is another example. Every situation is a little different and therefore it may not be cookie cutter. He suggested it may be good to think about a phased roll out, e.g., to start with primary care home models. Maybe think about specific conditions or population-health models.
- A Commissioner asked to what extent it was MedPAC's role to say telehealth was not well suited for FFS. *Chair Chernew* was not sure about the answer to that question. MedPAC can certainly describe the complexity of shoe-horning telehealth into FFS. However, he was not comfortable recommending no telehealth in FFS.
- *Commissioner Safran* noted a need to clarify that telehealth with FFS could potentially bust the budget. It raises the need to move to APMs.
- *Commissioner Safran* did not like the bundled concept that was discussed, but could get comfortable with bundles that Commissioner Sarran and others have proposed. She noted that chronic condition bundles have not shown evidence of saving money, but this could potentially change that.
- *Commissioner Ryu* was also interested in discrete bundles.
- *Commissioner Damberg* shared concerns about potential for overuse and overpayment. She wanted more information about where telehealth has been used effectively.
- *Commissioner Rambur* agreed with Commissioners Jaffery, Sarran, and Poulsen, and noted that telehealth should be provider agnostic, e.g., to include social workers or diabetes educators.

Interest in and ideas for recommendations that could work under FFS

- *Commissioner Barr* suggested thinking about telehealth similar to the chronic care management (CCM) services. It could still be triggered by an E/M. She noted that patients want telehealth from their providers. She supported telehealth but in a way that does not allow as much gaming. *Commissioner Jaffery* suggested the CCM approach would be problematic for many beneficiaries and could exacerbate disparities. He suggested the need to allow health systems and providers to innovate around providing this kind of care. *Commissioner Barr* acknowledged concerns about CCM services, but she noted that ACOs can waive cost-sharing.
- *Chair Chernew* suggested the questions from the Hill were about how to pay for telehealth in an FFS world, which is different from how the conversation is going. He suggested that one way might be to keep FFS, without the bundling alternative discussed, and, to just change the facility fee.
- *Commissioner Barr* noted ongoing concerns regarding simply cutting the facility fee and suggested needing to continue to consider value-based care.
- *Chair Chernew* noted the need to further discuss cost-sharing for telehealth. He did not believe that simply cutting the facility fee would solve all problems.
- *Commissioner Kan* asked whether the Commission could narrow the scope, noting that the permutations were mind-numbing.
- *Chair Chernew* noted that the Commission was trying to be responsive to Congressional ask. He did not want to close the door to a valuable service, but also worried about opening the door to abuse. He suggested that the Commission could possibly indicate that the work part of delivering a service is the same, but the practice expense is less, and monitoring is needed.
- *Executive Director Mathews* noted that, given the changes to telehealth payment that were implemented during the PHE (higher payment, expanded telehealth), the appetite for ideas of what the appropriate level and mechanism for paying for telehealth is tremendous.
- *Commissioner Safran* noted that the service is more efficient but there is not willingness to lower the price.
- *Commissioner Barr* continued to recommend that payment for telehealth should follow a CCM model, but *Chair Chernew* noted implementation and payment questions that would still need to be addressed.

Additional topics

- *Commissioner Ginsburg* asked when the PHE would be ending, noting that the Commission needs to factor that into its discussion. Staff indicated that it was outside MedPAC's domain.
- *Commissioner Barr* asked about the adoption rate of virtual check-ins. Staff noted that its use increased a lot between 2019 and 2020, and the staff will continue to look at data for 2021. Commissioner Barr suggested that many physicians refused to use virtual check-ins given low payment. Staff noted that a higher paid virtual check-in code was also finalized.
- *Commissioner Dusetzina* suggested that patterns of telehealth may have changed as patients and providers understand what types of visits may be effectively conducted via telehealth.
- *Commissioner Ginsburg* asked what is known about how MA systems are using telehealth and that she had a good experience with an MA plan. Staff noted that MA encounter data has problems with reliability and accuracy so that data will not be used for this report.
- *Commissioner Ryu* remained supportive of previous recommendations in the 2021 Report to Congress. Commissioner Rambur agreed.
- *Chair Chernew* noted the need to be cognizant of administrative costs. Administrative burden (e.g., documentation and coding) is crushing for many providers. Whatever the Commission does

should not make the administrative burden substantially worse.

