MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Thursday, September 2, 2021
1:17 p.m.

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P R O C E E D I N G S

[1:17 p.m.]

DR. CHERNEW: Hi, everybody, and welcome to the September MedPAC meeting as we kick off this cycle of meetings. You might imagine we are somewhat disappointed to be virtual but glad that you can all join us virtually.

We are going to start the meeting with a presentation by Rachel about the context for Medicare payment policy. Understand that every March, we publish a chapter about the situation that Medicare faces, and of course, this year has been a doozy. I'm not sure that's a technical term, but it is actually really important, and for those listening, I really think it is a great, great way to understand some of the important issues facing the program.

So, Rachel, I'm going to turn it over to you to describe the chapter, and I look forward to everybody's comments.

MS. BURTON: Good afternoon.

A PDF handout of these slides is available from the webinar's control panel, which is likely on the right-hand side of your screen.

In this presentation, I'll provide some big-picture contextual information for Commissioners to consider as they weigh payment policy changes this cycle. This information will be included in our March report to the Congress, to accompany our annual payment update recommendations.

In this presentation, I'll describe key short-term and long-term trends to be aware of. Obviously, the contextual factor in the short term is the COVID-19 pandemic. I will focus on the impact on beneficiaries. Later this afternoon, my colleagues, Kathryn and Jamila, will touch on the impact of the pandemic on MedPAC's assessments of Medicare payment adequacy for different types of health care providers. My presentation will also talk about the long-term context, focusing on spending trends nationally and in Medicare.

In the short term, the COVID-19 pandemic has upended our lives. So far, over 600,000 people have died in the U.S. The number of deaths per week has ebbed and flowed, with three pronounced waves hitting last April, last July, and last winter, and the start of a fourth wave hitting us right now.

COVID-19 has affected people ages 65 and older much more than younger age groups.

In this graph, the age distribution of COVID-19 cases is shown in blue. We see that the largest share of cases were reported among people ages 18 to 29, who may be more likely than other age groups to have public-facing jobs, such as jobs in health care, food, and essential services. A relatively small share of cases were reported among children ages zero to 4 and among people ages 65 and older.

The yellow bars show the age distribution of COVID-19 deaths. Deaths were concentrated in people ages 65 and older.

Adding up the percentages in this graph, we find that people ages 65 and over made up 14 percent of COVID cases but 80 percent of deaths.

As shown at left, 7 percent of Medicare beneficiaries have been diagnosed with COVID, shown in blue, and 2 percent have been hospitalized with it, shown in orange.

Among beneficiaries hospitalized for COVID, 17 percent died in hospital and 5 percent were discharged to

hospice.

Particular subpopulations have been diagnosed and hospitalized at elevated rates.

Beneficiaries ages 85 or older and dual eligibles have been hospitalized twice as often as the overall Medicare population. Beneficiaries with end-stage renal disease have been hospitalized six times as often.

Although disabled beneficiaries do not appear to have had a higher risk of COVID, this may vary by type of disability.

One large study found that after old age, the second strongest predictor of death due to COVID was whether a patient had intellectual disabilities.

Thankfully, the pandemic's effect on beneficiaries is diminishing. People ages 65 and older have gotten vaccinated at disproportionately high rates, with 81 percent of this age group now fully vaccinated. The FDA has also approved or authorized several drug treatments for COVID.

Thanks to telehealth and to providers temporarily canceling elective procedures, access to core health care services has largely been maintained during the pandemic.

As we talk about in the chapter, the share of people reporting foregoing or delaying care in the past month has declined over the course of the pandemic, and the share of aged Medicare beneficiaries foregoing care in the past year has stayed at pre-pandemic levels this whole time. This suggests that care that was put off in the past month, may have been obtained in subsequent months.

Despite these promising indicators, the pandemic is not yet over. In recent weeks, many parts of the U.S. have experienced high rates of COVID-19 hospitalizations, which is causing elective procedures to be canceled again and straining the health care system in these areas.

I'll now talk about the long-term context affecting the Medicare program, which mainly has to do with health care spending growth.

For decades, health care spending has grown as a share of the country's GDP. Total health care spending now consumes more than twice the share of GDP as it did 45 years ago, rising from 7.9 percent of GDP in 1975 to 18 percent in 2020.

Private health insurance spending has more than tripled over this period, and so has Medicare spending.

Please note that future-year projections in this graph and some others in this presentation do not yet reflect the pandemic. We will update this and other graphs to reflect newer data in the Medicare Trustees Report that just came out on Tuesday and to reflect other data that is due out in the coming months.

When we look at health care spending per enrollee, we find faster growth in spending per privately insured individual, which grew 27 percent from 2014 to 2019.

In contrast, spending per traditional fee-for-service Medicare beneficiary has only grown 14 percent over this same period. The higher spending growth in private insurance is likely due to health care providers' ability to negotiate higher prices, which has been facilitated in recent years by the consolidation of providers into ever larger organizations.

In contrast, as the largest payer in the country, Medicare is able to set the prices it pays administratively.

That being said, Medicare spending is nevertheless increasing and is projected to nearly double in the next 10 years, rising from $782 billion in 2019 to

$1.5 trillion in 2029.

In 2020, Medicare spending was estimated to be equivalent to 3.9 percent of the country's GDP. Medicare is primarily financed through three revenue sources: the Medicare payroll tax, shown at the bottom in blue; other general tax revenue, shown near the top in orange; and premiums paid by beneficiaries, shown in the middle in red. I'll talk about each of these one at a time.

First, I'll talk about the Medicare payroll tax. This is a tax that is collected from workers and their employers and deposited into Medicare's Hospital Insurance Trust Fund, which pays for Part A services.

Over time, the number of workers in the U.S. has not grown as fast as the number of Medicare beneficiaries. As this graph shows, there were four-and-a-half workers per beneficiary around the time of the program's inception, but that ratio has now fallen to just three workers per beneficiary. By 2029, this will decline further to just two-and-a-half workers per beneficiary.

As a result of the declining ratio of workers per beneficiary, the Medicare trust fund that relies on workers' payroll taxes is projected to become insolvent in

2026, according to Tuesday's Trustees Report. This is the same insolvency date as was predicted before the pandemic.

I should note that Medicare already spends more on Part A services than it collects through the Hospital Insurance Trust Fund in most years. The only reason the trust fund hasn't already been declared insolvent is it carries forward a surplus each year, left over from years when trust fund revenues exceeded Part A spending.

In recent years, this surplus has been dwindling, and within the next few years, the surplus will be depleted, meaning the trust fund will be operating at a deficit, unable to fully cover its obligations each year. At that point, payments to providers would be reduced to levels that could be covered by incoming revenues. However, lawmakers have never let this happen.

To keep the trust fund solvent over the next 25 years, the Medicare Trustees estimate that either the Medicare payroll tax would need to be increased from its current rate of 2.9 percent to 3.7 percent or Part A spending would need to be reduced by 18 percent, which is equivalent to $70 billion in 2022.

The next funding source I'll talk about is

general tax revenues, which help pay for Part B and Part D services. Since the federal government spends more than it collects each year, Medicare's general tax revenue transfers are partially funded through federal borrowing, which pushes the country's debt up.

To elaborate on what I just said, this graph shows spending on Medicare and other federal programs layered on top of each other.

The top red line shows the total amount of federal spending for all programs as a share of the country's GDP. The green line, below it, shows the amount of revenues the federal government collects to pay for this spending. The key takeaway from this graph is that Medicare spending, shown in orange on the bottom, makes up a substantial share of federal spending.

By 2036, spending on Medicare, other health programs, Social Security, and net interest will equal total federal revenues. 2036 is two years sooner than CBO previously predicted we'd reach this milestone. The change in dates is due to the pandemic.

This now brings us to Medicare's third main source of funding, which is beneficiary premiums.

In traditional fee-for-service Medicare, most beneficiaries pay no premiums for Part A coverage, but the annual cost of premiums for Part B is currently $1,782, and premiums for Part D coverage average another $456.

Beneficiaries also face cost sharing at the point of care, which averaged $406 for Part A services in 2019, $1,582 for Part B services, and $432 for Part D drugs. Taken together, beneficiary spending on premiums and cost sharing consumed 24 percent of the average Social Security benefit in 2020, which is up from 14 percent in 2000.

The Medicare Trustees estimate that in another 20 years, premiums and cost sharing will consume 31 percent of the average Social Security benefit. As a point of reference, Social Security benefits account for 100 percent of income for a fifth of seniors.

Medicare has three main program components: traditional fee-for-service coverage, coverage through Medicare Advantage and other private plans, and Part D drug coverage. Among these program components, spending is growing at different rates.

The type of spending that has been growing the fastest is Medicare Advantage, shown in yellow. Since

2014, spending per beneficiary on Medicare Advantage has been accelerating, and from 2018 to 2019 alone, MA spending per beneficiary grew 6.9 percent. The relatively faster growth in private plan spending per beneficiary likely reflects a number of factors, including MA demographic changes, the increasing number of MA plans receiving higher payments due to their quality bonus status, growth in the risk scores MA plans report for their enrollees, and Medicare enrollment growth in areas of the country where MA payment benchmarks are set at 115 percent of fee-for-service Medicare's spending per beneficiary.

Pulling back to the overall Medicare program, the Medicare Trustees project that spending will increase by an average of 4.7 percent per year between 2020 and 2029, not including spending growth due to inflation. Spending growth is expected to be driven by the increasing number of beneficiaries and the increasing volume and intensity of services delivered per beneficiary.

Because enrollment growth is largely outside of the program's control, the most promising avenue for slowing the growth in Medicare spending is likely to reduce the quantity and mix of services used by beneficiaries,

such as through efforts to reduce low-value care. Low-value care refers to services with little or no clinical benefit and services that have more risk of harm than potential benefit.

With that, I'll wrap up. In your discussion, I'll be looking to see if anything in the chapter needs to be clarified or if you have any other guidance as we finalize the chapter for the March report.

I'll now turn things back over to Mike.

DR. CHERNEW: Thank you, Rachel. That was wonderful, if not sobering.

I know we have a bit of a Round 1 queue. So I think I'm going to turn it over to Dana to manage the queue. Dana?

MS. KELLEY: All right. I have Jaewon first.

DR. RYU: Thanks, and thank you, Rachel. I would agree with Mike's comment about sobering.

I had just a couple questions on the last couple slides, so maybe starting with Slide 21, the drivers, I think, if could flip to that, the drivers of the cost or the spending growth that's projected. There's the number of beneficiaries and then the volume and intensity of

services. On the volume and intensity of services, is that controlled for the demographic change of age, or is that inclusive of the age dynamic? I'm just trying to figure out what could be driving the intensity mix change in the services.

MS. BURTON: You know, I don't know that off the top of my head, but that's something I can clarify in the chapter.

DR. RYU: Thank you.

Then kind of similar, if you go back to Slide 20, across these different programs -- and I don't know if this is even feasible, but it did dawn on me that -- is there are way or are these numbers already controlling for the mix for who's selecting these different programs?

MS. BURTON: That will be the same answer for you. I'll clarify that. I don't know off the top of my head.

DR. RYU: Okay. Thank you.

MS. KELLEY: Lynn?

DR. CHERNEW: Can I just jump in and say what I believe is an answer to Jaewon? I'm not sure this is right, Jaewon, but the volume and intensity is separate

from a change in the mix of beneficiaries. There's a separate category for beneficiary mix. But I think what they mean by intensity is a change in the service mix within the beneficiaries. So volume is the number and intensity, I think, is sort of, I think you can think about it as a mix of services within a given beneficiary population. But they do have a separate category for what they call beneficiary mix.

DR. RYU: Yeah, I --

MS. BURTON: Yeah. I just pulled that up in the chapter.

DR. RYU: Yeah, I noticed in the chapter there was a separate driver, which was a much smaller impact of the demographics itself. But it just begged the question, well then what else could be driving that service intensity mix change? That's why I asked.

DR. CHERNEW: So actually, again, I'll try and speak to that briefly, because I've actually had the privilege of serving on some OACT technical panels, although it was years ago, so don't take this as authoritative. But we're talking about projections, and the projections rely on the actuarial methods that the

Office of the Actuary uses. It's a combination of specifics they know about what's going on and their analysis of current trends in what's happening.

So they have sort of complicated models to figure this out. They do it by Part A, B, and D, and then they try and do their projections. As they get to the longer run, they begin to become less specific in their assumptions and adopt a long run assessment of that. But they don't have a specific, overarching set of assumptions. They do it by program, using actuarial assumptions.

DR. SAFRAN: The other thing I can just chime in from my experience in a commercial plan is that the drivers of intensity included new treatments and services as well as what I'll just call a drift toward care being received in more intensive environments or from a specialist, rather than a generalist provider.

DR. CHERNEW: Or an HOPD relative to an office.

Okay. Sorry. That was a bit of a digression, but thank you, Jaewon. I believe that slide is actually stunningly important. I'm glad you asked about it.

Sorry. Back to you, Dana, to move us through the queue.

MS. KELLEY: I think Lynn is next.

MS. BARR: Great. Thank you, Dana, and thank you very much, Rachel. This is great work here.

So I just have a couple of comments or questions about the data. One of them is, you know, in the beginning you were talking about, you know, we see that there's not real -- that access has come back and services have come back, and we're not seeing that in rural. And we've always had an access issue, so if I look at total E&M visits in rural I'm at 89 percent of the national average. And in 2020, that is 83 percent. So we are seeing a huge drop in access versus the rest of the country, and I would like to see, if you can, break that data out, because I'm not sure that just talking about this as one thing is really showing us what's happening in a very important part of our country.

And the second thing is also similarly related. I guess you'll all get to know me as the rural person here pretty soon. When you talk about cost-sharing there is really, really different cost-sharing in rural communities, as we know from the June 2012 report on rural that MedPAC created, where the cost-sharing in critical access

hospitals is 50 percent of the fee schedule, because of faulty policy. So I think that we need to continue to call that out and look at that when we're thinking about cost-sharing. It's not equal for all beneficiaries, and rural is severely disadvantaged in cost-sharing, even though they are poorer.

And my third question for you is I'm very concerned about the increase in fee for service per beneficiary cost, that we're starting to see the trends going up from 2017. And so we had this beautiful honeymoon since ACO, where our trends were, you know, a couple of percent, and now our per-beneficiary costs from 2017, we're now looking at 4 percent trajectory. And as we have to think about rate-setting and projections, can you tell us a little bit more about what's driving that higher rate, and is that we think is the new normal? I mean, are the days of 2 percent growth over, and do we need to start projecting 4 percent growth? I'd like to know more about what you're thinking there.

MS. BURTON: I can look into what additional details we can add there in the chapter.

MS. BARR: Thank you.

MS. KELLEY: And I have Larry with a Round 1 comment.

DR. CASALINO: And I think I'll pass.

MS. KELLEY: All right. Then I think that does it with our first round questions. Mike, should we go to Round 2, or did you want to jump in here?

DR. CHERNEW: I am thrilled that we are getting to Round 2 so early, so again, jump in the queue, and I hope you'll have some time for broader discussion. I think Betty was first, and then Dana.

DR. RAMBUR: Thank you. This was a fabulous report and very sobering, and I just want to underscore, sort of expand on the comments in reducing low-value care. Clearly it's not only an economic imperative but it's a critical one that I hope not only agencies but also health care providers really embrace.

I want to raise a bit of an alarm about a piece that I think needs more development in this piece, as if it isn't alarming enough, right? But the nation has been giving little systematic attention to the development of the workforce outside of physicians and dentist. And I'd like to think, just for a minute, on the nursing workforce,

which is getting a fair amount of attention nationally, as is the magnitude of the compassion fatigue and exhaustion.

In 1965, when Medicare first started, nearly 80 percent of nursing programs were hospital-based schools of nursing, and these have largely been replaced by institutions of higher education, appropriately enough. But I'm not sure. I could not find out what proportion of those programs receive Medicare passthrough funds but I assume it was substantial. And clearly now, in GME alone, we spend nearly $18 billion a year supporting medical education residencies, et cetera, and neither there nor elsewhere do we really do anything about supporting development of the nursing workforce.

And somebody needs to think about this, whether this is through Medicare policy or elsewhere. I'm very concerned about who will be there to take care of Medicare beneficiaries, but actually all of us, and if I just may briefly remind all of us, when we're admitted to a hospital it's because we need 24/7 nursing care, and if that's ICU it's one-on-one, 24/7 nursing care. Skilled nursing facility actually has "nursing" in the title. Home health, hospice -- it goes on and on. And yet in fee for service

it is a labor cost. Nursing care is a labor cost to be tamped down while physician procedural services revenue generators, something to be ramped up, from the organizational perspective.

So it seems to me there's an opportunity to better align these underlying forces so that we aren't at odds with ourselves for really creating the world we want to live in and age into.

And very briefly, in closing, across the country, including at my institution, interest in nursing remains very, very high, in fact, far more students returning than expected. At the same time there is a dramatic faculty shortage, and in our own institution almost a third of faculty are going to be exiting those roles now or within the next year. And this may not be anywhere within Medicare policy but somebody needs to think about this and the fact that the magnitude of debt at any level, for nursing students or faculty, is not balanced with their opportunities for revenue or income.

So I don't know how that lines up, but it mainly is a critical thing in terms of workforce that needs attention.

Thank you so much, and thank you for an absolutely fabulous, sobering chapter.

MS. KELLEY: Jonathan Jaffery.

DR. JAFFERY: Thanks, Dana, and thanks, Rachel. Echoing others, this has been a great chapter and it's always very grounding for us, to start off the annual cycle.

If you just go back to Slide 21 I just had one thing I want to emphasize maybe. So in your last bullet point here you just call out that spending growth could be slowed by reducing low-value care, and I don't think there would be a lot of argument from anybody on the Commission. But there is one thing that we keep talking about in addition to low-value care and that is -- it's been brought up a little bit already -- it's shifting the site of care. So Dana mentioned this at the end of Round 1 -- shifting the site of care to lower-cost or less-intensive settings. We're seeing big trends of that, even before COVID, and certainly during COVID, to more home-based care. We're seeing great opportunities and a lot of interest on the part of providers to deliver care closer to home and, in fact, in the home, across the spectrum -- hospital and

home, SNF at home, and whatnot.

