TRANSCRIPT (**SECOND VERSION, 15 MINUTES**)

https://docs.google.com/document/d/1ZOcgKZXzZByOqNBLY01aFZbaPe6wyuVV/edit?usp=sharing&ouid=110053226805181888143&rtpof=true&sd=true

Google Notebook Makes 2-Voice Podcast from My Policy Blog (CMS Lab Pricing)

BLOG:

https://www.discoveriesinhealthpolicy.com/2024/09/cms-releases-preliminary-crosswalk-for.html

How to Do It:

https://lifehacker.com/tech/use-google-notebooklm-ai-to-turn-your-research-into-a-podcast

NOTE:
This podcast is not entirely correct and misses some points of emphasis. However, it's still a remarkable new service within Google Notebook LM.

##

Debra:
All right, everybody get ready because today we are really diving deep-

... into the weeds of Medicare's Clinical Lab Fees Schedule.

Charles:
The CLFS?

Debra:

The CLFS, that's right.

Charles:

Yeah.

Debra:

This is the thing that puts the price tag on every single lab test that you see on your Medicare statement. It is a mystery.

Charles:

It is, it is for a lot of folks.

Debra:

It's true.

Charles:

But luckily-

Debra:

For us-

Charles:

... we have Dr. Bruce Quinn, our resident expert.

Debra:

He's fantastic.

Charles:

Oh, he's fantastic this guy.

Debra:

I mean, he even went so far as to file a FOIA request, a Freedom of Information Act request.

Charles:

He's committed.

Debra:

Oh yeah, he's committed.

Charles:

This is good insider baseball stuff he got.

Debra:

It is insider baseball, and that's our main source today.

Charles:

It is-

Debra:

[inaudible 00:00:47] where he analyzed how CMS, the Centers for Medicare and Medicaid Services proposes these new lab test prices.

Charles:

How they debate them, how they come up with this.

Debra:

Yeah, how they come up with it, and especially where CMS actually disagrees with its own expert panel.

Charles:

Right, and we're going to layer in some AI analysis too, from ChatGPT.

Debra:

Oh, very nice.

Charles:

Which Dr. Quinn actually used in his analysis. Very clever.

Debra:

Very clever. So we have a backstage pass basically to how this all happens.

Charles:

Precisely.

Debra:

So before we get too far, let's back up and just level set for everyone.

Charles:

Yes.

Debra:

What is the clinical lab fee schedule or as the cool kids call it?

Charles:

The CLFS.

Debra:

CLFS.

Charles:

Think of the CLFS, kind of like a restaurant menu, but instead of listing appetizers and entrees and all that, it lists every single lab test that Medicare covers. Right?

Debra:

Right.

Charles:

And each listing, just like on a menu, has a price next to it. And that is what Medicare agrees to pay for that specific test.

Debra:

That makes sense. But for new tests that come out, how do they get on the menu?

Charles:

It's a great question. And CMS has basically two main tools to do this. One is called crosswalking and the other is called gapfilling.

Debra:

Ooh, crosswalking and gapfilling.

Charles:

Yeah.

Debra:

Okay. So let's start with crosswalking. Is that kind of finding a close match?

Charles:

Yeah, basically if a brand new test comes out that's similar to one that's already on the CLFS, they'll often just base the price on that existing test.

Debra:

So if a new cholesterol test comes out that's similar?

Charles:

Right, like a new version or something.

Debra:

They'll just say, "Well, it's about the same as this other one."

Charles:

Exactly.

Debra:

"So the price should be similar."

Charles:

Makes sense.

Debra:

That makes sense.

Charles:

Yeah. Things get a little trickier when you have these really brand new tests, and we're talking about molecular diagnostics, things like that. These tests are so new that finding a comparable test on the CLFS, it's almost impossible.

Debra:

So that's where gapfilling comes in.

Charles:

That is where gapfilling comes in.

Debra:

Which sounds a lot more mysterious.

Charles:

It's a little more complex. It can be.

Debra:

Yeah. So walk us through gapfilling.

Charles:

So with gapfilling, CMS essentially says, "You know what? We don't have a good comparison here. So we're going to hand over the pricing reins to the regional Medicare contractors," and those are known as Ms.

Debra:

Wait, hold on up.

Charles:

Okay.

Debra:

Ms?

Charles:

MCs.

Debra:

Yeah. What are Ms?

Charles:

Medicare Administrative Contractor. And essentially they process Medicare claims. They handle kind of the day-to-day operations in different regions of the country.

Debra:

So if they can't crosswalk it, they hand it over to the Maxis and just say, "Hey, you guys figure out the price."

Charles:

Essentially.

Debra:

But how do they do that if there is nothing to compare it to?

Charles:

That's the thing.

Debra:

Do they just throw a dart at a board?

Charles:

It's a little more scientific than that, thankfully. They'll consider factors like the actual cost that labs face to run these tests, the equipment they have to use, the expertise needed, because these are very sophisticated tests. And they might also look at what private insurers are paying to get a feel for the market.