Chair Chernew closed by appreciating the robustness of the conversation. He noted that the public can submit comments at meetingcomments@medpac.gov

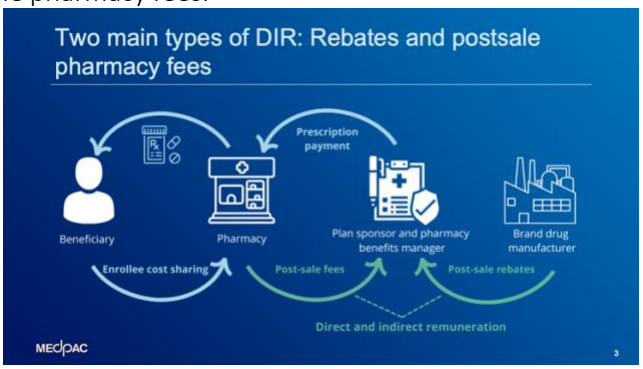
Analysis of Part D data on drug rebates and discounts

Presentation

Tara Hayes, Shinobu Suzuki, and Rachel Schmidt

Overview

First, staff offered an overview of mandated and negotiated price concessions in 2020—which totaled 33 percent of Part D spending. Then, staff discussed the two main types of direct and indirect renumeration (DIR): rebates and post-sale pharmacy fees.



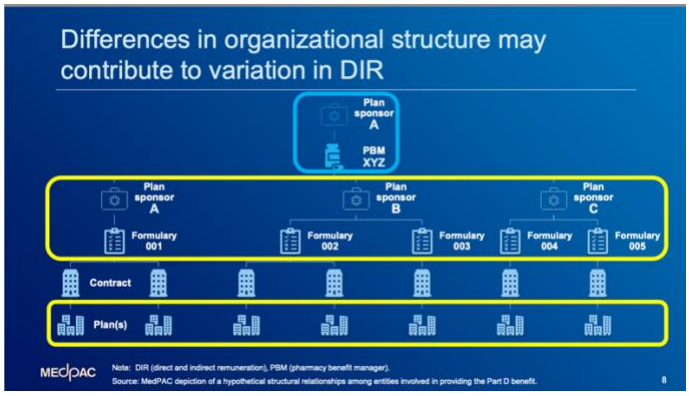
Next, staff discussed how plan sponsors apply their share of DIR—which have inherent tradeoffs. CMS retains a share of DIR to reflect price concessions on Medicare's reinsurance payments. Noted that plan sponsors typically use the ret to keep premium growth lower, which benefits all (including Medicate). Highlighted certain tradeoffs in this case: disproportionately high-cost sharing on rebated drugs paid by certain enrollees; and Medicare's low-income subsidy (LIS) and higher Medicare reinsurance.

Then, staff reviewed how Part D has incentives to maximize rebates. Noted how private plans compete for enrollees largely based on premiums, and how pan sponsors' share financial risk for benefit spending is small or absent in certain benefit. Highlighted how Medicare and taxpayers are at risk for about 60% of benefit cost.

After, staff shared other factors have contributed to DIR. Shared information on how case studies of three drug classes with large and growing rebates showed strong brand-brand rivalry but little or no generic or biosimilar entry. Highlighted how consolidation of plan sponsors and vertical integration with pharmacy benefit managers (PBMs) has increased bargaining leverage for manufacturer rebates and pharmacy fees.

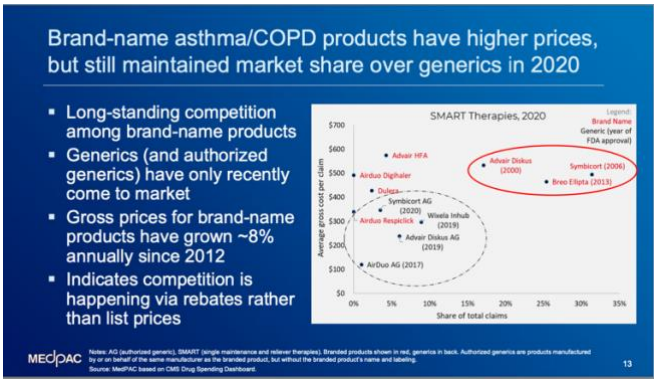
Next, staff shared analysis of the 2020 DIR data for 30 brand-name drugs from 10 categories of drugs with a varying degree of brand-brand competition (one category each from antineoplastics, anticoagulants, and anti-rheumatoid drugs; three categories of asthma/COPD therapies; and four categories of diabetic therapies). Highlighted than average rebates ranged from less than 10 percent for antineoplastics to less than/equal 50 percent for diabetic therapies. Noted that the analysis was based on average rebate amount per standardized prescription.