There was a good study a couple of years ago out of the Brigham where they did a randomized controlled trial of their hospital and home program and saw same or better quality, same safety, and such, and I think it was a 38 percent lower total cost of care.

And so I just think it's important that we call out that that's a significant opportunity, I think, as well for us. And just to tag onto Betty's comments, because I know she mentioned this, but sort of emphasize some of the inpatient needs. You know, as we're trying to build out some of these home-based programs we're seeing the exact same things, that one of the big bottlenecks is the nursing workforce. It's not the only workforce bottleneck but it's probably the biggest one.

So thank you for that.

MS. KELLEY: Bruce.

MR. PYENSON: -- like others, thank you for the excellent chapter. I've just got one overall comment, which is on the context from a personal income standpoint. The chapter presents Medicare expenditures and personal expenditures from the standpoint of Social Security income,

as it has in the past. That's one context. What's happened with retirement income over the past decades will make that look even worse. As pension plans have been replaced by 401(k)'s, personal retirement income is declining for retirees, or for many retirees. So a broader context, bringing in some of the issues of retirement income more broadly, might be very useful, not that the chapter isn't gloomy enough as it is.

Another context issue is the taxes on active workers that's funding a lot of the Medicare benefits. And the context for that, similarly, is relatively stagnant wages for decades. And if we think about what's happening with health care spending for people, commercially insured people, for workers who largely get coverage through their employers, while wages have stagnated health care costs have not. So the escalation of health care costs for workers is making a tax hike less palatable.

So I think although we always struggle on how the Medicare program can affect commercial health care spending, I think the context here is making it harder to support a tax hike to support the Medicare program.

So I think that context might also be helpful in

terms of creating a picture. And I would emphasize the tax issue, because although I am very enthusiastic about health care becoming more efficient, and support that wholeheartedly, I'm skeptical about the ability to extract much value from that. It seem as though despite our best efforts, and even successes in efficiency, it seems not to have -- we don't have a good track record on actually reducing spending through those mechanisms.

Thank you.

MS. KELLEY: Dana?

DR. SAFRAN: Thank you. So Rachel, I'll just start by adding my appreciation for this outstanding chapter. Every year, you know, this chapter is such an important way to ground our work, and I always find myself wondering how we can sit calmly and have the discussions that we have with this real urgency looming ahead of us. So thank you for laying it out so clearly and well.

I just have two quite small points, but I thought they were worth making, for your consideration. One is in the part of the chapter where you're talking about the distinction between Medicare and commercial and rates of rise, and pointing, appropriately, to the value of the

price control that the Medicare program has, you make the point about APMs working on reducing utilization and you make it in the context of doing so to be another lever to address costs. I think it's worth highlighting there that there are additional values of making sure that care is appropriate or not overused, including avoiding harms and, you know, the safety implications. So I just wanted to raise that for your consideration.

And the other is that where you're talking about inequities in access and getting to equity, the chapter focuses exclusively in that section on health equity around race and ethnicity with respect to access, and it seems worth including rural access issues as we talk about those inequities, to, you know, Lynn's earlier point on that issue.

So those were just two things I thought I'd highlight for your attention, but really tremendous work, and thank you for such a great chapter.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Very nice chapter, as usual, Rachel, if one can call such a grim picture "nice."

Two points about maybe making the context a

little larger. I think we, and many other people, have grown all too accustomed to seeing, year after year, in these chapters and in other places, how grim this situation is looking forward. But I think it would be a real contribution to try to add some context to that context. In other words, if we were going to be able to balance the budget, so to speak, for Medicare spending, what would that take?

There's a little bit in the chapter about this, you know, the trustee's comment that it would take either about a 25 percent or more increase in payroll taxes or an 18 percent cut in, I think that was Part A spending, if I remember correctly, and then a 2-point-something percent per year increase in volume and intensity, that's on another slide. It's hard to put that all together, at least for me, and it would be really great if there were a page or two -- I'm not sure how much it would take -- that would try to get a sense in terms of what it would take to generate the kind of savings that appear to be necessary, and how much are we getting from the various value-based incentive, you know, value-based payment programs that we have. How much would we have to get in order to achieve

the kind of savings we would need? Some kind of calculations of that I think would really help put thing in context.

And think those are figures, in my mind, that we should all have, all of the Commissioners and staff, we should kind of have it on the tip of our tongues, where we'd have to save X, we'd have to save Y in these ways in order to do it.

That's my main comment. I'll make something, which to me is fairly common-sensical. I will say something that's a bit farther out, and that for a lot of reasons I wouldn't probably expect to see on the report, in the chapter, but I think it's still worth flagging. You know, the last few decades -- it was really Bruce's comment on medical costs are going up a lot, year after year, and wages are not. And in the years in which that's been happening, the last 30 years or so, we have also seen incomes at the top and wealth at the top going up and up tremendously but not for most Americans. And there's really been a kind of a sucking of wealth from the great majority of the population to a relatively small amount of people.

And I think that could probably, in health care as well, be very interesting to see where are the dollars going in terms of the highest drug prices, the biggest Medicare Advantage profits, the highest-paid physician specialties, medical devices and equipment, and home health agencies. And so it would be interesting to know, although probably maybe a little too much for MedPAC to handle, to try to get a sense not just of, you know, what kind of savings could we expect from our various programs to try to generate savings but where is a lot of the money going? It's not going to home health aides. It's not going to nurses. It's going elsewhere.

And I think it would be quite illuminating to get a better sense of the context of that, although I'm not pushing for that in this chapter. But I would push for some estimates of how much savings can we expect to generate out of the initiatives we have going now, compared to how much savings we would need to get.

DR. PAUL GINSBURG: If I could follow up Larry's points about what type of spending reduction would it take is there's a reality, in my perception, that we've already taken the easy steps to try to control Medicare spending,

and we're squeezing the rates, particularly hospitals and physicians, and kind of almost a whole generation of ideas has been put into facts. What remains is really to take all their action. Action is actually going to have an effect, more of an effect on how care is delivered, and it might be useful for the chapter to get into that issue, just kind of reviewing.

Look, a lot of things happened to address spending, but obviously, more is needed.

DR. CASALINO: If we continue as we are with some incremental improvements in savings, how much of the gap is that going to close, or how much more would we have to do if we were to not increase payroll taxes a lot or decrease payment rates a lot?

DR. CHERNEW: Yeah. So let me just jump in quickly and say a few things broadly.

First, Larry, I think that's a really important point that I have already chatted with Jim about how we will begin to address that in the chapter. I think it is important to give a context for that.

I do want to emphasize a few points. The first one is MedPAC is not IPAB. In other words, understand that

our mission is to come up with payment models to preserve access to quality care for Medicare beneficiaries, and while we certainly are aware of this issue, which is why it figures so prominently in the context chapter and why we spend a lot of time thinking about how payment can be better at the core, we are not going to balance the question between more revenue versus less benefit. That, I think, is beyond where we will be.

The second thing I'll say which is important is in the latest Trustees Report -- and this is very much in the spirit of what I think Paul just said -- if you look at their illustrative or alternative scenario, which assumes payment rates rise faster than current law -- they're doing current law projections -- we are actually in a more difficult situation than the baseline numbers appear because current law fee trajectories are very, very flat. We've taken a lot out of the fee trajectories already in these forecasts.

The last thing I'll say on this super important point is we don't have to lower spending. We have to lower the rate of growth in spending. So understand savings, if you will, in this context is relative to the assumed volume

increase that we were talking about before, and that's the trick, in my opinion, and if you look at the chapter, there's a very strong annual increase in volume and intensity assumed, and I think the challenge there is going to be how we manage to provide access to high-quality care. It's somewhat less volume, and in the mix of site-of-service issue, some with less intensity, and that, I think, is going to be a key thing.

And I think your point, Larry, is the chapter needs to be maybe more explicit, clear, or some version about how much needs to be done, and I think that's true, but realize there's a whole other type of discussion around revenue and taxes, which I think we're going to avoid.

DR. CASALINO: If I may just say the last thing you just said, I think, is very important. I should have said it. We're not talking about how can we, in one swoop, save 18 percent or something like that through various payment and delivery system incentive or innovations. We're talking about reducing the 2.5 or 2.9 percent a year or whatever it is.

Really, it's hard to find discussions of this kind of thing. What would it take? In other words,

current programs, how much would they be reducing this 2.5, 2.9 percent, whatever it is, growth per year, and how much would they have to reduce it to make the situation going forward less grim? It's very, very helpful to have some discussion of that as opposed to the very illuminating facts we have now, but they're not really connected to initiatives to try to bend the curve, so to speak.

DR. CHERNEW: Yes. No argument, but I do think in the chapter, we can emphasize it more.

Jim, I think you and Rachel did a great job.

There is some recognition that if all the MedPAC recommendations are adopted -- and there's a number of payment things that we think could be done to save money, and you'll see that in our March reports and you see that in our June reports, without enumerating all of them -- we don't actually get close to the gap that needs to be filled, and so we will continue to try and be aggressive in this space but doing it with the motivation of making sure that we achieve the other goals of the program, which is providing access to high-quality care dealing with disparities and things of that nature.

But your point, Larry, was not about the policy,

per se, as much as the discussion, and I think on that point, you're spot on.

So sorry. That was a bit of a digression. Dana, do you want to go back to the queue?

MS. KELLEY: Yes. We have Marge next.

MS. MARJORIE GINSBURG: Yep. My comment actually is a little similar to Larry's.

This line about low-value care, it suddenly occurred to me that we need to think about augmenting our definition of low value. I don't think anywhere in this chapter explicitly talks about our overpayment of MAs. We have a chart in the chapter that shows -- I believe on this chapter -- that shows how much more we're paying. As we know, we have many initiatives out there trying to reduce that, but I think maybe it's time to elevate the importance of it into the concept of low value because that, in fact, is exactly what's happening. We are getting low-value care by how much we are paying MA plans.

I know the idea of incorporating that in this chapter may be beyond our ability to do now, but I would certainly like the Commission to think about doing that, and I would love it if, in fact, it could be done.

Thank you.

MS. KELLEY: Brian?

DR. DeBUSK: Hello? Oh, okay. Hi.

First of all, I'd like to actually build on Marge's comments. Marge, I thought your comments were very, very timely. I'd like to thank the staff for another very sobering chapter on context that doesn't get easier to read each year, but I too would like to focus on MA but focus on it really from a different angle.

If you look on page 31 and you look at the share of beneficiaries in MA, last decades, we witnessed a steady migration of about one point per year of beneficiaries moving from original Medicare to MA, but in the last two years, we've seen more, like a three-point migration, which is a distinct acceleration of the program. And I'm not implying that that's a good or a bad thing, but I think it underscores a really important issue, which is that un-addressed inefficiencies in original Medicare translate into higher MA benchmarks, and higher MA benchmarks translate into extra benefits and larger marketing budgets for MA providers. At least for me, that creates a heightened sense of urgency.

You know, Marge, I do get your point about overpayments to MA, and I agree, but I think it also creates a heightened sense of urgency around the need for more dramatic reform within original Medicare, because I think, for example, we should consider incorporating some of the practices from private plans and from MA into the original Medicare program.

A great example would be site-of-service enhancements when it comes to payment policy, and I know that creates some discomfort when we talk about original Medicare, but my concern here is that I think in a well-intended effort to preserve the original promise of Medicare, the program's strongest advocates might be fueling its consumption by MA. So I think understanding the interrelationship between these two is important, and again, to me, I have a heightened sense of urgency that we need, for example, alternative payment models to succeed. We need better ways to address low-value care in original Medicare, because I'm afraid we may be inadvertently fueling its consumption.

Thank you.

MS. KELLEY: Stacie?

DR. DUSETZINA: As others have said, thank you for this outstanding report.

I just had two things that struck me as something that might be helpful. One is the figure you showed on Slide 20, the one that breaks out the MA plan, same one that Brian was just mentioning. Yeah, those trends.

When I was reading the report and glanced at this, that question about MA versus others is there but also the service components. When thinking about low-value care, being able to see the different sets of services under fee-for-service, in particular, you know, Part A, Part B, for example, drug versus other medical, that would be really helpful for thinking about targeting and where the growth is really happening.

And I know in the report, it references that there is this kind of service breakdown in other reports, but if possible to incorporate, I think it would be helpful for just thinking through where we're maybe able to move the needle more.

The one other comment is I think there's so much value that was in this report around affordability for beneficiaries and thinking about how much they're spending

relative to their incomes, but I do worry a little bit about -- there's some data pulled from the Medicare Current Beneficiary Survey around the affordability overall and access overall, and I worry a little bit about that maybe missing what's going on for people with more rare or complex conditions and wonder if there's some opportunity to think about is there a way to look at the subset with more complex illness to see if that percentage has changed at all.

But echoing the others, this is a really outstanding effort, and the report is excellent.

MS. KELLEY: Okay. I have Lynn next.

MS. BARR: Thank you. Just two quick comments. One of them, I just really want to support Betty Rambur's comments on nursing. Seventy percent of our CEOs have expressed extreme nursing shortage.

We in our ACO programs use nurses to provide more access to primary care, and so we have nurses in our clinics doing a lot of primary care services. The vast majority of those nurses are no longer in the clinics. They've all been pulled into the hospital, and in rural, particularly, we are experiencing an extreme shortage of

nurses because the higher rates they can be anywhere else, they can travel, and we don't have a pool to pull from, from our communities. So, please, as we're thinking about these nursing shortages, I think we have to also pay attention to the disparities of availability of nurses in these rural communities. So thank you, Betty, for bringing that up.

And the other thing I wanted to follow on, on Jaewon's comment about hospital outpatient departments being one of those sites of service we don't like, there's some complicated things that are going on behind that, and I know we saw in the report, the March report, there's a 25 percent increase in HOPD outpatient clinics, which we all perceive as a negative because we're going to pay more for those clinics.

What I'm seeing in the market is that the majority of those clinics are converting so that they can get 340B access in response to the fact that Medicare cut their 340B on Part B, and then pharma is about 20 percent of the drugs that are being withheld through contract pharmacies.

So this is a very complicated problem that is not

just about providers going to try to convert to a more expensive billing method so that they can make more money. That's not it. They hate it. It's got double bills. Nobody likes it, but it is very, very tied to the 340B program. And I think that we need to -- I would like to see us try to pull apart that data on the HOPD increases to see how much of that is related to 340B entities that are trying to recover lost revenue that's being pulled away from them without any recourse.

MS. KELLEY: Amol, did you have something on this?

DR. NAVATHE: No. A separate comment. I'll be quick.

MS. KELLEY: Can I put you at the end of the queue, then?

DR. NAVATHE: No problem.

MS. KELLEY: Pat, you're next.

MS. WANG: Thanks.

Just real quickly, I want to support Stacie's suggestion of maybe trying to include a few more of the big components that comprise Part A spending -- or fee-for-service spending, I guess, particularly Part B. There is a

table on page 19 in the chapter that talks about the projected costs over the years from 2020 to 2029. Part B spending looks like, you know, whether it's utilization or intensity, it's a big component, and to Stacie's point, I think it's helpful sometimes to look at what Medicare has control over when it sets prices and what it actually doesn't have control over when it sets prices because, obviously, it doesn't set prices for drugs and devices, and so we're really dealing with a different component of the delivery system that seems to be maybe proportionately shrinking in significance in terms of total spend compared to some of these other components. So I just want to endorse that.

The other thing, it's just a question. There's a great text box in the paper that starts on page 13, whose point is that, you know, price growth in the private sector has not affected Medicare yet. It talks about lots of different trends and happenings, including consolidation.

On page 16, in particular, there's a reference to physicians increasingly becoming part of vertically integrated organizations, but I wonder whether we're kind of not mentioning another major thing that's going on,

which is the types of entities that physicians are organizing into, whether they are insurance companies that are, you know, now sponsoring owning very, very large groups of physicians, private equity which has really kind of changed the landscape for many physician pathways.

I don't know what conclusion to draw out of it because when we've discussed this in the past and there was a phenomenal paper on private equity in health care, that it was incredibly educational and descriptive. I feel like even absent like a blockbuster conclusion about what the significance of that is, it feels like such a significant thing that's happening in the shape of the health care system, consolidation, new entities, lots more money, that it should at least be mentioned or included in the text box.

MS. KELLEY: I have Jaewon next.

DR. RYU: Yeah. Thanks.

Just a few really quick points. I really think this chapter sets a nice stage and context. It's almost a call to action for the work that lies ahead of us this year, so really appreciate the work.

I think Slide 14 for me, I found to be

particularly sobering. It's the ratio and how that has changed between worker and beneficiary since the inception of the program and where we find ourselves today. I think this really demonstrates, to me at least, that there's some large, very significant structural challenges here with this trend, and I think if there's ever an imperative for large structural significant solutions, I would say this slide pretty much underscores that.

It leads me to -- I think it was Slide 21. It was the slide that I had referenced in the earlier question. It would be good, and I know others have mentioned this, I think Larry mentioned a little bit of it, Stacie as well and others, but it would be good to see some unpacking specifically around the volume and intensity of services because, of course, the number of beneficiaries, there's not a whole lot we're going to do on that. But the volume and intensity, I think there's a lot of areas that are ripe for opportunity, and we've heard many of them mentioned, whether it's place of service and the HOP billing or other aspects of low-value care. Folks have pointed out the Medicare Advantage per-beneficiary spending. I think even if there were some sensitivities

around meaning, hey, you do this and it could yield this kind of value, just to illustrate and contextualize what those potential levers are and also to demonstrate how significant they need to be to offset the significant trends that you would see in Slide 14 and other places.

And then, lastly, just touching on Pat's comment on the text box on consolidation, I think I would echo and agree with her comments. I think there's all sorts of consolidation, but it's also taking place on the payer side. To the extent we're going to mention it, I think a comprehensive mention sometimes is tough to pick out what's the chicken and what's the egg in terms of this consolidation begetting that consolidation, but I think the fact of the matter is it's happening across the entire industry. And I think that does deserve a mention.

Thank you.

MS. KELLEY: Amol?