Debra:

So you're saying there's a little bit of regional variation in there?

Charles:

There can be. Absolutely.

Debra:

What's considered a fair price for a test here in New York City might be different than what they think is fair in, I don't know, rural Kansas?

Charles:

And that's actually one of the kind of advantages of gap-filling.

Debra:

Okay.

Charles:

It's that it allows for that regional flexibility.

Debra:

That makes sense.

Charles:

Especially with these new technologies, maybe tests that target very specific patient groups. It allows for the price to reflect those regional differences in cost and things like that.

Debra:

That makes sense. But I'm sure it's not all sunshine and roses.

Charles:

Of course not.

Debra:

What are some of the downsides to this gap-filling?

Charles:

One of the biggest criticisms is that you have this potential for a patchwork of prices across the country.

Debra:

Oh, okay.

Charles:

So imagine your lab and you're trying to figure out how much Medicare is going to pay you for this test. If it's based on gap-filling, it's going to be really hard to predict.

Debra:

Because it might be different in one region?

Charles:

Right. And so that can actually make it riskier to offer the test in certain areas.

Debra:

Interesting.

Charles:

If you don't know what you're going to get paid, it's hard to make that investment.

Debra:

So it's like we're trying to walk this tightrope between having these groundbreaking diagnostic tests and making sure that everybody can afford them and access them.

Charles:

You got it. And that's where it gets even more interesting, because you know that FOIA request that Dr. Quinn filed.

Debra:

Yeah.

Charles:

He uncovered something really fascinating about how CMS makes decisions, especially when it comes to these pricey new tests.

Debra:

Oh, really? Like what?

Charles:

So he found that when CMS and their expert panel disagree on a test price, it's more likely to happen with these high-cost tests, the tests that cost over $1,000.

Debra:

So again, with this tension, the balancing innovation with affordability.

Charles:

Exactly. Yeah.

Debra:

So what did they find?

Charles:

Well, this is where I think Dr. Quinn's use of chat GPT gets really interesting. He actually used it to analyze the language that CMS uses in their rationale documents.

Debra:

Very interesting.

Charles:

And it's pretty insightful. I mean, it gives you a peek behind the curtain a little bit.

Debra:

Into how they think. I like it.

Charles:

And basically what it highlighted was that while the expert panels, they tend to focus on the very specific details of a test. How accurate is it? What's the clinical value? That sort of thing.

Debra:

They're focused on the science.

Charles:

Exactly.

Debra:

Yeah.

Charles:

CMS is also obviously very focused on the bigger picture. Okay. How much is this going to cost Medicare?

Debra:

Right. The budget.

Charles:

If this becomes widely used, the budget. Exactly.

Debra:

Right. So it's not just enough to be revolutionary. It's got a revolution and affordable or at least-

Charles:

And fit within Medicare's parameters.

Debra:

It's a tightrope.

Charles:

It is.

Debra:

Do you have an example of maybe where this played out?

Charles:

Yeah. There was one case that Dr. Quinn highlighted that involved a new genetic test, I think it was for a rare cancer. And the expert panel, they were really impressed by its accuracy and its potential to really guide treatment decisions.

Debra:

Of course.

Charles:

And they recommended a price that reflected that complexity, the value that they saw.

Debra:

Sounds pretty straightforward.

Charles:

But CMS, while they agreed it was a valuable test, they ultimately decided on a lower price.

Debra:

Wow.

Charles:

And their reasoning was they were concerned about the budget impact.

Debra:

Interesting.

Charles:

Especially if it were to be used more widely.

Debra:

Wow. So they're really thinking long-term. It's not just about-

Charles:

It's not just about that one test in isolation.

Debra:

That one test. It's like what happens when everybody needs it.

Charles:

Exactly. Exactly. Interesting. So it's a tough job they have.

Debra:

Yeah. So we've got cross-walking, we've got gapfilling, we've got CMS trying to balance all these different factors. It really makes you realize how much goes into-

Charles:

A lot going on.

Debra:

... just seemingly getting a blood test that's covered by your insurance.

Charles:

And this is where things can get, especially, I guess, frustrating is the word for labs who are really on the cutting edge.

Debra:

Yeah. Why is that?

Charles:

Well, imagine you're a lab and you've poured years, potentially millions if not billions of dollars into developing this new test. And you go to CMS to get a price for it, and they come back and they say, okay, well, we're going to base the price on gapfilling, but that means the price could be different in every region.

Debra:

Oh, wow.

Charles:

Because remember those MSCs.

Debra:

Right, the Ms.

Charles:

They're the ones who decide.

Debra:

So a lab could be looking at a very, very different reimbursement rate depending on where the test is being given.

Charles:

Exactly.

Debra:

Wow.

Charles:

So you can see how that would be very difficult.

Debra:

It would be very hard to manage as a lab.

Charles:

To manage. Yeah.