After, staff highlighted how the differences in organizational structure may contribute to variation in DIR. Staff noted how large sponsors use their own PBMs and for some products, PBMs may customize rebate per plan sponsor.

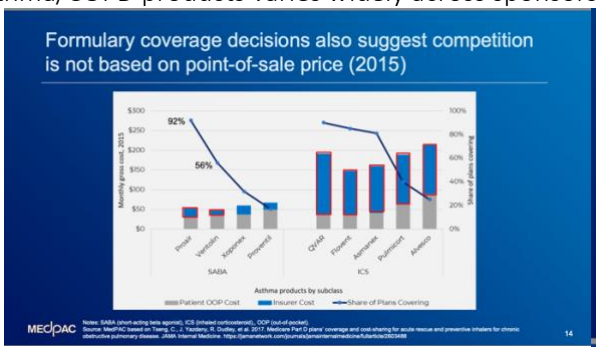


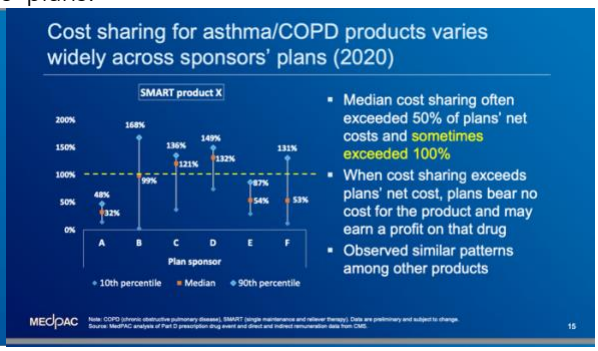
In analyzing the 2020 DIR data, staff discussed how rebates received for the same product can vary widely. Among the six largest plan sponsors, the median rebate ranged as much as 2.5 times. Rebates for a given product can vary widely even among plans operated by the same sponsors. Large sponsors tend to use multiple formularies. The use of different formularies could explain why rebates vary among plans operated by the same sponsors. Staff also discussed how plans using the same formulary may face widely divergent costs. Plans using the same formulary tended to receive similar rebates, but staff found instances where large differences remained and the extent of the variation differed across plan sponsors, individual formularies, and by product. It was interpreted that this means that the net-of-rebate cost of a given product may vary widely even among plans using the same formulary and that implications for cost sharing paid by beneficiaries and Medicare's low-income cost-sharing subsidy. Staff then discussed that for drugs with high rebates, cost sharing can exceed plans' net costs. For six largest plan sponsors, cost haring for some products exceeded 50% of plans' net of rebate costs. In some cases, cost sharing exceeded plans' total net costs, highlighting that: plans did not incur any benefit costs for these prescriptions; beneficiaries and Medicare's LIS paid more than the total cost of the drug; and in many instances, the highest cost sharing involved LIS enrollees, where Medicare paid most of the cost sharing.

After, staff shared more specific examples related to the case study focused on Asthma and COPD medications. For these medications, rebates have estimated to grow substantially (from about 30 percent in 2016 to upwards of 49 percent in 2020). Brand name products continue to dominate the market—in most of the subclasses, brand-name products accounted for 75 percent of more of Part D claims in 2020. Staff noted that unique characteristics create regulatory hurdles that may inhibit generic entry. Staff also reviewed how brand-name asthma/COPD products have higher prices, but still maintained market share over generics in 2020.



Staff then reviewed data on formulary decisions among asthma products, and cost sharing for asthma/COPD products varies widely across sponsors' plans.





Next, staff summarized initial findings: there is wide variation in rebates, sometimes even among plans using the same formulary; for highly rebated drugs, cost sharing can exceed plans' net costs (beneficiaries and Medicare may pay more than drugs' costs to the plans); and factors contributing to large rebates may vary widely across drug classes and products and likely evolve over time.