DR. NAVATHE: Thank you. I also, like Jaewon, want to make a couple of hopefully quick comments. First off, I just sort of formally wanted to support Dana's suggestion. I very much appreciate the section on disparities, and would just support expanding beyond racial

and ethnic minorities also, as she said, to rural benes but also based on socioeconomic status particularly, because it has so much relevance to other parts of the Medicare program, like Part D, for example.

The second thing is, I think the MA discussion actually is very interesting, because the chapter, in my read, you know, when I read it and reread it it's amazing how much good information is packed in there, and oftentimes I think, oh, it would be good to have this in there, and then I read it and I'm like, oh, it's in there actually. So that's fantastic.

There are a couple of places where there are some programmatic pieces that kind of may counteract or dull the incentives of other policies that kind of under the Medicare program umbrella. An example of that would be the supplemental Medigap plans, for example. And so I think to the extent that it's possible to feature where we have some contextual, conflicting policies, basically, that might be helpful in understanding the context without obviously going overboard, because there's already a lot in the chapter.

And then I've always been a fan of the Table 2 in

the chapter, which shows us basically how much do we need to increase payroll taxes, how much do we need to increase Part A spending to get to solvency. I wonder if other hypotheticals, for example, in the context of how MA spending is growing or other parts of the program, how they might impact the general solvency, certainly for the kind of trust fund part of it but also, in general, the Medicare spending trajectory. I don't have a particularly actionable suggestion there other than to say that I think it might be worth brainstorming how Table 2 could be a little bit, or even more informative than it already is. Thanks.

MS. KELLEY: That's the end of the queue, Mike.

DR. CHERNEW: So that was a really rich discussion. Let me make a few broad points, beyond what I said in response to Larry's comments. The first one is, and I think all of you know this, we will not miss -- we will try not to miss any opportunities to price more efficiently. That includes clearly MA but it also includes all of our update recommendations, which we'll see in December and vote on in January.

So the emphasis on low volume, which includes

site of care, the emphasis on the volume side, volume intensity, is not to imply that the pricing things are unimportant. The challenge that I think the actuaries point out is even if you take those savings in various ways there are a lot of other pressures that make the actuaries worry about the sustainability of the overall fee trajectory. But I again will emphasize, we will not be shy in looking for ways to price more efficiently writ large, understanding that our goal is not to hit a spending target. Our goal is to price more efficiently and make sure that people get access to care.

The second thing I want to say is about the MA numbers. Understand that a lot of what's going on in MA is driven by fee for service spending. That's how the benchmarks are set. And what we're seeing there involves certain things like where people are moving, so there's growth in the 115 percent counties, and there are coding issues that you know our recommendations that are all on top of.

So we will continue to look at that, but I don't think we should think about it as inefficiency in MA the same way. What a lot of what was driving MA is very

different than what's driving projected volume growth elsewhere.

So we're going to continue to think about things in this cycle going forward that will promote efficiency. So a few things for people that don't know where the agenda is going to go this year, we obviously have a lot of work to do on APMs. I know the rest of my fellow Commissioners know that's a passion of mine, and I think different types of payment models, we haven't gotten a lot from them. I think with better design we can do a lot better. But they certainly address issues of volume intensity well by giving some autonomy of the delivery system to transform in various ways.

We have a section we will be kicking off this cycle on launch prices, high-priced new technologies, that include, but is not limited to, drugs. We think that's very important. We're going to be doing work, as we always do, on site-neutral payments, which remains a priority or relates to a lot of this discussion. And in response to some of the things that Lynn said in the very well-placed comments on disparities, we are going to be having a discussion of safety net providers, broadly defined, to try

and think about what we might do. Our goal is to make sure we pay efficiently where needed but not overpay in other places, and there will be some discussion about it. Again, we're at the beginning of the mountain there.

So those are just a few of the areas that we're going to get into this cycle that relate to this whole discussion, and I think the context chapter and your comments about it are really helpful and hopefully set the stage for those topics.

So that's my summary of where we were. I hope it's helpful. I realize it is sobering, and I realize we have a somewhat prescribed role in the entire system. But I think we are -- any last-minute comments on the context chapter? Otherwise, we will move on to another stunningly sobering discussion.

[Pause.]

DR. CHERNEW: Okay. Hearing none, I think we're going to move to the next item on the agenda, and that has to do with how we will deal with COVID. COVID has obviously been an unbelievable tragedy for so many Medicare beneficiaries and for the country writ large. I don't think one could overemphasize its importance. We are going

to have, with Kathryn and Jamila, a somewhat narrow discussion of what it means for our daily work. And my takeaway from this, if you had to pick one word, is "challenging."

So with that said, Kathryn, are you going to start off? Jamila, are you going to start off?

MS. LINEHAN: This is Kathryn. I am going to start us off.

DR. CHERNEW: Okay, Kathryn.

MS. LINEHAN: Okay. Good afternoon. Jamila and I are here to discuss effects of the coronavirus public health emergency and considerations for MedPAC's 2022 assessment of Medicare payment adequacy. Before beginning, we would like to thank many of our MedPAC colleagues for their contributions including Alison, Ariel, Carol, Evan, Geoff, Jeff, Kim, and Lauren. And I'd like to remind the audience that they can download these slides from the control panel.

The Commission is required by law to annually recommend updates to the base rates for providers paid under Medicare's fee-for-service payment systems. This cycle, we will be recommending payment updates for 2023,

and will be examining data from 2020, the first year of the coronavirus pandemic, for many of our indicators. We are currently working on those analysis and our findings will be presented at our December meeting.

To determine payment updates for future years, the Commission assesses the adequacy of Medicare payments using the most recent data on beneficiaries' access to care, the quality of care, providers' access to capital, and how Medicare payments in each sector compare with providers' costs. The metrics within each of these domains are shown on the slide.

Before we complete our analysis and present results in December, we want to use this presentation to review the pandemic timeline and policy responses to the pandemic with the goal of showing how each of our payment adequacy indicators in 2020 may be affected. We will be speaking generally and not about any one sector in particular in this presentation.

This year we will examine our indicators as rigorously as we always do, but given the confounding effects of the pandemic the results are going to tell us little about the adequacy of Medicare's payments.

The information presented in your mailing materials and in this presentation are not going to be a stand-alone chapter but will inform our analyses and provide some of the language in our March report.

As Rachel described in her presentation, and as Mike just discussed, the coronavirus has had devastating effects. To review the timeline, in January 2020, the Secretary of Health and Human Services first declared the coronavirus public health emergency. In late March 2020, the nation's health care system began to experience enormous strain as COVID patients filled hospital emergency rooms and intensive care units.

Frontline health care workers have faced risks to their health and safety treating COVID cases. In nursing homes, staff and residents had high rates of morbidity and mortality due to COVID. The volume of ambulatory care services, along with all other types of services, dropped sharply.

While some of the pandemic's impacts have abated, the pandemic and its effects persist. COVID-19 hospitalizations and deaths fell through the early part of the summer of 2021, but in recent weeks cases and

hospitalizations have once again surged. In some parts of the country, the number of new cases and hospitalizations are at record highs.

To help our health care system respond to the enormous challenges of the pandemic, the Congress and CMS altered Medicare payments and policies and granted regulatory flexibilities starting in March 2020. Providers could also access Federal grants and loans.

All the specific Medicare policy changes are too numerous to mention here, but they notably include suspension of the 2 percent sequestration payment adjustment applied to all Medicare fee-for-service claims; add-on payments for COVID patients in hospitals; expanded access to telehealth, which the Commission has discussed in previous meetings; and, in post-acute care settings, waivers of facility and patient criteria. We will discuss these policies as they pertain to each sector in more detail in December.

The Congress also responded by providing funding for providers. The Provider Relief Fund furnished qualified providers with payments for healthcare expenses or lost revenue due to COVID-19; the COVID-19 Accelerated

and Advance Payments Program provided advance Medicare payments that must be repaid; and Paycheck Protection Program (PPP) loans for small businesses, including health care providers, which do not need to be repaid if recipients meet certain conditions.

We will now turn to discussing the likely effects of the coronavirus public health emergency and related policies that will confound our analysis of Medicare payment adequacy. In general, these effects are, first, the coronavirus led to increased mortality, as Rachel discussed. Second, the coronavirus caused volume to decline sharply in the spring of 2020 before gradually rebounding for most sectors. Third, the pandemic and related policies affected the acuity and mix of patients treated. Fourth, providers' costs were affected. And fifth, Medicare providers received additional payments in the form of coronavirus relief grants intended to offset COVID-related patient care costs and lost revenues due to reduced.

These effects and their interactions have implications for our measures of payment adequacy. Jamila will now walk you through some of those potential effects

in more detail.

DR. TORAIN: To measure access to care for beneficiaries, we analyze capacity and supply of providers, the volume and mix of services provided, and marginal profit which is an indicator of whether providers with excess capacity have an incentive to treat more Medicare beneficiaries. We expect the pandemic to have affected these metrics in 2020, complicating our interpretation of trends as indicators of Medicare payment adequacy. Specifically, provider capacity was constrained in some settings and expanded in others. Moreover, capacity constraints varied geographically and over time.

The service volume we observe in 2020 will also be affected by the pandemic. As Kathryn mentioned, service volume declined sharply in the spring of 2020, for most sectors due to reduced demand stemming from patients avoiding health care settings or suspension of surgical services in the pandemic. Fee for service volume gradually rebounded in most sectors in 2020, though remained below 2019 levels for the year.

We also will need to keep in mind that fee for service volume has been declining as Medicare Advantage

enrollment increases. Volume reduction due to the pandemic was likely mitigated by waivers and policy changes related to telehealth, which also offset some of the volume declines. However, as Evan will discuss tomorrow, we cannot know the extent to which telehealth services were provided in home health settings.

Marginal profit will be particularly hard to interpret this year because demand declined due to COVID-19 overall. Therefore, providers would have served fewer beneficiaries regardless of marginal profit. Providers also received one-time payments and faced unique costs during the public health emergency.

The trends in quality measures in 2020 will be confounded by the effects of the public health emergency, so much so that quality trends in 2020 will not be useful as indicators of Medicare's payment adequacy this cycle.

Many factors related to the coronavirus, including hospital capacity constraints and patient avoidance of health care settings, may affect hospitalization and readmission rates in 2020. Also, mortality rates increased in due to COVID-19, which will impact our measures of mortality.

Reflecting the difficulty of measuring and interpreting quality measures for 2020, many of CMS's surveys and quality reporting programs were revised during the pandemic and were suspended for at least a portion of 2020. In addition, hospital Consumer Assessment of Healthcare Providers and Systems data, CAHPS, will not be available for the first two quarters of 2020 and fee-for-service CAHPS data was not collected in 2020.

To define access to capital in each sector, we present evidence of profitability of the industry, projected demand for services, and costs of care by analyzing all-payer margins, industry analysts' assessments and projections, public company financials, non-profit ratings, and industry activity such as mergers and acquisitions and outlook in the trade press.

We expect that providers' access to capital will be affected by the public health emergency and related policies. For example, all-payer margins in 2020 will reflect the take-up of any public health emergency-related funds we mentioned earlier. Also, many mergers and acquisitions may have been disrupted by the pandemic due to the uncertainty surrounding COVID-19's impact on health

care operations in 2020, and the longevity of those risks.

The COVID-19 environment has the potential to affect Medicare costs and payments. Costs per unit may be affected by the higher costs of personal protection equipment and changes in the cost of labor. They may also be affected by changes in per-unit fixed costs due to volume decline and changes in case mix.

Payment per unit may be affected by changes in the case mix and several of the temporary Medicare payment policies and key federal assistance mentioned earlier in the presentation such as the COVID-19 add-on payments for hospitals and significant subsidy received outside of Medicare payments. Also, the CARES Act originally suspended sequestration payment adjustment percentage of 2 percent applied to all Medicare fee for service claims from May 1 through December 31, 2020, which increased payments. This suspension has since been extended to December 31, 2021.

As we learn more in the coming months, we will come back in December to present more information on the effects of the public health emergency on payments and costs.

Medicare cost reports present several challenges in our assessment of payment adequacy this cycle. Specifically, the timing of cost reports will complicate our analysis of the impact of the PHE on providers' costs and Medicare's payments in 2020, because within each sector, providers' cost reports can start and end on different months of the year. For example, one provider may have a cost reporting year from April to March and another may have a cost reporting year from October to September.

Additionally, all providers must report Provider Relief Fund payments on the cost report's statement of revenues for informational purposes. These data may not be completely and accurately reported, which will impair our ability to understand the impact of those funds on margin calculations.

As we learn more in the coming months, we will come back to you in December to present more information.

The coronavirus pandemic has had significant impacts on beneficiaries and health care providers. This year, the Commission will be examining data from 2020 for many of our indicators of payment adequacy to inform the

payment update recommendations for Medicare's fee for service payment systems in 2023. In general, these data will not be as clear of a signal of the adequacy of Medicare's payments as they are in typical years due to the effects of the pandemic and pandemic-related policies.

To the extent that effects of the public health emergency are temporary or vary significantly across providers in a sector, they are best addressed through targeted temporary policies. Ideally, only permanent effects of the pandemic will be factored into recommended permanent changes in Medicare base payment rates. Where possible, we will present data to help us discern whether changes have persisted, such as with service volume, but unknowns about the duration of the pandemic and the persistence of its effects will remain.

This concludes our presentation. Staff seek Commissioner guidance on additional effects of the public health emergency on our payment adequacy analysis and strategies for analyzing or interpreting data from 2020.

As always, staff will present our analyses of payment adequacy for all the sectors at the December meeting.

I'll now turn it back to our chair.

DR. CHERNEW: Jamila, thank you. That was really valuable and I think did a good job of explaining the challenges that we're going to face.

I will just emphasize a point that you made actually on slide 13, which is we are trying to have recommendations for 2023 and so as opposed to, say, compensate people for challenges they faced during the pandemic. So a lot of this discussion is going to be about how we use the data we have. In some cases, we may have to throw out 2020 or 2019 data to get to some sense of what's appropriate payment in 2023, understanding that if there's particular temporary effects of the PHE or differences by sector, we would have those be targeted. So that really is, I think, the key message I'd like to give.

Now let's go through the Round 1 questions, and then we'll move to Round 2.

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

MS. BARR: Thank you.

So I actually have a number of clarifying questions that I'd like to add. So the PHE hits urban and

rural at different cycles, right? I mean, there were some rural areas that were affected, but many of our rural areas were not affected in 2020 and are hammered in '21, right? So there is a timing issue of this, and so I'm curious about how in your thinking about this are you accounting for the differences between how the pandemic affected and the timing of the pandemic in rural and urban settings.

Do you want me to just go through my questions, or do you want to respond?

MS. LINEHAN: It's up to you. I can answer your question now.

MS. BARR: Okay.

MS. LINEHAN: So, generally, we'll look at -- you know, we look at the entire year, and so we're aware that there are -- that, you know, the pandemic hit different places at different times, and we also know that this isn't the only year we're going to be dealing with pandemic effects in our update work. This is going to be with us for at least another year and maybe another year after that.

I think with all of our options for trying to sort of tease out some of the effects of the pandemic, our

constraints are going to be data and time. So we could do some geographic stratifications and some looking at -- you know, we generally present annual data, but I think we mentioned in the paper, it's possible we could look at some monthly volume changes to kind of see how persistent the changes were.

But we're also making recommendations for national payment policy in our updates, and so we have to be focused on that. Does that help?

MS. BARR: Yeah, it does, although it gets very complicated now, right, because of COVID. And I just wanted to raise some of those concerns because we have to think about the differences. It's not just one -- we need a national recommendation, but we actually don't have one system. We've got multiple systems, and they're all affected differently, and it's very concerning.

One of the questions I had, are all payer margins for hospital determined separately for safety net hospitals versus all hospitals? We're looking at payment adequacy. Part of it is we've got these margins, but do we look at margins in safety net hospitals versus other PPS hospitals, or do we just look at all PPS hospitals at the same? I

know we look at their adequacy first.

MS. LINEHAN: We do stratify by provider characteristics, and I believe we look at critical access, but, Jim, maybe you could correct me if I'm wrong.

DR. MATHEWS: We do break out financial performance by class of hospitals, and as you know from the roadmap document, this year, we have a dedicated body of work that we are planning on safety net providers.

MS. BARR: Got it. I just want to sort of bring in some of these issues because if we're going back to 2019 data, then how -- are we looking at policies since 2019 that have either increased or decreased payment and adjusted the models for that?

So, for example, I'm going to beat a dead horse here on 340B. 340B supports safety net hospital margin, but the pharmaceutical industry has lately stopped paying for a lot of 340B on contract pharmacies, and Medicare took their piece of 340B Part B. So are we going to incorporate that into the analysis of safety net margin? I'm curious on how you're taking policies, and another policy would be site-neutral payments. How are these policies going to be incorporated in sort of the trajectory as we're thinking,

trying to compare 2019 data to 2020?

MS. LINEHAN: We'll be looking -- did you say 2020 data?

Oh, sorry. Did someone else want to speak?

DR. CHERNEW: No. You go ahead, Kathryn, and then I'll make my point.

MS. LINEHAN: What we typically do is when we do our projections, we take into account policy changes and the projected impact on payments and costs. So we do think about all of the policy changes between the data year and the projection year.

MS. BARR: Got it.

So then you already account for the Medicare cuts to 340B, but you won't necessarily account for what's happening in the industry. 340B is the lifeline for these hospitals, and it is a huge impact on margin. It's like a million dollars for a rural hospital, and what we've seen is about a 24 percent reduction in 340B payments because the pharmaceutical industry, Eli Lilly and others, this isn't policy, but it's an external factor that is having a huge impact on safety net providers. So just is there some way to consider what's happening there, I think it would be

helpful, but with the lack of transparency on 340B, it's extremely difficult. So I don't know how to do it.

DR. CHERNEW: So let me make two summary points, Lynn. The first one is we struggle -- and you will see this in every update chapter -- with all aspects of heterogeneity. We see it for hospitals. We see it for every post-acute sector. We have a national program with an update recommendations, and it is difficult to get that right because if you pay what you might need for one group, you may end up overpaying for all the other groups. And remember we just had an entire session on the dire fiscal strains that the program faces.