Debra:

So we're back to that accessibility issue.

Charles:

And it highlights just this other layer of complexity.

Debra:

It's so calm.

Charles:

It's very complex.

Debra:

And it's good that we're talking about it because not a lot of people are spending their free time reading FOIA requests and trying to-

Charles:

Thankfully, people like Dr. Quinn and-

Debra:

Yeah, exactly. And us.

Charles:

And us. We're happy to dive in and then bring it back to you.

Debra:

So knowing all this, what are our listeners, what's the key takeaway here? So we have been really in the weeds here.

Charles:

In the weeds.

Debra:

Of this clinical lab fee schedule, the CLFS.

Charles:

CLFS. It's a mouthful.

Debra:

It is a mouthful. And we've learned about crosswalking and gapfilling and all these disagreements between CMS and their expert panel. But what's the takeaway for our listeners?

Charles:

What's the so what?

Debra:

What's the so what? Because not everybody listening to this is going to be joining CMS next week.

Charles:

Exactly.

Debra:

So what?

Charles:

Well, I think the biggest takeaway is that this is complicated stuff. Setting prices for these new medical technologies, especially in a system as big and complex as Medicare, it's not easy.

Debra:

It's not as easy as putting a price tag on a loaf of bread.

Charles:

Exactly. There's no simple formula.

Debra:

It seems like this constant tension.

Charles:

It is.

Debra:

Of we want to encourage all this amazing innovation, but we also need to be realistic about the cost.

Charles:

And we all want these new tests. Right? We want the ones that can detect these diseases early.

Debra:

Right.

Charles:

Personalize treatments, get us closer to cures. But the question is, who pays for it?

Debra:

Who pays for it? And then on the other side of it, if the labs innovators don't feel like they can make their money back. They're not going to want to do it.

Charles:

There's no incentive. Exactly. Why would they?

Debra:

Right.

Charles:

So it's really... Yeah.

Debra:
So how do we fix that?

Charles:
Well, that's the million-dollar question, isn't it?

Debra:
Right.

Charles:
And there's no easy answer.

Debra:
Yeah.

Charles:
But I think what Dr. Quinn did, his work here, especially using the AI to get inside the head of CMS.

Debra:
Right.

Charles:
I think that gives us some clues.

Debra:
Yeah, like what?

Charles:
Well, first of all, I think it's pretty clear that CMS gets it.

Debra:
Okay.

Charles:
They understand-

Debra:
They see both sides.

Charles:

They see both sides. They understand that they need to encourage this innovation, but they also need to be responsible about how they spend taxpayer dollars.

Debra:

Because they're managing a huge program.

Charles:

Huge program. Exactly. And they're using these different tools, crosswalking, gapfilling to try to find that balance. But I think what's interesting is that their decisions, especially when it comes to those really expensive tests, it's more nuanced than just saying, yes, this is a fair price, or no, it's too expensive.

Debra:

They're really thinking about it.

Charles:

They're thinking about it. They're looking at the long-term implications. What happens if this test?

Debra:

Right? What happens if everybody needs this test?

Charles:

Exactly.

Debra:

Yeah.

Charles:

So it's not just about what the price tag says today.

Debra:

It's about the bigger picture.

Charles:

It's about the bigger picture.

Debra:

Yeah,

Charles:

Exactly.

Debra:

I like that.

Charles:

And I think that's really important message for anyone out there who is developing new tests, new technologies. It's not enough to just create something amazing in the lab. You have to be able to explain why it matters to the people who make the decisions.

Debra:

You have to speak their language.

Charles:

You have to speak your language. Exactly.

Debra:

That's so interesting.

Charles:

And that means going beyond just the data. It's about saying, here's how this test is going to improve patients' lives. Here's how it's going to make the system more efficient.

Debra:

And potentially save money in the long run.

Charles:

Exactly. Exactly.

Debra:

Yeah, it's really fascinating.

Charles:

It is.

Debra:

So to wrap things up, what's the one thing you want our listeners to take away from all of this?

Charles:

I would say don't underestimate how complex this is.

Debra:

Okay.

Charles:

It's easy to sort of take for granted, right?

Debra:

Right.

Charles:

You go to the doctor, you get a blood test, you don't really think about-

Debra:

All the stuff going on behind the scenes.

Charles:

What it took to get that test approved and covered and priced. But there are real people behind these decisions. People wrestling with really tough questions. And I think by understanding that hopefully we can create a system that-

Debra:

That works for everybody.

Charles:

Exactly.

Debra:

Well said.

Charles:

That's what we're hoping for anyway.

Debra:

Well, on that note, I think we'll wrap up this deep dive.

Charles:

I think that's a good place to stop.

Debra:

Into the clinical lab fee schedule. But the conversation doesn't end here.

Charles:

It never does.

Debra:
So keep asking those tough questions.

Charles:
Absolutely.

Debra:
And until next time.

Charles:
Happy diving.

Debra:
Happy diving, everybody.