Finally, staff offered considerations of a changing landscape. Staff noted that the drug pricing provisions included in the recently enacted *Inflation Reduction Act* (IRA) (related to Part D benefit redesign, inflation rebates, and price negotiation) may affect rebates. Staff noted that the DIR analysis conducted provides a baseline for evaluating these and other changes.

Next Steps and Discussion:

- Analyze other years of data to better understand the relationship between rebates and changes in competitive dynamics;
- Examine rebates for drugs affected by specific policies (such as, protected classes or specialty-tier drugs);
- Focus on understanding the potential implications for beneficiaries and Medicare program spending.

Note: It was disclosed that slide 14 presented some product specific information on rebates. MedPAC is citing an external study, *not* reporting out on drug manufacturer rebate arrangements.

Commission Discussion

Commissioner Kan: I am enthusiastic about the chapter based on rich and powerful data. Highlighted Page 17 and Page 20 on reading material related to how IRA could change many of the information discussed – I believe [the IRA] may mitigate many of the cost-sharing and access implications of the study.

Chair Chernew: Noted that MedPAC would not going to go forward on a specific policy response at this time given the policies enacted in the IRA. We will be able to continue to monitor this in the future. The drug pricing provisions in the IRA have connection to topics that MedPAC has been talking about for a long time.

Commissioner Dusetzina: Inquired on the rational for rebates. Why not just have competition for prices? Offered minor comments on the report. On Page 7 – there is mixing two concepts – high price of specialty drugs and gross-to-net price growth. IRA will solve some issues over time, but we don't know yet if plans will use co-pays or co-insurance for coverage gap. Suggested that an additional follow up question may explore how often plans use co-pays for drugs that have these large rebates. Discussed how insulin is an extreme example. Inquired about showing additional context on the same issues patients face with other high priced brand-named drugs.

Commissioner Saran: I think there should be some exploration of pros/cons of making all rebate data public. I understand it is not a simple topic, but it should at least be discussed.

Vice Chair Navathe: Discussed the issue of price transparency is complicated. We have a trend towards real-time benefit checks through electronic health records – including into what the cost is to a patient at point of care. Inquired if transparency related to rebates – is giving this information to the beneficiary the transparency they need? Can you comment on that in context of dynamics around price transparency? *Answer*: [Beneficiaries] are not seeing a rebate piece of it. I wouldn't say it is not beneficial at all. If [beneficiaries] are using copays, at least they could be aware of that and the options. At least in terms of copay. It would not be getting to the absolute lowest cost. In the paper we highlight how manufacturers receive rebates for better formulary placement. There is a benefit for beneficiaries to see co-pay amount versus co-insurance amount.

Commissioner Dusetzina: Discussed issues explored in a previous report on variability of rebates. Highlighted long-standing arguments surrounding transparency between plan sponsors and PBMs. Noted lawsuits related to the topic.

Chair Chernew: broadly – price discrimination is not inherently bad in certain types of markets. But there are many places where that goes array – the most egregious being patients paying more out of pocket for the drug more than the cost of the drug. Our main concern is having the data and understanding of what is going on. Noted that the issue raised related to the price transparency of copays vs. coinsurance is interesting. We are not in the stage now to make recommendations. The IRA won't solve all the problems, but we will see impact.

Vice Chair Navathe: On price transparency – what we mean may not be interpreted by everyone the same way. A real-time benefit check tool would accomplish that for price transparency for the beneficiary. We need to be aware of that.

Commissioner Damberg: How come we are not talking about consolidation? I hope MedPAC would try to spotlight that more- either in this chapter or a future chapter—and what policies changes could influence that.

Chair Chernew: This is complicated because many of these things are happening outside of MedPAC. Many of bigger-picture issues and how the prescription drug market works is beyond us, but it is important to point out in the context of these chapters. It is great that we have this data – we have a particular concern with how beneficiaries have access to medications (this a core goal to promote quality in many of chronic conditions). Going forward – we will continue to monitor this, the IRA, and the markets—and see where we may be able to find opportunity to make recommendations on policies.

Chair Chernew thanked the commissioners and the staff and adjourned the meeting.

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The next MedPAC meeting will be held on November 3-4, 2022