MS. BARR: Right.

DR. CHERNEW: So I think this is why -- and I'll say we decided to do this even before you were appointed, although your appointment has been wonderful -- to really look at the safety net hospitals, and I want to say for now that's broadly the case. Not all rural hospitals are safety net and not all safety net hospitals are rural.

But, in any case, we will be thinking a lot about how to deal with that heterogeneity because I think our overarching philosophy is increasingly about targeted

programs to help organizations that need to be helped to preserve the access and quality we need as opposed to broad payment updates or whatever that help the groups that need help but also provide funding not needed to other groups, and that nuance is a particular challenge in a range of ways. And at least for now, I will apologize in advance if we don't get as far this cycle as you would like, but it's going to go -- you don't strike me as a -- you strike me as a person -- I'm trying to avoid saying the word "impatient," but since I don't have time, I'm just going to stick with "impatient."

MS. BARR: That's better than "impulsive."

[Laughter.]

DR. CHERNEW: Yeah. There you go.

We are at the beginning of this journey, but your points are well taken about how we will deal with that.

MS. BARR: Thank you.

DR. CHERNEW: There's some other Round 1's, Dana.

MS. KELLEY: Yes. We have one more Round 1 question from Bruce.

MR. PYENSON: I was going to ask about regional variation, but I think your response and questions from

Lynn addressed that, so I'll pass.

MS. KELLEY: All right, then. Shall I move to Round 2, Mike?

DR. CHERNEW: Sure.

MS. KELLEY: I have Jon Perlin first.

DR. PERLIN: Thanks, Dana, and thanks, guys, for a really thoughtful chapter. It is, indeed, both sobering and complicated to juxtapose these two chapters.

As I think about the post-COVID world, I am reminded of the words of the great philosopher, Yogi Berra, "The future ain't what it used to be," and obviously, it's changed things a good bit.

I appreciate your outlining the numerous distortions that 2020 presents. There were certain funds that were provided to caregivers, and here, I'll probably speak a little bit, you know, at the centigrade in terms of hospitals, secondary to the public health emergency.

There are also certain costs. The point I'm going to make is that some of these costs may be ephemeral; some may be durable. I think that labor has changed. We've had a generation of nurses who left care, as Betty Rambur and others have made, are struggling to stay on, and

in certain states, there's mandatory staffing ratios. Candidly, in some areas, I'm not sure that all hospitals are able to meet those.

At the same time, thank you for calling out not only the cost of labor but cost of supplies. Those come together in things that may not be out of the basket of regulations from HHS, such as the OSHA ETFs, emergency temporary standards, that have to be fairly durable that lead to both equipment consumption and staffing requirements.

You mentioned PPE, but also, oxygen, as you know is at a premium, and for states like California, which have a mandate for vaccine as well -- or in lieu of that for COVID testing. The cost of COVID tests is extremely expensive.

And so I just note these that some of these things may be durable because -- I hate to say this -- it looks like COVID may be durable.

I know that in our charge at MedPAC, we look at the juxtaposition of cost, quality, and access. Looking at quality this year, there was a paper that came out just today in an unfortunately named journal, ICHE, which stands

for Infection Control and Hospital Epidemiology, that said it was from the CDC. It showed that while there was improvement in clostridium difficile and surgical site infection, the majority of hospital-acquired infections substantially went up on things like central line-associated infections and MRSA, and the theory was that the reduced labor, physical barriers, and the attention that COVID is taking. And I would bet my bottom dollar that we're going to see the exact same report on patient experience and other indicators of performance as well. So I just note this because in our charge, we do have to balance that.

While we hope that COVID may be ephemeral, and maybe it won't be, there's a confluence of not only the changes related to public health emergency but also policies that change or expire, and I thank you for mentioning one of those. And that's the end of the moratorium on the sequestration, and so this collision between temporary and permanent effects is problematic. So let's just take a look at next year as the trajectory of federal fiscal year '22 as the trajectory into '23. We've got a 2.5 percent update, essentially. If you remove the

moratorium and sequester, that's minus 2 percent. That takes you down to plus 5 percent.

You've also got the ATRA effect, which is another minus 4 percent. So net-net, you're at minus 3.5 percent, and for those institutions that benefitted from the accelerated payments program in June, they'll owe back at a rate of 15 percent per year. So they're effectively down to a minus 18.5 percent in terms of the update.

So I just note that because there is this collision between a temporary and what we're calling a permanent policy, and just give me a plus one on issues of regional variation and plus one on COVID apt to wax and wane, and so it comes to a conclusion for me that while 2019 is generally the guidepost -- and appreciate what you all, what the staff put into a letter recently as our proposal for [inaudible], we need to look at the superimposed effect of the puts and takes that aggregate, oh, for the next year as a glidepath into 2023.

And I say that with all respect for the absolutely sobering first chapter on context that we look at. Thanks very much.

MS. KELLEY: David, I have you next.

DR. GRABOWSKI: Great. Thanks, Dana, and thanks to the staff for this great work.

Mike used the term "challenging" earlier. I completely agree. Trying to think about payment updates and payment adequacy in the context of the pandemic is super challenging.

I wanted to kind of raise an issue that Jon started along, and my comments really fit well with his. How do we tease out what's temporary that's best dealt with the provider relief funds and other one-time dollars versus kind of what's more permanent in this kind of going to be business as usual going forward? Where are we seeing sort of an inflection point?

And Jon building on kind of Betty's earlier comments pointed to workforce. Absolutely. Jon touched on supplies. So I won't talk about those two issues, but I did want to kind of touch on two other areas where I think we really want to pay attention, things that really changed, and both of these were raised in the chapter.

But first -- and we spent a lot of time on it last cycle -- is telemedicine. I do think care is going to be delivered very differently. We're going to want to

think about that in terms of our updates going forward. We've thought a lot about that issue, so I just wanted to touch on it. I won't spend much more time on it today.

The other issue, and it was really stark in the chapter, most other sectors have -- I won't say bounce back but at least look like kind of they've returned something close to their 2019 volumes. The one exception there -- and I can see Mike smiling. He probably knows what I'm about to raise, but skilled nursing facilities, they're still down. They haven't yet rebounded, and I'm wondering -- and I don't know the answer to this -- when they'll rebound and if they'll rebound and if things are going to look very different. They share some of those workforce challenges and supply challenges that have already been noted with nurses and RNs but also certified nurse aides, and I just wonder if we want to think about payment policy differently there. It's not a one-size-fits-all in terms of thinking about this issue. Each sector, obviously there's heterogeneity within sector but also across.

So, yes, there was provider relief funds, but unlike some of the other sectors, we haven't quite seen that return to maybe the pre-pandemic levels that we're

hoping for. Thanks.

MS. KELLEY: I have Paul next.

DR. PAUL GINSBURG: Oh, thanks.

Yeah. This was a really good piece of work, and the more I think of it, the more I see how challenging a job this is going to be for us to make wise recommendations for updates. The last straw was the fact that maybe six months ago, we might have thought, well, for 2023, we can just assume that things are not back to normal but in the sense that COVID won't be a major influence, except to the degree that some changes like telehealth that David mentioned become permanent parts of our system from that experience.

But I keep thinking we know so little, and in a sense, the experience in 2020 and 2021 is not helpful in understanding what a more normal situation might be like in 2023. And I'm thinking more and more that in a normal period, our recommendations from year to year for updates don't vary much because the changes are not that great. They evolve slowly. But, of course, this is different, and I'm thinking that maybe we should be putting more of our energy into focusing on one-time payment rate updates. In

a sense, we'll still do what we're required to by statute and recommending on the baseline, no the rate increase, the updates that will then become the baseline for the next year, but we might be better off saying we don't expect to do much on that beyond, say, what we did last year, but that we really should be spending time on one-time temporary changes to payment rates because the pandemic's effects have really been profound.

Let me just stop there.

DR. CASALINO: How would that be -- if I could just interject a question for Paul -- just to make sure I understand, how would that differ from what we usually do? What are you suggesting?

DR. PAUL GINSBURG: I think the difference would be that we wouldn't spend, you know, as much time on doing what we usually do, but would devote that time into saying what types of one-time changes that do not affect the baseline for the future should we be recommending?

So, as I said, I think we'll need to do both, and it's really a matter of how we allocate our staff time and energy at Commission meetings to balance them. I just think that, you know, we can accomplish more of value to

the Congress by talking about, you know, what types of one-time adjustments appear to be justified by the data, and, you know, reminding them that, you know, we don't think that it should necessarily go into the baseline for the future.

DR. TORAIN: Paul, could I ask a question for clarification, just so I make sure that I'm following? So are you saying that within like a given cycle we should consider the one-time policy changes or one-time federal subsidies that have been in that year? Is that what you're saying?

DR. PAUL GINSBURG: I'm just thinking more about coming up with recommendations about, you know, this is what's -- yeah, that say one-time changes, and the problem is they're going to go into effect in 2023. That's going to be later, you know, than they should be going into effect. So maybe this would be we have some suggestions for one-time changes that should go into effect as soon as possible, and then here are our regular, updated recommendations for 2023, and, you know, it has a baseline for future years as well.

So I'm glad you asked that question. I'm

starting to think that maybe we just have, you know, usual recommendations applying to 2023, which will be the baseline of the future, but, you know, as a result of looking at all this data, you know, recommending some one-time changes to be implemented as soon as the Congress can work them through.

DR. CHERNEW: There are several ways I think we could implement something like this, and again, I was going to ask this at the end but I'll ask it now as we go through Round 2. I'd like to get everybody's sense, loosely, on how we deal with the uncertainty, if not just that we want to have a very good point estimate of what things should look like in 2023, there might be a wide range of uncertainty around that. You know, we're always picking a recommended update within a range of things we think is reasonable, and getting peoples' sense of how to deal with that uncertainty matters.

We could envision, for example, an update recommendation that might follow similar to what we've done in the past, with a recommended supplemental update that wouldn't go into the baseline, that still might apply in 2023. I'm not saying we should do that, but that's what I

took from your comment, Paul.

DR. PAUL GINSBURG: Yes. That's correct.

MS. KELLEY: Okay. I have Brian next.

DR. DeBUSK: Thank you. You know, really, to summarize the chapter that was sent out in the presentation, I mean, my real takeaway is we're just not going to know, by geography, the effects of COVID. I mean, you know, as Lynn and others have pointed out, the geographic variation is tremendous. You've got variability in the timing, the intensity of the outbreak, and even the region's response to COVID.

You've also got all these second-order effects. I mean, what was the underlying health status of the community? What were the state-level policies that were carried out, and when were they carried out? And, you know, my takeaway is I think it's really impossible to unravel all of these effects, and I think we could really put ourselves through a lot of -- you know, experience a lot of frustration trying to unravel it.

And I think really the capstone for me was a point that Jon Perlin and David made, which is that some of this is going to be permanent, and we don't know what's

permanent, and we don't know what will be transient. For that reason -- and I think, you know, Paul, you mentioned it, and Michael, you mentioned it earlier. I think we were building to this anyway.

I really think of this upcoming payment update as an opportunity to do some targeted updates. We've been needing to do more targeted updates anyway, and I believe, I think it was 2018, we actually did a split update. I think we had the HVIP, I think. It was the Hospital Value-Based Incentive plan. We had a base update, but then we also had an additional recommendation in the March report that spoke to providing some additional funding to hospitals, based on a proposed quality program. So there's a precedent there, where we do a split update or a targeted update, and I think back then we did call it a differential update at the time. We had a good reason then and I think we have an excellent reason now.

I think Paul might have been the one who mentioned this earlier too. You know, the raw market basket update doesn't differ that much from year to year. I mean, there's slight variation. Now, the statutory adjustments and things will vary, sometimes significantly.

But the raw number doesn't vary that much. And, you know, my recommendation would be instead of trying to unwind this incredibly complex situation, should we look at the previous years, previous trends, try to do a little bit of extrapolation, but then take that number -- you know, maybe that number's 3.2, or maybe that number's 2.9 -- take that base number and then try to tease it apart so that we're doing some focused payments towards some of these safety net hospitals. Again, it was a good idea in 2018, before anyone had heard of coronavirus, or COVID-19. It's a great idea now.

And then the final comment I want to make is, you know, we did witness the collapse of the supply chain, particularly for personal protective equipment. We also watched the collapse of their workforce. I think Betty and Lynn and others have mentioned, for example, in nursing. But I think there are some real lessons learned here, and I don't think that gets addressed in a specific payment update. I think it's impossible to boil that down to a single number.

But I do think that there should be some lessons here incorporated into permanent payment policy, even if

it's just done at the conditions of participation level, that I think that the lessons learned here on how to protect their supply chain, both their drug, device, and workforce supply, I think are critical. Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks. First, Kathryn and Jamila, you know, fantastic job I think of outlining the picture here and the challenges. I think to reup on the challenging point -- Mike said "challenging," David said "super challenging" -- I'm going to go ahead and say "super, super challenging" situation here.

So I really have two points. One is to support Paul's idea, which is that, you know, maybe we should consider the idea of, you know, one-time updates here that aren't necessarily permanent, given the, hopefully, one-time nature of such a pandemic, although, of course, it's extended a little bit longer than probably many of us thought it might.

The second point is I think it's extremely challenging to look at the data and try to tease out, I think as David pointed out, tease out, you know, what is permanent, what is dynamic, what is temporary. There's a

whole bunch of pieces here that were unlikely to be able to truly separate, decompose.

And while I agree, in general, that the idea of looking at stratification by geography is probably difficult, what I wonder is if we can look at some of the relative changes. You know, is there kind of re-sorting, re-ordering, if you will, of what the financials look like, along margins, along the other payment adequacy indicators, et cetera, within categories. Stratified based on things like that receipt of provider relief funds, other kind of COVID-related but not necessarily geographically related measures or dimensions. Not that any of them by themselves would be particularly meaningful to say we should make our payment updates based on this, but rather that it might give us a more comprehensive view of the dynamics here.

That being said, again, I feel like making any inferences here is super, super challenging, and so I generally agree with the idea of trying to pursue the path of more temporary or one-time types of updates. Thanks.

MS. KELLEY: Stacie.

DR. DUSETZINA: Echoing everyone else, Kathryn and Jamila, great presentation and great job on the report.

As a person who uses these data sources as well, I also have been struggling with what do you do with 2020, and now what do you do with 2021? And I think in the chapter, Figures 2 through 4 are very insightful for seeing, you know, this massive change in utilization of services, and I guess my gut reactions on thinking about strategies or even trying to do some sort of general update are March through May never happened. You know, like those are such outliers, there are so few services used relative to prior months that it seems that, you know, determining if we could censor those points and then look at the trends that are going on in absence of those.

I guess one of the other things that was really interesting, looking at the use of services plotted by month, was I kind of expected a little bit more of a rebound of serviced used, but from the claims lines it doesn't look like that's happening as much as I would have thought, especially as we move farther along, but maybe we start to see that in 2021.

So I think the 2021 data maybe will help us get a little bit better of a sense of do you see a little bit of rebounding, where then maybe we think about, you know, kind

of on average, do we get back to baseline if we average 2020 and 2021, and what's going on with services?

But this is a problem, and I do also agree with what Paul said and what others have said about, you know, one-time updates versus just trying to figure out, as best we can, what things would have looked like in absence of the public health emergency. Tricky stuff to deal with, for sure.

But I will also say I think the geography points have been well made, that it would probably be too complex to try to incorporate them, and then what's happening on the ground around access to services is going to really vary a lot after some of the initial surges that happened. So we all know New York was hit hard, but then everything else sort of goes into a regional kind of where care is accessible, which hospitals are shutting down access to services. So I think geography might just be something we can't really fully incorporate.

But, you know, this is going to be a lot of work. It already has been a lot of work, and you've done a great job so far.

MS. KELLEY: Betty.

DR. RAMBUR: Thank so much for a very interesting chapter and conversation, and I really appreciate the Commissioners' thoughts that help me think about the tentacles of interconnection, which is how I think about it.

Very briefly, in terms of my thoughts, this section talks about the labor costs and doesn't mention quality indicators that are nurse-sensitive indicators, actually. And in the last section we talked a little bit about the antecedents of some of these workforce issues, and COVID uncovered them and exacerbated them, but they were there because of other actions and inactions.

So I would strongly support sort of an effort that's more -- in health care we call it "acute and emergency," like just on the immediate, so that we can really think about antecedents that don't create long-term and unintended consequences, as some of these things would become baked into the cake. So I don't know exactly how that is done, but I do think that it's really important that we think about those antecedents and not address them in permanent policy when there's probably other more appropriate and effective ways to address them. Thank you.

MS. KELLEY: Lynn.

MS. BARR: Thank you. This is a little bit of a technical question, but does MedPAC or Medicare have any ability to, say, hypothetical, we're going to raise the rates 2 percent but we're going to take 1 percent and put it in a pool that Medicare can distribute amongst providers as we learn more? I mean, you know, what I think we're all struggling with is this is not an even situation, and a national policy is going to overpay significantly in order to keep all the boats afloat. So I like Bruce's or Brian's idea about, you know, targeted payment policy. I think that's really a great idea.

Is there any flexibility, because this is so far into the future, to give Medicare some flexibility on how they would determine, you know, providers that were in need, so we don't need the legislation to bail people out again? Because I don't know if anybody remembers what it was like before there was a bailout, but April of 2020, I had rural hospitals that just were like, well, we've got three days left of cash. We don't know what to do.

DR. CHERNEW: I'm going to defer to Jim in a second, so Jim, this is a heads up. But we need to have

update recommendations the way we always have update recommendations, that will function the way update recommendations function. We can decide, if we want, to have any other related recommendations, for one-time things, for targeted things, for whatever we think we may decide. That is sort of separate.

But come December and January -- and again, Jim, I'm looking at you. You're quite small on my screen -- we will have update recommendations and they will be applied broadly, and we will keep any recommendations of other actions separate from our traditional update recommendations. That doesn't mean we can't have them. It just means that we will have update recommendations as traditionally done, and then we can decide how we want to deal with the uncertainty or other challenges or things we don't know as sort of a supplemental type of activity, if we think a sector deserves more payment, or we could adjust our update recommendations.

But I think, Jim, I'd really appreciate you jumping in to make sure I have the institutional requirements correct.

DR. MATHEWS: Yes, that is correct, and I'll loop

back to that in just a minute, if I could. But to go back to answer Lynn's question directly, I am unaware of any such existing authority whereby Medicare can set aside a pool of dollars that can be allocated within the Secretary's discretion, as needed. So I think that, in and of itself, would require a statutory change of a fairly fundamental nature.

With respect to the differential updates or targeted updates or one-time updates, I've been thinking a little bit about this, and I do see a path whereby, again, depending on, you know, the information that we are able to extract from the 2020 data, that's going to be difficult to work with, but to the extent we could identify particular subsets of providers within a sector I think there are ways to accomplish what we are talking about here, even in the context of recommending regular order updates at the same time.

So, for example, just to focus hypothetically on the hospital sector, we could conclude that a general current law update is warranted. However, hospitals that meet existing definition -- you know, they are rural, they have some other characteristic, they serve only left-handed

patients, whatever it is -- might warrant an additional percentage point that does not get compounded with the update. So you've got a $100 base payment rate. The current law update is $2. So everyone gets $102, except for rural and they get $103. But when it comes to updating in the following year, everyone is updated from $102. The $103 for rurals doesn't compound.

And I think there has been recent precedent in the physician fee schedule world where to offset changes to the E&M codes Congress authorized a kind of, you know, separate bucket of dollars that were allocated to physicians over a period of three years, if I recall correctly, that didn't get built into the base.

So this would definitely be atypical for us, not doubt about it, but we will keep it in mind as we start digging deeper into the data that we use for our assessment of payment adequacy.

DR. CHERNEW: And, of course, there's nothing we're going to do that's not going to be atypical, just to be super clear.

So, Larry, I think you wanted to say something about just this, and then maybe we'll jump back to the

queue.

DR. CASALINO: I do, and I'm barging in because I think it may be important. You know, we're using words like "baseline," "one-time," "temporary," "targeted," and we're talking about, on the one hand maybe doing special things for certain types of providers. But on the other hand -- and I think this is where the discussion started -- talking about doing special things because there's a lot of uncertainty because of COVID, so I think it was said at one point we might do a baseline recommendation and then some special thing because of COVID one time.

And I'm not sure that all of us, or even very many of us, have the same images in mind of what we're actually talking about with these words. I mean, I may not understand broadly, but my understanding is we have to make a recommendation. That recommendation is going to set a payment rate, if Congress accepts it. If any percentage changes of that payment rate, any percentage changes in future years would come off that payment rate, I think. I think that's what people may mean by "baseline," if I understand correctly

So to me the core problem is very, very

important, rural versus urban providers and all of those kinds of things, and I think it would be great to talk about how those issues could be addressed. But I think the core issue here is that we have to recommend an update, and there's no way to get around there's a lot of uncertainty in that update, so what can we do about that? I don't think we can pretend that we're not recommending an update, a baseline, whatever.

The only thing I've really seen was kind of offline, addressing this directly, I think, at least as I understood what people have said, is Mike's comment offline, which is that maybe we just have to acknowledge our uncertainty and be a little less aggressive with our update recommendations, possibly trending forward, as others have said, acknowledging that that's what we're doing. It's unsatisfactory but there's nothing better.

But if other people have other ideas of how we can address that core uncertainty, in whatever recommendation we have to make, leaving aside issues of what to do, we could add on separate things about different kinds of providers, and so on and so forth, but we still have to know how to address that core uncertainty. Being

less aggressive in our recommendations, up or down or usual is one way. I'd be very interested if there were other ideas, or do I just have this wrong?

DR. CHERNEW: Short answer, Larry, is I think you have that basically right, and I know we want to continue on in the queue, but, Brian, you also sent a message on -- well, okay. We're going to have a problem with a lot of on these points. So I promised if we had quick Round 1's, which we did, we'd have a little bit more discussion.

So, while we're here -- I don't know. Dana, how many people who are in the queue had comments on this point? Because they should probably get the comments on this point first, otherwise Brian wants to have a comment on this point. I think Bruce wanted to have a comment on this point. Let's just go a little bit this way, and hopefully, our on-this-point discussions will totally destroy the queue. I apologize to all of you for my inability to manage this remotely. I would be no better in person, by the way.

So I guess Brian.

DR. DeBUSK: I'll be super quick. Thank you for the time, Mike.

We may want to go back and revisit the 2019 recommendation where we did the differential update. I actually pulled it up while we were having this discussion, and the HVIP, the value-based program, uses their peer grouping mechanism, and so something to consider is doing, say, a base update of 2 percent to everyone. What we might want to do is put some of that extra money in the HVIP and basically stratify it so people in the higher socioeconomic risk groups -- this is illustrative; this isn't prescriptive. But you may be able to put some additional money into HVIP by peer group and have a more targeted approach here where the safety net hospitals, the hospitals that are caring for more of the beneficiaries who are socioeconomic risk would do better, which I think does address some of our concerns about targeted payments.

So, if long story short is the HVIP proposal from 2019 in January, it might actually be a chassis to introduce this new money.

DR. CHERNEW: Thank you, Brian.

Bruce, you're going to be the last on this point, I think, if I can follow what's going on in the chat. Maybe I don't have that right, and then I think there's a

bunch of to her people still in the queue. Very quickly, Bruce.

MR. PYENSON: I want to follow up on and agree with Larry's point on the uncertainty but point out that this kind of situation happens surprisingly often or historically has happened in the private insurance industry where, for a variety of reasons, it might be very difficult to come up with premium rates or forecasts for the next year or two. Perhaps a claim system falls apart, things of that sort.

What happens in that kind of environment is typically what Brian and Larry were referring to is that past trends get applied going forward with perhaps a little bit of alteration based on what information you can have, and I think we're at the point now where we can decide pretty well if that's what we're going to do and save staff a lot of effort of trying to come up with something more substantial.

A starting point might be to look at how much our various recommendations have, in fact, changed from year to year. Many of our recommendations are rather consistent, my recollection, from year to year to year, and that might

be a good use of staff's time to avoid trying to get into exquisite analysis in an environment of a lot of uncertainty. Just a thought.

DR. CHERNEW: Okay. Go on, Dana.

MS. KELLEY: I think Pat has something on this point, and I also have her next in the existing queue.

MS. WANG: Actually, I think Bruce's suggestion is a really good suggestion.

I guess I'm a little bit confused about the sensitivity around making an update recommendation that, quote/unquote, goes into the baseline. I think I understand, because if folks said the update should be higher, then somehow there's an expectation that going backwards from that, if there's an assessment that the COVID impact has dampened, it's very difficult.

The way that I am -- and I appreciate Larry's question about what could these words mean that we're saying. The way that I'm hearing the conversation -- and I don't know if this is feasible, Jim, to think about an update factor this way -- is that the update factor is kind of like a fixed and variable. It has two different components, and the fixed update factor is our best

estimate of, you know, based on past data, but I would urge also assessments about future disruptions or changes. For example, labor and supply chain, that's going to be with us after COVID recedes, which hopefully is sooner rather than later. I feel like we should do our best. That's a more forward-looking forecast, to Bruce's point, that there will be certain effects that are likely to carry forward for a period of time, that we try to build those into the baseline.

And then on this variable COVID adjustment impact, I wonder whether it's feasible to sort of identify the buckets of greatest variability and give ranges, so that Congress can have some material to make judgments as they get closer to 10/1/2022 about what the COVID infection rate is in the country, for example. If we are blessed, it will be very, very low, but if we are not blessed, it could be another spike. And, in this variable component, would it be valuable to Congress to say we think that aside from the additional labor costs that we have simply built into the baseline, the range of COVID-related labor costs could be X to Y, so that they have something to pick from?

The other thing I wondered about in terms of the

2020 experience -- and I don't know if this is feasible at all, but to the point that some of the others have made, it did travel differently in 2020, and by the end of the year, I think everybody was getting more than their fair share, obviously. Is it even feasible to think about, like, a control group of hospitals whose 2020 experience for the first half of 2020 is just some sort of -- it doesn't have all the noise in it? And to use things like that to try to pick apart what is sort of steady-state versus this extraordinary crisis that happened. It's just a thought.

DR. CHERNEW: So let me do just some quick responses, Pat.

We always try to be forward-looking, although obviously our data is coming from the past because the future data hasn't been generated yet. Even in a normal time period, we always try and make recommendations that are forward looking by understanding what's happening to trends. It's just there's a lot more uncertainty going forward than there has been in the past, and once we make those recommendations, whatever actually happens, any future recommendations, 2024, 2025, that gets built on top of whatever happened when we get to 2023. That's kind of

what's meant in the baseline. So that's essentially what we're trying to sort through. I just wanted to clarify that general point.

MS. WANG: That's great.

The one last thing, if I could --

DR. CHERNEW: I'm sorry. One more to this thing, and then I'll look to Jim. Part of the problem is we don't have data for half-a-year cost report. So it's very hard for us, for some of our measures, to see what happened to hospital costs in the beginning of -- before the pandemic. So some of our data in cost reports is lumpier than other data like access, which we could think about claims in a different way, but some of the key indicators like, for example, hospital costs, we simply don't have the granularity to break it up in the way you might want to know what was happening by different time periods.

MS. WANG: Okay. Thank you.

The only other thing that I wanted to say is that I appreciate the discussion around the safety net issue. This could be the same thing. It could be different things. I think in the update factor, to the extent that we can prioritize what I would put under the umbrella of

equity, to make sure, extra sure that populations that were the hardest hit by COVID -- and we know where they were, and we know the characteristics of those communities -- that we make extra sure whether through social vulnerability index, identification of communities, that we maybe do a separate run in the type of provider.

I know right now, we do things according to DSH and things like that. Maybe that's a good proxy, but I would just ask us to take extra care to make sure that access is preserved for those communities in particular.

DR. CHERNEW: Okay. Let's get back on to the general queue. So, Dana, where were we?

MS. KELLEY: I have Larry next.

DR. CASALINO: I'm good, Dana.

MS. KELLEY: That is all I have in the queue, unless anyone wants to raise their hand.

DR. CHERNEW: Okay. Let's get back to thoughts in the general queue. So are there other comments along these lines? I actually think this has been a very useful discussion as we begin to think throughout -- I'll sum up in a minute, depending on where everybody is, but if anyone wants to jump in before I do that, now is the time.

[No response.]

DR. CHERNEW: Okay. So my takeaway is this is super, super, super challenging. There is going to be an update. The update is going to work the way Medicare payment works; in other words, going to apply to everybody. We acknowledge the uncertainty, and that may have us change the updates more this year than typically happens year to year, and we will rely on data from prior years, prior years meaning, say, 2019, more than we would have in the past because we're concerned about the data. This will be very indicator-specific. So I'm not sure, for example, if we see big drops in volume, we would conclude -- normally, in a normal year, if we saw big drops in volume, we would argue there's a real -- we would worry there was an access problem, and we might account for that access problem in our updates.

This year, if we saw a big drop in volume, we might attribute that to COVID and not react the same way we normally would. I think that's a poor type of example.

In the past, when we see quality measures, we might see changes in readmissions or whatever happening, and we would then adjust for that in our update

recommendations. This year, if you see changes in readmissions or even in admissions, you're going to infer something different because of everything that was going on with COVID in a whole variety of ways.

So I think what I hear is a few things. One is we should spend some time thinking about how to use the pre-2020 data more because we may have to trend some of that forward a little bit more to get to that, and then the other thing that I hear is we should think about if we perceive there's a problem in a sector or a type of facility or something else, we should think about policies that might not go into baseline. Those would be supplemental recommendations to our standard update recommendations, and I'm not -- you know, we have a long ways to go until we get there, which is why we want to have this discussion early. Honestly, I'm not sure exactly how that will work. I'll have to discuss it with Jim and the staff.

And the third thing is we may have to think through aspects of the uncertainty and how we deal with that all going forward.

So that's kind of where I am and what I'm taking

away from this. When at the end of the cycle we give the normal applause to the staff, which is always heartfelt, we will make it an extra 50 percent longer for getting through all of this with us, but we do have a job at hand. And we are going to have to do it with the cards we are dealt.

Are there other comments? Did I miss something in my summary? Are there general reactions to how I just laid out where I think we're going to go?

Jim, anything on your end since you're actually the point of the spear in some ways?

DR. MATHEWS: No. All good.

DR. PAUL GINSBURG: Actually, Michael, one thing that perhaps it was in your summary, but I would want to reinforce is how by looking at the data from 2020, which will be the last we have, how little we'll be able to learn about the underlying trends because, in a sense, the impact of COVID and its uneven impact by time, by part of the country, by types of providers is really going to dwarf other factors that influence what rates should be. So, in a sense, it just makes us more humble in approaching this thing. The data may be very useful for giving us ideas about one-time adjustments but really won't contribute very

much to telling us where the trend should be.

DR. CHERNEW: Yeah. And one thing I might add, Jim, it might be useful if you send out to the Commissioners, sooner rather than later, last year's update recommendations. My guess is at least for our new Commissioners, Lynn and Stacie, it might be useful for you to see what we recommended and, of course, also what was actually done by Congress to give you some sense of where we were going forward, because I would like to hear how people feel about specific sectors going forward in a range of ways.

There will be a chairman's recommendation in December, and we will have, hopefully, a rich discussion around each section, each sector, when we do that. But this is a year we're understanding what you're feeling a little sooner might actually be helpful.

I know for the continuing Commissioners, you've seen all of that. It may not be top of mind, but I think that might be -- would that be a useful thing for people to see as they ponder this? Okay.

DR. PERLIN: Hey, Mike?

DR. CHERNEW: Yes?

DR. PERLIN: It's Jon. I tried to weigh in on the chat, but I think your summary was terrific.

I just would encourage that we have the courage to actually look at the 2020 data and make some assessments of what we think is transient and what we think is more durable. Clearly, unless there is some magic, I don't see a new -- a bolus of nurses. So I think there are things that we'll write off. Some of the updates will be transient – sorry, I mean some of the public health additional funds may be transient, et cetera, some of the volume. Who knows? But I feel completely confident in my assessment of the workforce.

In fact, living in the world with 185 hospitals, we've made some other contingencies because we are so secure in out conviction about that.

I just think we can't dismiss the 2020 entirely, and I think there are different pieces that we should use in terms of what was fairly COVID-light periods and what we can take away from that, what were COVID-heavy periods and what we take away from that, what were the effects of temporary policies, what can we take away from that, and what things changed that probably are not going to go back.

DR. CHERNEW: Thank you, Jon.

I think to summarize, we have a fundamental forecasting problem, per Pat's comment. We're trying to predict something in 2023, and we're trying to use data that we're going to have available, and some of that data is noisier in the past. So we will certainly look at it.

It might be we use the same data, but we use it in a different way, for example. So, in the past, we've looked at hospital margins, but we may not have tried to dissect them as much as we might this year. But there is going to be limitations on staff, time, and effort and how we deal with this. So this will be super, super, super, super -- I can't even remember how many we're up to -- super challenging, but again, we will do our best, and we will try and keep you posted.

And, of course, the reason that we have you all as Commissioners is because some of the deviations between what would be normally happening and some of the trends that are going on that might not be picked up are things that your insights will be helpful for.

So I am sure we will hear comments like that, Jon, as we get closer to the update months.

DR. PERLIN: Well, Mike, you've opened yourself up to that for another Yogi Berra quote, even better, as Yogi Berra said, that forecasting is always difficult, especially about the future.

DR. CHERNEW: Yes, exactly. And, in fact, he should have said five or six "supers" before that, but I'm not going to keep saying "super."

All right. So we are now going to shift to a very different topic. It is a little bit more what I would call in the normal course of business, and again, to emphasize something I said in context of the context chapter, our activities writ large are often devoted to understanding where there are inefficiencies or problems in the current way that the Medicare program is running. We pick a number of targeted issues in a range of ways, and Eric is about to go through some issues particularly related to Part D's low-income premium subsidy.

So, Eric, I'm turning over to you.

MR. ROLLINS: Thanks, Mike. Good afternoon.

I'm going to conclude our work today with a session on the Part D drug benefit.

Last year, at our November meeting, we gave a

presentation on the program's low-income subsidy, or LIS. We described how the LIS subsidizes premiums for eligible beneficiaries and how it has features that limit competition among Part D plans. The Commission expressed interest in doing more work on this issue, so I'm back today to talk about some potential reforms that could improve competition and reduce program spending.

Our goal today is to assess your interest in working towards a recommendation that we would include in our June 2022 report to the Congress.

Before I begin, I'd like to remind the audience that they can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

Let me start with a little bit of background. Part D's low-income subsidy was created to ensure that low-income beneficiaries have access to drug coverage by helping them pay their premiums and out-of-pocket costs. This year, almost 13 million people receive the LIS, and they account for 27 percent of overall Part D enrollment. Total LIS spending on premiums was about $3.8 billion in 2019, the most recent year available.

The approach that the LIS uses to subsidize premiums has two key features -- a dollar limit known as the benchmark and an auto-enrollment process that I will briefly review.

The benchmark is designed to encourage LIS beneficiaries to enroll in lower-cost plans. Under Part D, each plan offers either basic coverage, which consists of the standard Part D benefit or its actuarial equivalent, or enhanced coverage, which is basic coverage plus some type of additional benefits. The benchmark equals the average premium for basic coverage across all stand-alone prescription drug plans, or PDPs, and Medicare Advantage prescription drug plans, or MA-PDs, in a region.

The benchmark is the maximum amount that the LIS will pay for basic coverage. LIS beneficiaries who enroll in basic plans that are less expensive do not have to pay a premium, and these plans are thus known as benchmark plans.

In contrast, LIS beneficiaries who enroll in basic plans that are more expensive must pay the difference between their plan's premium and the benchmark. In addition, since the LIS only subsidizes basic coverage, any beneficiaries who enroll in enhanced plans must pay the

extra premium that those plans charge to finance their richer benefits. By statute, there must be at least one benchmark plan in each region. If the average premium is lower than all of the PDP premiums, the lowest premium for a PDP is used as the benchmark instead.

The Part D program relies on beneficiaries to select a drug plan on their own, but policymakers also wanted to ensure that LIS beneficiaries had drug coverage. They balanced these goals by automatically enrolling these beneficiaries in a benchmark plan if they did not choose a plan when they first became eligible for Part D. CMS also uses auto-enrollment to reassign beneficiaries to a new plan when the premium for their current plan rises above the benchmark. In both cases, the goal is to ensure that beneficiaries do not have to pay a premium. Beneficiaries are randomly assigned to a benchmark plan, and each plan in a region usually receives the same number of auto-enrollees. Those who have been auto-enrolled can easily switch to another plan if they wish.

Although the LIS helps ensure that beneficiaries have drug coverage, it also creates incentives that limit competition among benchmark plans and result in higher

Medicare spending.

Part D relies on competition among private insurers to encourage the development of plans that beneficiaries find attractive and to control overall program spending. Plans that want to serve LIS beneficiaries have an incentive to keep their premiums below the benchmark. They don't know exactly what the benchmark will be when they submit their bids, but they can often make a reasonable estimate based on the current benchmark and projected spending growth.

However, once a plan qualifies as a benchmark plan, it has no marginal incentive to lower its premium any further. If the plan does lower its premium, it won't receive any more auto-enrollees, since every benchmark plan in a region receives an equal number. The plan also won't become more attractive to LIS beneficiaries who select their own plans, a group often known as choosers, because the LIS covers the full premium for all benchmark plans. As a result, a benchmark plan that lowers its premium receives less Medicare revenue for the same number of enrollees. As I said last fall, it's the same dynamic that you see on "The Price Is Right." Plans want to set their

premiums as close to the benchmark as they can without going over.

This graphic demonstrates how this dynamic plays out. It shows the distribution of PDP premiums in 2021 based on the difference between the plan's premium and the benchmark. In the top half, which shows the premiums for basic PDPs, you can see that the premiums for most benchmark plans are very close to the benchmark. In contrast, you can see in the bottom half that there's more variation in the basic portion of the premiums for enhanced PDPs, and that many plans have premiums that are lower than the benchmark.

The policy challenge here is to find ways to encourage benchmark plans to lower their premiums, which would reduce the clustering you see now, essentially shift the premiums for at least some plans to the left, and fill in some of that empty area you see now. Getting plans to lower their premiums would reduce LIS spending and save Medicare money. The differences between the premiums for basic plans versus enhanced plans are large enough to suggest that basic plans could reduce their premiums to some extent and that savings are achievable.

Now that I've given you some background, I'd like to discuss some potential reforms you could make to the LIS premium subsidy. Given the shortcomings of the existing system, these reforms seek to create stronger incentives for plans to bid competitively and reduce Medicare spending on premium subsidies. At the same time, we want to maintain a sustainable level of competition and plan choice, and when I say "plans" here, I'm referring specifically to benchmark PDPs.

We've come up with two basic approaches for you to consider. Option 1 focuses on changing the auto-enrollment process to improve competition among benchmark plans. There would also need to be some supporting changes to the benchmark, but the changes to the auto-enrollment process are the focus. Option 2 would lower the benchmark without making any changes to the auto-enrollment process.

Under the current system, the main feature that limits competition among benchmark plans is the practice of assigning the same number of auto-enrollees to each plan. Option 1 would replace that with a new auto-enrollment process that assigns more beneficiaries to plans with lower premiums. We discuss several ways to do this in the paper,

but one approach would be to award progressively larger shares of auto-enrollees to plans with lower premiums. This reform would give benchmark plans an incentive to lower their premiums in exchange for higher enrollment. We think that CMS would need flexibility to decide exactly how the share of auto-enrollees for each benchmark plan would be determined and to refine its method as the agency gains experience with the new system.

As part of Option 1, policymakers could also revisit the de minimis policy, where plans that narrowly miss the benchmark can waive the remaining premium for their LIS enrollees and avoid having them reassigned to other plans. This policy reduces reassignments, but it also discourages competition among plans by reducing the consequences of missing the benchmark. The policy could either be eliminated or modified to reduce LIS payments to de minimis plans, and we discuss some ways to do that in the paper.

If policymakers changed the auto-enrollment process, they would likely need to modify the benchmark as well. Right now, the benchmark equals the average premium for basic coverage, and the premium for each plan is

weighted by its LIS enrollment. Assigning more beneficiaries to lower-premium plans would thus put downward pressure on the benchmark and could reduce the number of benchmark plans. Policymakers could still use the average premium as the benchmark, but they may want to consider increasing the minimum number of benchmark PDPs to ensure that LIS beneficiaries have sufficient plan choice. Currently, there only has to be one benchmark PDP in each region. Under this approach, CMS would increase the benchmark if needed to ensure that the minimum number of plans was available. Another option would be to have CMS specify how many benchmark PDPs would be chosen in each region and use the premium for the last plan chosen as the benchmark.

Let's turn now to the second option, which would lower the benchmark without changing the auto-enrollment process. Under this approach, plans would need to lower their premiums to stay below the new benchmark, which would generate savings. However, these plans would still have incentives to keep their premiums just below the benchmark, and we'd expect to see the same clustering pattern that we do now. As a result, program savings would depend largely

on the extent to which the new benchmarks are lower than the existing ones.

We evaluated three potential changes to the benchmark formula, which I have listed here. We found that the second and third alternatives would both lower the benchmark because they would include the Part C rebates that many MA-PDs use to reduce their Part D premiums. Many regions would see reductions of 10 to 20 percent, which could reduce the number of benchmark plans. As on the previous slide, one potential way to address those concerns would be to increase the minimum number of benchmark plans.

This presentation has focused on the competitive dynamics for benchmark PDPs, but I'd also like to touch on the implications for MA-PDs and LIS beneficiaries. The impact on MA-PDs would largely come from changes to the benchmark. Many MA-PDs use their MA rebates to reduce their Part D premiums, and some plans, particularly D-SNPs, focus on reducing their premium down to the benchmark amount. Changes to the benchmark would thus affect how those plans use their rebates.

As for LIS beneficiaries, the reforms we've discussed could reduce the number of benchmark plans and

increase the number of beneficiaries who are either reassigned to new plans or need to switch plans to avoid higher premiums. Unfortunately, it is unclear how large these impacts would be due to the uncertainty about how plans would respond.

Now to wrap up. This slide gives you a side-by-side comparison of the two options that I've just discussed. Starting with the first row, the first option would give plans stronger incentives to bid competitively by assigning more auto-enrollees to plans with lower premiums. In contrast, under the second option, plans would need to reduce their premiums to meet the new lower benchmark, but once there, they'd have the same marginal incentives they do now, which is to keep their premiums just below the benchmark. We expect that both approaches would result in lower benchmarks and generate program savings, but it's worth emphasizing that the savings from the first option would be driven largely by greater competition among benchmark plans, while the savings under the second option would be largely driven by changes in the benchmark formula. Both options have the same potential drawbacks. The number of benchmark plans that are

available could be limited, and there could be more year-to-year turnover among benchmark plans, and the number of LIS beneficiaries who need to be reassigned to new plans could increase.

One challenge here is that we can't say definitively which option would generate more savings or potentially have larger drawbacks. That's partly because we don't know exactly how plans would respond to these new incentives, but also because you'd need to specify some key details, such as how much plans would be rewarded under the first option for lowering their premiums and how much the benchmarks might be reduced under the second option.

That brings us to the discussion portion of the session. First, we'd like to know if the Commission is interested in working towards a recommendation on this issue during this meeting cycle. If you are, we'd return to you in March to discuss a draft recommendation, which could lead to a vote on a final recommendation at our April meeting and a chapter in our June 2022 report.

Second, if you are interested in a recommendation, we'd like your feedback on the potential reforms that we outlined today.

That concludes my presentation, and I'll now turn it back to Mike.

DR. CHERNEW: So we're about to jump into Round 1 and Round 2. I just want to emphasize one point about how incredibly tight this timeline is. So I am very amenable to getting to a recommendation, but understand the next step after this session is likely to have a draft recommendation. So we need to come out of this with not just a "keep working" but some sense of what type of recommendation people are thinking about. Before we jump to the questions, did I get that right, Eric, about the timing?

MR. ROLLINS: That's correct.

DR. CHERNEW: Yeah. So I'll save my wrap-up until the wrap-up, but I think I'd be interested to hear from all of you, and, Dana, that means you should take us through the queue.

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

MS. WANG: Thank you. It's actually -- so, Eric, thank you. This is very clear, as usual.

Can you remind use when a LIS beneficiary joins a

benchmark plan and the following year that plan may not be the benchmark anymore, but the de minimis policy may give some protection about their need to switch, so that's why you concluded that elimination of the de minimis policy could result in more beneficiaries needing to switch their plans year to year?

MR. ROLLINS: Correct. Essentially, right now, the de minimis policy acts as a bit of a cushion on the reassignment process. It sort of says we're not going to reassign people in plans if they miss the benchmark by a relatively small amount of money.

So, without that, you would probably expect plans to try and bid a little more competitively than they do now, but you would probably also see, you know, more instances where plans are missing the benchmark, and beneficiaries would need to be reassigned to a new plan.

MS. WANG: If there is more intentional auto-assignment to the lowest-cost plan as opposed to this everybody gets an even share, do you think that -- so the goal of that is to create more competition so that the PDPs bid lower and the program saves money. Do you think that that could increase the chance that a beneficiary would

have to switch plans year to year? I mean, would that increase competition result in more sort of -- of the plans switching position about who was the cheapest? Do I have this right? I'm not sure. I just want to make sure I understand the dynamic here. Is it that everybody would -- you would qualify as a benchmark plan, but the lowest-cost benchmark plan would get the most assignment? Is that the idea?

MR. ROLLINS: The idea is that the -- it's actually the lower you bid, the larger a share of the auto-enrollees you would get, and again, we talked about a couple of different options for doing this in the paper, but one option would be that the lowest-bidding plan gets the largest share. Second lowest-bidding plan gets the second largest share and so on.

MS. WANG: Okay. But they're all benchmarks. Okay. Thank you.

The final question I had was, can you go through the mechanics of this idea that -- this goes to the sort of restructuring the calculation of the benchmark. Today, sequentially, PDPs bid. They establish the benchmark, and MA-PD spends its Part C rebate to come down to the

benchmark level. so how would it work that you could take their rebate into account in setting the benchmark? It's like I'm getting caught up in some kind of circular. How would that work?

MR. ROLLINS: So right now, it's done on a two-stage process. When the plans submit their bid, they indicate whether or not they intend to have a premium that's at the low-income benchmark amount, and they make an estimate of the rebates they'll need to -- they make an estimate of the rebates they're going to earn, and they make an estimate of how many dollars they think they'll need to use to set their premium at sort of the benchmark amount. And so then the bids are handed in. CMS comes up with what's the national average premium for Part D. They calculate what the benchmarks are for each region, and then they go back to the plans that said, well, we want to make sure our premium is at the benchmark amount, and they go to those plans. And they say, well, now that we know what the benchmark actually is, you get a second chance to kind of adjust your rebate allocation a little bit up or down to make sure you're, in fact, hitting that target, now that we know what it is.

And so I think if you were going to have an option where you're going to include the MA-PD rebates in the benchmark calculation, you would be using sort of the information that's on that initial bid submission, and then once that's in, again, you'd still need the second stage of allowing the plan to kind of true up their rebate allocations a bit once the benchmark became known with some certainty.

MS. WANG: So the rebates, the Part C rebates would -- I guess -- I don't want to belabor it. I don't understand how that actually lowers the PDP benchmark bid.

MR. ROLLINS: It would not affect the bids that the PDP submit. So the benchmark is the average of the premiums that PDPs and MA-PDs charge. So the premiums for PDPs would not be affected. The premiums for the MA-PDs in many cases that you're using in that calculation would go down if you're factoring in the rebates that they're going to allocate to their Part D premium, and that's what would give you a lower benchmark.

MS. WANG: But you would be taking more of the Part C rebate in order to do that, to accomplish that?

MR. ROLLINS: Well, right now, none of the

rebates are used in the calculation of the benchmark.

MS. WANG: So the answer is yes?

MR. ROLLINS: The answer is yes. As the paper points out, CMS did this initially, and then I think it was 2010 or around then, they were excluded from the calculation.

MS. WANG: Thank you.

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

DR. GRABOWSKI: Great. And first, Eric, thanks for this great work. Can I ask you about the table on Slide 13? This is sort of the classic MedPAC table, comparing different options of all the sort of tradeoffs. And usually we can really see those tradeoffs, and you mentioned in your presentation it's really hard to know which would generate greater savings and which would have greater drawbacks without sort of layering on some details. And I'm wondering, like before we get to the end of this are we going to try to work in some of those details or are we just going to sort of think more conceptually here about this and these two different approaches? I was curious.

I was going to ask you if we could score these --

you already answered that. But then are we going to try to layer on more detail, or are we just going to go with something that's sort of higher level?

MR. ROLLINS: So I think that's an issue where, speaking personally for me, I think, you know, I would benefit from getting your collective thoughts on that. Like I said, I think, particularly if you're going to go with the option on the left, where there's a new auto-enrollment process, I think CMS is going to need some flexibility to figure out what it wants to do specifically.

But to the extent that we want to weigh in on the details, you know, I'm not sure that we would necessarily be completely specific about what we have in mind. But if we said something like -- again, I'm just picking two areas -- you know, the new auto-enrollment process should really, you know, you want to make sure that the lowest, I don't know, two plans, or three plans are really getting the bulk of the LIS lives. You know, something like that would really send a really strong signal to the lowest premium plans, as opposed to an approach where, you know, maybe they only get a couple percentage more points than they do under the current system, which would be, you know, sort of

a stronger incentive than we have now but maybe not as strong as it could be. That might be one issue that we sort of weigh in on, to some extent.

Another would be this issue of sort of if we are going to revisit, so what's the minimum number of benchmark PDPs that are required in each region. I think, like I said in the paper, right now, in 2021, it's between 5 and 10. That number is probably going to go down a little bit, because we're going to have some plan consolidations. We really only have seven companies that are kind of active in this space right now.

So, I mean, if we had a minimum number of plans -- and again, I'm just kind of pulling numbers out of the air here -- if the minimum number of plans was five, well, that may not be very different than the system we have now. But if we had, say, a minimum number of plans that was more like two or three, that would, I think, generate a stronger response from plans and thinking, you know, like we really need to get our premiums down.

But again, I think that's one thing to sort of weigh in the discussion, is sort of like how much do we want to sort of say about these particular elements, even

if we're not going to make a specific recommendation of, you know, you need to do X.

DR. GRABOWSKI: Okay. Thanks.

DR. CHERNEW: Let me just jump in for a second here, because I think this may help the conversation. I fully understand the challenge here that we're being asked for a direction and a policy option to get us somewhere there's going to happen in loosely March, without knowing a lot of the specifics. So it's very hard to ask you what you would like to do now, because we don't have a lot of time to discuss sort of another iteration between then and now. That's, I think, the challenge of the timing.

I'm going to save another minute, but again, Eric, am I basically right?

MR. ROLLINS: Yes, I think so. Jim, I don't know if there's anything you want to weigh in on.

DR. MATHEWS: Yeah, I'm going to give Eric a heart attack here, but we may find an opportunity to have another bite at this apple before March.

DR. CHERNEW: There we go. So now we're having a constructive meeting. If Eric's video goes on pause, we're going to have a problem.

So let me make a general comment in that context. What I think would be useful now is two things. First, of course, is how important do you think it is to get to a recommendation, your general enthusiasm about that. Obviously, if we get to March and we don't have a direction where we want to go, we won't actually have a recommendation then. And then second, a sense of which direction folks would want to go. So because there's a lot going on here, Eric, is there a slide where you talked about, within your first column, a number of different aspects of that? There's the de minimis policy. There's a few other things in there. I can't remember what slide number that was, but do you know what slide I'm referring to?

MR. ROLLINS: I think it's the one that's up right now, Mike. Or, no. It maybe Slide --

DR. CHERNEW: It was where you talked about the de minimis policy. There's a bunch of things beyond just assigning more -- yeah, right. So there's a number of things here. So, for example, I'm not in favor of getting rid of the de minimis policy. If anyone things we should get rid of the de minimis policy, you would probably say so

now. That's my view. I think the impact's de minimis on competition. I guess it's in the title. And I'm worried about stability. If folks disagree with that I'd love to hear as we go through this discussion.

Can you go to the previous slide from here? There's several of these.

So I am, actually, quite in favor of this, if I went through it. So if people are quite opposed to this I'd really love to hear, just to give you an example of what I think feedback would be useful as we have this discussion. I think there are some challenges in how one does this. So I would add one other thing to the criteria, which is operational ease.

I have a Round 1 question too, by the way. But to give you some idea of what we're looking for is, one, how important is this to go forward? Two, are there things in these different policy options that you really support or really oppose? And then we will try and craft something within that. And if we get another bite of the apple that might really help, depending on how many other apples there are to bite. I'll regret that later. No one tweet that out.

Okay. Hopefully that sets some ground rules, and we can continue this discussion in Round 2. But maybe we should go through the rest of the Round 1 before we get there. Dana.

MS. KELLEY: Yes, Marge has a Round 1 question.

MS. MARJORIE GINSBURG: Yeah, I have a couple of comments but I'm going to take Mike's earlier advice and I will email them to Eric for some clarity on the content.

But I do have one question. On page 29, it says, "Under the current system the benchmark equals the average premium for basic coverage in a region with the premium for each plan weighted by its LIS enrollment." I guess I just -- I didn't understand what that meant, if you could explain it.

And then one other comment that's sort of both Round 1-ish and Round 2-ish, and that is, has MedPAC ever done any focus groups or individual discussions with LIS enrollees about their response to auto-enrollment or their views about what happens if they get bumped each year, from one plan to another? In other words, we've put a lot of emphasis and concern on what the impact might be on enrollees, so I wanted to know whether we'd ever done any

research with enrollees on how they regard the use of auto-enrolment and the idea of changing plans each year.

So anyway, those are the two questions.

MR. ROLLINS: Sure, and I'll answer them in reverse order. On your second question, we have not, to my knowledge, in the six years I've been here, done sort of focus groups with beneficiaries to sort of get at the questions you're talking about. As we noted in the paper, the effects of the reassignment process itself have not been sort of very extensively studied. So I think our information base there, you know, right now it's somewhat limited.

On your first question of what does the weighted premium mean for, you know, that's what we used for the benchmark, so if we have, you know, five plans in a region we're not taking a straight average where we just add them all up and divide by five. That's sort of an unweighted average. Each one is weighted by the share of enrollees in each plan, so the plans that have more enrollments get a larger weight, and they have a larger impact on the overall average.

MS. MARJORIE GINSBURG: So as with the current

number or percentage of people that are LIS, is in their benefit, in terms of they will continue to get more if they already have a significant number of LIS enrollees?

MR. ROLLINS: So I think the way I would say it is the plans that have more enrollment, they have a larger effect now on the benchmark. You know, they count for more than sort of a new plan that maybe doesn't have a lot of enrollees, and, you know, arguably that makes it easier for them to get a sense of what the benchmark might be for the following year.

Having said that, if they miss the benchmark and they lose their benchmark status they could still have their beneficiaries reassigned to other plans.

DR. CHERNEW: But Marge, I think the way it works is your enrollment affects who the benchmark is, but if you are a benchmark plan, right now enrollees are divided evenly amongst them. Eric?

MR. ROLLINS: That is true within a given year, Mike. The only point I wanted to sort of amplify what you're saying is over time if you have a plan that's been a benchmark plan, like every year for the last five years, and you've had some other plans that have maybe dropped in

and out, they've only ben eligible for maybe two years, they've had some people reassigned, the plans that have been there for a longer period of time can have a larger share of enrollment. So it's not like if you have five plans in a region they've each got 20 percent of the market. The new people that are being auto-enrolled that year, yes, that's being split 20 percent into each plan. But the cumulative effect of what's been going on in previous years means that some plans may have 15, 25, 30 percent of the market and others may be lower.

DR. CHERNEW: I think that was our last -- oh, Jaewon is the last Round 1. I think.

MS. KELLEY: Yes.

DR. CHERNEW: Jaewon.

DR. RYU: Yeah, and I just wanted to clarify, because I'm not sure I'm understanding this right. But if you go to the last slide with the two options and the chart, it seems possible still, though, that these aren't necessarily mutually exclusive, right? There are elements of the formula changes in the right-hand column that could be incorporated with, you know, the auto-enrollees being distributed differently as effects of the first column. Am

I understanding that right?

MR. ROLLINS: To some extent I think of them as distinct, because I think on the left side there are changes to the benchmark for formula, but I think they're sort of being pulled along, you know, behind the new auto-enrollment process, and you're trying to think about sort of are there protections or sort of guardrails that you would want to put on the benchmarks if you put this new, competitive dynamic into play? And you're trying to, you know, standing back to some extent and letting the competition play out and see what the new benchmarks are going to be.

The one on the right is a little more sort of top down. We're just going to try and push the benchmarks down to a certain degree and see how the plans respond to that. So I think to the extent, in my head, I think that's sort of the distinction that I have when I try and compare these two.

DR. RYU: But if you just hypothetically, if you took the formula change, and I think, let's say, you're including the rebates from the MA-PDs to reduce that Part B premium, and that was an aspect which would be in that

right-hand column, sort of take that as an a la carte option, you could still then auto-enroll those into benchmark, lower premium plans differently, right? Or maybe not. I don't know. That's why I'm asking.

MR. ROLLINS: I think you could consider doing those two in tandem.

MS. KELLEY: Okay. So do we want to move to Round 2?

DR. CHERNEW: Actually, I have a question on Slide 8, and it's a Round 1 question. I'm not sure I asked to get in the Round 1 queue, so I'll get in the Round 1 queue.

My question here, Eric, is really an operational one. If we assigned more auto-enrollees to plans with lower premiums, the weighting amongst the benchmark plans would change and the benchmark itself would change, and some plans may no longer be benchmark plans once we did that. And so I'm just a little unsure about the circularity between having the benchmark and then assigning people with different weights to plans under the benchmark and having the benchmark change. So am I missing something, operationally, about how this would work?

MR. ROLLINS: If I understand your question, no, I think that's going to be an issue that would need to be worked out. That would be another argument for why you might want to bump up the minimum number of plans in a particular region.

DR. CHERNEW: Yeah. Or you could set a process where the benchmark is computed, say, equally, in certain ways, but the enrollment is shifted. So the benchmark is not necessarily a weighted enrollment version of things. I guess the key point here is we will have to, when we come back, think about operationally how to deal with some of these things once we narrow some stuff further. That's what I took from your answer.

MR. ROLLINS: Yes, and one alternative that we touched on in the paper was, for example, if CMS said in advance, you know, we're going to pick four benchmark plans, in that case, you know, you don't need to do a weighted average. You just find what are the four lowest plans, and the last plan that makes the cut, that's what the benchmark is. You don't need the weighted average under that kind of mechanism. That would be one option.

DR. CHERNEW: Yeah. That's like the second-

lowest silver plan.

MR. ROLLINS: Yeah, I would say.

DR. CHERNEW: Yeah. I understand. Yeah, the challenge there is you give a ton of weight of that marginal plan to what the benchmark is, right. If you're the fourth you then come very close to the benchmark, right?

MR. ROLLINS: Yes.

DR. CHERNEW: All right. So let's go on to Round 2 while I continue to ponder the math here, and we'll see where we get after this.

MS. KELLEY: Larry, did you want -- we can't hear you, Larry. One second. It might be me. Okay. Try now.

DR. CASALINO: Okay. Yeah, this is very basic. It should have probably been asked at the beginning of Round 1, if at all, and it shows my lack of sophistication on this topic.

But Eric, so what happens. The plans -- and we're only talking about the MA plans now, but the plans that would like to be the benchmark plans, they basically guess where -- I'm asking you if this is what happens -- do they basically guess where the benchmark will be and then

try to position themselves a dollar or two lower than that, and they're able to predict very well where the benchmark is likely to be under the current system? And that's why we get that clustering so close to the actual benchmarks that come out? Is that how that works?

MR. ROLLINS: Essentially, yes. They will try and guess where they think the benchmark is going to be, and then they want to be just a little bit short of that. You know, depending on where the actual benchmark comes out, they may have overshot, in which case they might be a de minimis plan, or the benchmark may actually have ended up being a little higher than they thought it would be, and instead of being $1 below maybe they're $3 or $4 dollars below. But, you know, I think that's the incentives that they're working under.

DR. CASALINO: And so, longitudinally, it is possible that -- on the kind of more technical points that we'd be talking about aside -- it is possible that year on year the benchmark could go down, right? They might guess a bit lower if they knew there was going to be weighting of auto-enrollment. And if that didn't work they might guess a bit lower the next year, a bit lower the next year, a bit

lower the next year. Is that how you would see it playing out?

MR. ROLLINS: If the auto-enrollment process were changed?

DR. CASALINO: If the auto-enrollment process was weighted, yeah, by the benchmark. Probably most plans weighted in the very first year plunged to way below what they would think the benchmark would otherwise be, but take a more cautious approach. But year on year, the benchmark could go down, at least for a while, if auto-enrollment was weighted by premiums. Correct?

MR. ROLLINS: I do think it's a process that would need several years to play out. I don't think they would find whatever the new equilibrium is just in one year. You know, I think you would see an evolution.

DR. CASALINO: Yeah. But right now they're incredibly good at predicting what the benchmark is going to be, it seems like.

MR. ROLLINS: They all have incentives to come to the same conclusion.

DR. CASALINO: Yeah. Thank you.

DR. CHERNEW: Okay. Dana, I think we can go to

Round 2.

MS. KELLEY: All right. Round 2, we have Bruce first.

MR. PYENSON: Eric, thank you very much.

I'd like to talk a little bit about Slide 6, I think, which shows the benchmark plans and the enhanced plans, and I really appreciate the alternatives you set out. And I think they would work with what I'm about to propose, and the plans, the benchmark plans, are basically plans for poor people, and the green plans are plans that don't want poor people. Both of the plans start out with basic benefits, and in fact, even in the bids, at least -- it's been a while since I looked at the bid forums, but you start out with basic benefits, and you have enhanced benefits that the member has to pay for. And if you don't want poor people in your plan, you add some enhanced benefits. It might be a dollar's worth, and in fact, the premium might actually be pretty low, as you're showing here. Look at how low some of the premiums are on the left here.

So we have a situation which I don't think any of us would be real happy with saying, well, if you're a poor

person, you go to this hospital, and there are some other hospitals you can't go to because you'll have to -- you know, maybe they're better hospitals, or maybe they're less expensive hospitals. That's actually what we have here, even though the plans in green are offering the same basic benefits.

So a way to change that, which in my mind isn't terribly hard to do from an administrative part, is to think of the enhanced plans as having a basic benefit and an enhancement. If someone wants to buy the enhancement, they can buy it, and if a poor person wants to go to one of the green plans, they can do it. All they're going to get is the basic benefit and, of course, the LIS.

And the reason I don't think that's a big administrative hassle is that people with the LIS can currently go to -- can currently buy enhanced plans if they want.

So I know we're on a tight time frame, but I'm thinking we can address this big disparity that's in front of us, and it would seem to be able to save the Medicare program a fair amount of money if we would change some of the rules to bring in the basic components of enhanced

plans and treat them the same as everything else, as the basic plans that are in red.

So that's a suggestion I'd like to make to not persist with the disparity that the Part D program has created because -- I mean, I appreciate the language that's used in the chapter that plans that want to serve LIS do certain things, and that's reflected in the red.

DR. CHERNEW: Bruce?

MR. PYENSON: Yes.

DR. CHERNEW: I'm sorry to interrupt. Can you state succinctly what you're proposing? Is it that you're simply allowing LIS beneficiaries to join enhanced plans if they want?

MR. PYENSON: Well, they can do that now. It's to incorporate the various options that Eric had, including auto-enrollment, and the calculation of the benchmark based on the basic components of all the enhanced plans as well as basic PDPs.

DR. CHERNEW: So would you assign LIS beneficiaries to enhanced plans that are below the benchmark? Is that --

MR. PYENSON: Yeah. Or to the extent they were

auto-assigned, you could do that. I think that would be a reasonable option. They would only get the basic benefit, but that would be surrounded by the LIS.

DR. CHERNEW: Yeah.

MR. PYENSON: A cost-sharing subsidy and the premium subsidy.

DR. CHERNEW: Yeah.

MR. ROLLINS: Is that -- I'm sorry, Mike.

DR. CHERNEW: No, you go, Eric.

MR. ROLLINS: Not, Bruce, to put words in your mouth, if a sponsor is offering three plans, we would look for whichever one has the cheapest basic premium and use that one in the auto-enrollment process. Is that kind of what you're thinking?

MR. PYENSON: Yeah. I think that's -- I hadn't thought that far, the three different plans, but I think that's right. And I think the -- I think that would accomplish many of the goals that we're seeking to accomplish here.

Let's see. Bear with me for a moment. I had some notes that I wanted to take a look at.

The other component of that that I think is

important is that, as you've pointed out, there is a remarkable concentration in Part D and especially in LIS, and this kind of change would open up the potential for new competition, which I think is something we think is probably a good thing.

So I'll stop there. Thank you.

MS. KELLEY: Stacie?

DR. DUSETZINA: Now I'm trying to digest what Bruce was just saying and trying to think about that.

Eric, this is a great effort. I always like a good "Price is Right" reference, so I appreciate that very much.

And I think this graph is perfect for showing kind of what type of problem the current system has created.

I guess in keeping with Mike's original comments about sort of things you're excited about, things you're less excited about, I think limiting the disruption as possible for reassignment is very important. I really like the concept of adding more competition and rewarding those plans that are pushing their premiums down. So I like the idea of changing the auto-assignment process to get more

enrollment in the ones with -- the plans with cheaper premiums.

There were a couple of things that struck me. One was in the report. You mentioned that six sponsors had 98 percent of the enrollments here, and it made me worry a little bit about reassigning to a sponsor outside of the original sponsor and what that meant for coverage for drugs that beneficiaries were on.

So I know that in the current process, there's an effort to get people into the same plan sponsor but different plan, which to me would say that there's more consistency in the formularies within a sponsor rather than across sponsors. So I worry a little bit about maybe having a higher chance of disruption and especially if there's kind of a big reward for the lowest-price option, you know, if you end up having more people needing to be reenrolled.

So I think that I'm enthusiastic about the idea that the way that that would introduce price competition but also think we have to be really cautious about what does that mean for coverage of specific drugs for beneficiaries.

But I would love to see this continue to move forward. Thank you.

MS. KELLEY: Jonathan Jaffery?

DR. CHERNEW: I think Amol had a comment on this point.

MS. KELLEY: I'm so sorry. Go ahead.

DR. NAVATHE: So my question -- actually, I guess this may be putting Eric even more on the spot than he already is. So this is going back to Bruce's point about this particular chart here and the way -- I'm just trying to sort of understand what we think is going on in the economics of the plans.

When we look at the green part of this graph, is this basically telling us that there's a subsidization of the basic part of the benefit in the subtype of enhanced plans, and there is a relative higher price, if you will, for the enhanced portion? And is that how the economics were working our here that we're getting the spread, particularly the density that we're seeing near negative $30 and negative $40 on the green, or do we have a sense of that? If we do, it would be great to hear. If we don't, then I think it would be interesting to try to unpack that

to better understand what Bruce is getting at.

MR. ROLLINS: So I probably don't have a fully fleshed-out theory, if you will, to respond to your question.

I think the way I look at it is, you know, again, a lot of times, your big plan sponsors have three different PDPs in the market or they have three products out there, and when I look at this figure, I think, to some extent, they had managed to segment the market based on willingness to pay. They have found that for the non-LIS beneficiaries, a lot of them are interested in a plan that has a very low premium. There's a fair amount of research that when beneficiaries pick plans, the premium is very important to them, and so that sort of explains why for a lot of sponsors, they want one. They want one product that's definitely a low-premium option, and that sort of explains, you know, on the bottom half, that sort of bolus, if you will, of sort of green plans on the left side.

At the same time, with the auto-enrollment process and sort of the incentives for everybody to cluster at the benchmark, I think plan sponsors have figured out that they don't need to offer that low-premium product to

their LIS beneficiaries. They can have a higher-premium product and still get those people in the plan, given the way the auto-enrollment process works. So they don't need to use the same low-premium plan for the LIS people. They can have a separate product for that, and that's essentially kind of the red cluster you see.

And then, third, a lot of them have sort of a higher-end deluxe model PDP with very generous enhanced coverage, and that's the much smaller sort of cluster of green plans you see on the right.

So, as I think about it, I sort of think of it as these three lanes they're trying to fill with their products.

DR. CASALINO: Eric, I'm sorry. Do these bars represent -- maybe this is another very basic thing. Do these bars represent the price, the premium for the basic coverage and the enhanced coverage or just for the basic coverage part of an enhanced plan, or is that not a sensible question?

MR. ROLLINS: It is a sensible question. The entire figure just shows the premium for basic coverage. So it doesn't include the additional amount that you have

to pay if you want to enroll in one of the enhanced PDPs.

Having said that, even if you included it, the picture wouldn't look dramatically different.

DR. CASALINO: But these green bars are for enhanced PDPs but only the basic coverage part of the premium? Is that it?

MR. ROLLINS: Yes. To make it more of an apples-to-apples comparison with what the price is for a basic PDP, for what it's -- the coverage essentially offering.

DR. NAVATHE: So does that mean that for an enhanced subtype of plan that you can still have a difference between the plan premium and benchmark that is negative in total, including the enhanced portion?

MR. ROLLINS: You mean even when the enhanced portion is included? Yes.

DR. NAVATHE: Yeah. Huh. So, to me, just to give a quick reflection, that probably is the most compelling point to address Bruce's observation here.

Thanks. I'll stop. I have another comment later on, but I'll stop here. Thanks.

MS. WANG: Can you state your insight one more time, please?

DR. NAVATHE: Sorry? Who was that directed to, Pat?

DR. CHERNEW: Eric?

MS. WANG: Yeah. I'm sorry. Amol and Eric, can you state that insight one more time?

DR. NAVATHE: I can take a shot at it, and then, Eric, you're the expert, so correct me where I go wrong.

The insight is that what we have plotted at the green is the portion of the premium that is allocated to the basic portion of the coverage, not the enhanced portion, but the enhanced portion of the coverage need not be so large that the premium has to be greater than zero, for example, at least in terms of the difference between the plan benchmark and the -- plan premium and the benchmark.

Because the enhanced portion is priced separately, that could be a relatively small dollar amount, and then it would still be an added amount that a beneficiary has to pay. So it may be $2 because it's the value of that enhanced benefit, but the total amount that is -- the place where you land, basically, in the bottom part of this graph, if you did the basic coverage plus the

enhanced coverage, it can still be to the left of zero. It can still be lower than the benchmark.

MS. WANG: But isn't cost sharing missing from these charts? I mean, wouldn't that have a big impact on what the premium is? For LIS, obviously, it's statutory, but for the enhanced, wouldn't it?

MR. ROLLINS: For the enhanced, the premium -- again, the premium you're showing here is just for the standard benefit that they offer to everybody. To the extent that they're offering enhanced coverage and that includes, effectively, you know, we have a lower deductible or something like that, the costs of that are included in the additional amount you'd have to pay as part of the premium for that plan.

The only thing I would sort of add to what Amol just said is CMS does have some requirements in place about how much of a difference there has to be between the coverage that a basic plan offers versus an enhanced plan. So I think it's something like $22. An expected per member per month out-of-pocket cost has to be the difference between what you get from the basic plan versus an enhanced plan.

This is part of CMS's effort to make sure that there's meaningful differences between the plans. There are some requirements that plans need to meet in terms of how much sort of the enhanced benefits, you know, the richness of those benefits compare to what you get from just basic coverage.

DR. CASALINO: If I understand --

DR. CHERNEW: Go ahead, Larry. Then I'll make another comment. Then I want to move on.

DR. CASALINO: If I understand correctly, the reason Amol said "huh" just makes me think there's a real point to what Bruce had to say. If I understand correctly, we're seeing in these green bars here, which are paying for the same basic coverage as the red bars above, if I understood Eric correctly and Amol, then what we're seeing is that there are plans, and they're the plans that are offering -- they're enhanced plans, but they're charging way, way, way lower for the basic premium, for the basic coverage than the benchmark plans are, and that suggests that we could see these red bars go way to the left if their competition was opened up with these enhanced plans.

I think there's a lot more to think about with

that, if I understand correctly, in terms of what plan behavior would be, but that seems to give some indication that a lot of money is being given away by CMS here by not having the real -- look like the green bars, essentially, to the left.

DR. CHERNEW: I want to move on, but I will say two things about this.

I think it's much more complicated than some of the conclusions we're drawing for several reasons. One is I'm not so certain the allocation of the basic versus enhanced part of it, enhanced plans in the green. My guess is, although I don't know and look to Eric, there's some discretion in how those numbers play out.

The other thing that's important to understand, as someone said, is the benchmark plans and the basic PDPs for LIS people are actually much more generous than the enhanced plans because the cost-sharing subsidy is being wrapped around. So all these uses of utilization and stuff that cost sharing does are working very differently in the enhanced plan bar than the basic bar because even though you're getting basic coverage -- even though you're in a basic plan, you're getting a plan that is much more

generous than many of the enhanced plans.

And the third thing that I think makes it hard to draw these conclusions -- I'm not saying they're wrong; I'm just saying it's hard to draw them -- is there's a bunch of complicated selection issues that are going on between the type of people enrolling in the different plans that affects utilization in ways that I think make looking at these numbers and trying to draw inference about what would happen a little complex.

My saying it's a little complex kind of means I don't fully understand it, and I will try and talk to Eric about it later. But I think we should move on before looking at these pictures and inferring what would happen if you did various things because the green is a subcomponent of a premium, which has some actuarial numbers on it. The actual generosity of the benefit, the utilization numbers, if you will, are affected by the overall generosity from the point of view of the individual, and the individual in the basic plan, who is an LIS individual, has much more coverage than many of the people in the enhanced plans. And the selection issues across them are important.

So I think there's some risk -- there's a bunch of other things going on, risk adjustment and other things, but I guess where I am now is I think it's a little more complicated than some of this discussion might lead one to believe. It might not be, in which case I just might be a little more in the dark than everybody else, but that's my thinking about where we are now.

Yes. And I guess what I would say in response to the risk adjustment point is the risk adjustment for clinical things, but there's a bunch of social determinants of health in use and other things that might not be reflective in aspects of how the risk adjustment portions and stuff are working.

So I think we can have a broader discussion of this, but I think for a range of reasons, Dana, we should probably move back into the regular Round 2 queue.

MS. KELLEY: All right. We'll go to Jonathan Jaffery next.

DR. JAFFERY: Great. Thanks, Dana. This has been a great discussion and clearly a very rich one, as we keep going on.

I guess, you know, like others, I don't think

I've thought much about the things that Bruce had brought up beforehand. I think a lot of it is intriguing, and per everyone's comments, and particularly what Mike just said, there's a lot of other details there and things maybe -- certainly I don't fully understand. But I guess, as a general principle, I really like the idea of us thinking long and hard about how we sort of try and minimize disparities through programs, and when we look at something where seems to be so many differences between how we're treating different subgroups of beneficiaries based on income and other access issues, I think we should try and think about that probably a little bit more than we have in the past.

I think, to get to kind of Mike's initial charge about how should we think about this going forward, I would just say I'm supportive of thinking about it more, and when thinking about the chart on page 13 I'm more in favor of the competition approach, and thinking about assigning more to auto-enrollment rather than lowering the benchmark and then maybe recreating the other charts, just with a little bit of a lower benchmark.

One other thing I wonder about, without trying to

complicate this even more, it seems like per this discussion and reading things in the chapter that there's a lot of uncertainty really around what the effects would be and what planned behavior might come out of any of these changes. You sort of proposed different kinds of auto-enrollment, and, again, expressed some view about how plans would behave. I wonder if there's an opportunity for CMS in this situation to pilot maybe more than one approach in different regions and see what plan behavior actually is. I mean, it's established in a program but I don't think you just need to -- I think potentially you could pilot things, multiple approaches, without trying to get too complicated and then evaluate things after a period of time.

Anyway, just something else to think about, I guess.

MS. KELLEY: Pat.

MS. WANG: Thanks. Can you go back to Slide 6, please? Okay. So, you know, I think that there were some good questions, including this sort of like circularity of the calculation of what the lowest benchmark plan would be. Generally, anything that stimulates more competition, and if giving more auto-enrollment would do that, I think

that's a good thing.

The thing that I guess that I'm a little bit confused about is the PDP market, as somebody pointed out, is already incredibly consolidated. Like almost all of it is run by six plans. And so if the goal is to create more competition, is it possible -- just a question, but it has the opposite effect because you start making one of those six even bigger than they are, and is that actually, longer term, a positive thing for the program? It's just a question.

On the issue of restructuring the LIS benchmark, particularly through the use of Part C rebates from Medicare Advantage Part B plans, dual SNPs specifically, I have a lot of concerns about that. I think that the fact that the ACA removed that practice, I think in the interest of stability of the program, you know, there was probably good reason for that and I can understand why, because Part C rebates, by plans, differ from plan to plan and region to region, and I think that the impact would be significant and valuable, year to year and place to place.

Just to sort of, conceptually, the idea, I think, behind that proposal is that dual eligible who currently

get that supplemental rebate in the form of extra benefits would lose some of the extra benefits because that supplemental rebate is now going to be subsidize LIS. That might be fair. That might be fair to say, you know, they should kind of, quote/unquote, "pay more," but they are paying in the form of reduced benefits. And if that is a good policy goal then I think there's probably a better way to accomplish that, that is a little bit more stable.

The thing that I think is really interesting about this table -- and I just want to add one other concept to, I guess, to Mike's point about we don't exactly know what's going on. So more than half of duals, or LIS beneficiaries, are now enrolled in MA-PDs, not in standalone PDPs. The paper made it really quite clear that if you plotted the MA-PD Part D bid on this it would be to the right of the benchmark plan, in red, because they are already taking Part C premium to pay down to the benchmark.

So I think it's just an interesting thing to observe, because the LIS Part D benefit that is delivered by MA-PDs is more expensive than the standalone PDP. Why is that? And I think it's good to just keep in mind since the trend seems to be that duals are enrolling in MA-PDs --

and Eric, you kind of had this in the paper, in the discussion about intelligent assignment -- there's a difference. If you're a standalone PDP, your incentive is to sort of arrange drugs on your formulary to result in the greatest, or the lowest net Part D cost. If you're an MA-PD, you are putting together your Part D formulary to drive the lowest total cost, Part D and medical, as well as drive stars performance.

So a very specific example of this, and how these two things differ and why MA-PDs are needing to spend down, is there are adherence drugs -- cholesterol, diabetes, blood pressure. These are incredibly important star measures. Every MA-PD, their lives are just like dictated by trying to ensure adherence rates. If there are generics, and they're expensive, I'm putting those all in Tier 1, with zero cost-sharing, to drive utilization to increase the chance that somebody is going to be adherent. If I'm a PDP and my goal is the lowest net drug cost, it's possible that I will take an expensive adherence drug, generic or otherwise, and put it into a higher tier, where the cost-sharing is higher.

So I just want to point that out, because sort of

the rationale or the driving philosophy behind how somebody structures the Part B formulary for an LIS beneficiary is different if you're a PDP than if you're an MA-PD. And the majority of LIS beneficiaries are now in MA-PDs. So it's just an interesting thing, because an MA-PD serving duals is already spending money down to this PDP benchmark, which is constructed from a completely different set of priorities.

So it's just another complicating thing to add to this chart, but, you know, I feel like the current structure, where, you know, if the increased auto-assignment to lower-cost plans results in MA-PDs having to spend more of their Part C rebate to spend down to the benchmark, I think that that's the consequence. But I really am not comfortable with the idea of going further, and taking Part C rebates and building them. Sort of the way I think about it is you're taking supplemental benefits from the duals to subsidize the cost of the LIS program to Medicare. Like I said, if everybody thinks that that's the goal and it's a good goal, I think there's probably a better way to do it. Thank you.

MR. ROLLINS: Pat, if I could just add one quick

thing to what you said, I don't have a national at my fingertips to put in front of you, but one thing I did look at a little bit was sort of pulling the benchmark apart and seeing sort of what does the PDP component of that look like versus the MA-PD. You know, essentially it was the average premium just within the PDPs versus the average premium for the MA-PDs. And -- you know, this conversation clearly needs more complexity -- the relationship between the two was not straightforward. There are regions where the MA-PD component is higher. There are regions where it is lower. It can change from year to year. So, you know, there are a lot of different things going on.

MS. WANG: But in the aggregate, I think the paper sort of indicated that MA-PDs are spending a certain percentage of the Part C rebate to spend down to the benchmark. But I guess if that's the aggregate, and you're saying that inside of that there's a lot of variation, got it.

MS. KELLEY: Okay. I have Paul next.

DR. PAUL GINSBURG: Yes. Well, Eric, you've done a superb job of taking us through this, and I think it's really made it more feasible to happily jump into some work

in this area.

I had a thought that may be crazy but I wanted to raise it. You know, I think when we're talking about switching plans here, we're talking about the non-choosers. You know, we're not talking about forcing a chooser to switch plans, unless their plan goes above the benchmark and they're not willing to pay more, but people who don't choose a plan.

And I'm thinking that when I compare Part B to MA -- and MA, you know, changing plans is a big deal, because you're changing a provider network, and that, of course, is very disruptive. To me, what Part D plan you're in is relevant only if, you know, their formulary better matches what drugs you might use, but people that don't choose, you know, presumably they're telling us, "That's not important to me because I'm not going to make a choice." So I'm just saying that I'm kind of more tolerant of some auto-assignment instability in Part D than I would be in Part C or elsewhere.

Overall, I prefer the first of the two groups that Eric sketched, you know, the group that depends more on competition. I think that with six or seven, you know,

major plan organizations that's potentially a lot of competition. And, you know, I think what you're seeing here is competition which, for the extended, enhanced PDPs probably works pretty well, but it's all distorted. And it was vigorous with the basic PDPs, but obviously the signals are all wrong so you're getting the wrong results.

So I like Bruce's idea. I think that might be a way to move towards having the right incentives to have kind of competition. So anyway, I think this is a very promising area. I think without the work that Eric to get us started it wouldn't have been feasible to contemplate something soon, but perhaps it is.

MS. KELLEY: Marge.

MS. MARJORIE GINSBURG: I thought I understood this when we started. I'm a SHIP counselor. I actually help people choose their PDP so that they're not auto-enrolled, or to make sure they're actually getting a plan that is most financially beneficial to them.

So one question, because now I'm really confused about the MAs, and I guess I realize probably most of my work has been people on original Medicare who are picking a PDP on the side. So if you're in an MA plan and you are

stuck with whatever the drug plan is that's aligned with that, are you saying they don't have an option to self-select a different PDP if they're in an MA plan? So that's, first of all, a question.

And then in terms of a recommendation, and somebody said this earlier, and that is, is there any way that we can move forward to adopt a trial period? So if we could ever come to agreement of what we think might be the best way to move forward, is this something that can be established as a five-year trial period without committing us forever?

So, anyway, those are my suggestions. And if somebody could answer the question about the MA plans, and if you're stuck with the plan if you're in MA.

MR. ROLLINS: So I'll answer that. If you're in an MA plan that provides drug coverage and you want to switch plans, obviously you can do that as part of the annual open enrollment process. If you are a dual eligible or an LIS beneficiary you have some opportunities to change which plan you're in during the middle of the year. You don't have to wait for open season, necessarily.

So you can switch. Having said that, as I think

you would recognize, Marge, there are a lot of factors that weigh into should I be in an MA plan versus fee for service, you know, things like your accessibility to Medigap coverage and things like that. So there are other factors at play, but if your question is are you stuck in the plan or do you have a chance to switch, you will have opportunities to switch at various points during the year.

MS. MARJORIE GINSBURG: But you have to switch your entire MA. You can't just switch your drug plan within the MA.

MR. ROLLINS: By and large, yes. Now, you know, a lot of MA insurers offer, you know, a variety of products. They may offer a couple of HMOs, a couple of PPOs. I could not say, off the top of my head, how much the medical provider network differs across those products as opposed to the formulary on the Part D side for those products varies.

MS. KELLEY: Brian.

DR. DeBUSK: I'd like to echo other comments, and thank you for such an intriguing and interesting chapter. I think this entire topic is just an exercise in game theory. The chart on page 6 really says it all. Even if

the mean of this distribution has been shifted due to risk adjustment and some of the other factors that we've discussed, the variance, these are two completely different distributions.

At one point I really did like the idea of removing the de minimis policy, but once you consider the impact you could have on beneficiaries and the volatility you could create, I don't think that would be good for Medicare's beneficiaries, which leads me more toward this thought of the weighted auto-enrollment. And Michael, I'd like to echo some of your comments earlier. As I was reading through the materials, if the auto-enrollment is weighted and the benchmark calculation is weighted, I do think we run the risk of a positive feedback loop there.

And the other issue that comes out of that is if you have the risk of a positive feedback loop I also suspect it's something that could be manipulated or gamed, based on careful placement of the bids, because if you do auto-enrollment over a series of years, which leads you to a tremendous weighting in the benchmark category, you could be left with certain geographies where the entire benchmark could be moved simply by one plan, by that one plan that

aggregated all those auto-enrollments.

I think the answer there is you probably need to decouple the benchmark calculation. If you're going to weight the auto-enrollment, then I think decoupling the benchmark calculation breaks the feedback loop, at least I think. I would defer to Eric on that, and I'm sure we would need to sort of play out those analytics.

The other thing that was in the chapter that I'm glad we aren't pursuing is the intelligence assignment approach. You know, it was discussed in the reading materials. I'm glad we're not pursuing that. It's things like that that really skews the entire actuarial process. I think, you know, we'd defer to Bruce on that, but I think Bruce told me once that risk is risk. So I don't think we want to interfere with that, but I also think, just a comment on intelligent assignment, I think it runs an even larger circularity issue, because in theory you could design plans that would attract very specific categories of LIS beneficiaries through auto-assignment, which then could interact with rebates in a really detrimental way. I think you'd have two pretty vicious positive feedback loops there.

Thank you. Great chapter. Those are my comments.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, thank you, and I also want to thank Eric, because this is extremely complex. I'm not sure I'm grasping everything, and after the discussion I'm pretty sure I'm grasping even less than I thought I was.

But a couple of comments. I think the Slide 6 that we have up and the red bars strikes me the same way it strikes many others. I think we have many times, in many different settings, the Commission has talked about avoiding cliff effects, and this seems about as big and compelling as a cliff effect as possible. And so I like the idea of a weighted auto-enrollment for that reason. I think the smoothing and the incentive to continue to drive greater affordability I think is a compelling one.

I do remain kind of intrigued, though, with a la carte options that tinker with the formula on top of that. And I don't know how feasible that is. Maybe it's not the wisest idea. But it seems like there's an opportunity to potentially combine the two as an option. I don't know, but I do think that's worth looking into.

And then I want to get back to Slide 12, some of Pat's comments, which she articulated much better than I ever could. But it does strike me that there's a lot of unintended consequence potential with the interplay between standalone PDPs and MA-PD. I think, you know, I agree with everything that Pat said, but in particular I found her comments about the two types of players are really playing two slightly different games with two very different aims. And to the extent, you know, one game is impacting the other, I think we need to understand exactly how that could be and what some of those nuances are.

MS. KELLEY: Amol.

DR. NAVATHE: So, Eric, thank you for a fantastic writeup and a nice outline of potential options. I echo the comments of prior Commissioners that it's very complicated, and you've done a very nice job of distilling it to some discrete options and giving us kind of the discrete areas where there are some potential distortions to try to address.

So first I am strongly in support -- again, just to state it for the record -- of trying to move this toward recommendation, because I think it's critically important

that we do so. Even if we can't get the perfect policy design in there, I think it's worth trying to push forward on that.

I will also say that given the complexity, especially based on what we've discussed, I would also put in a plug for seeing if we could have an added discussion before we get to the April recommendations chapter, recommendations session.

So a couple other points. So one, I personally think the auto-enrollment piece, and doing it in a weighted fashion, a la Jaewon's point of avoiding cliff effects and trying to create the incentive to drive down the way that bidding occurs here, makes a lot of sense. I think weighting it, in some sort of proportional way relative to the benchmark, might make a lot of sense, rather than a priori setting percentages like, you know, the cheapest plan gets 25 percent, the next plan gets 20 percent, the next plan after that gets 15. Instead of sort of structurally trying to define what those percentages are, I think doing it some formal like proportionate way might make more sense. That's, again, kind of in the vein of Jaewon's we want to avoid cliffs and actually make a

continuous incentive to try to save the Medicare program money.

I also strongly support Brian's point of trying to decouple the weighting, if you will. So either we do something on the weighting side for auto-enrollment, but then I think that makes it harder to do that on the benchmark side, and I would err on the side of not doing that. Or if the Commission were to come to a consensus around trying to do something on the weighted benchmark side then I would err away from doing it on the auto-enrollment side, because I think we could very much get what is kind of the analog to an adverse selection spiral and we would end up with real problems of having enough plans and markets and geographies. And then we would probably defeat a lot of the impact of these policies if we start to mandate four, five, or however many minimum plans that we want to have there, because that introduces another factor into the process of trying to come up with bids.

And so I think it's better to avoid that kind of situation, avoid, you know, essentially a cliff effect in terms of how we might try to overcome some of the drawbacks of those options.

I think coupling with the auto-enrollment part, another piece that's important that we didn't really talk about is, I think Marge, you know, mentioned that she helps with plan enrollment and selection of plans. The idea that amongst individuals who, because of increasing premiums or plan exit or whatever, end up having to switch plans, if we can make a stronger push for better, easier support for actual voluntary selection, essentially to opt out of auto-enrollment in the situation where yo0ur plan is no longer an option, as the benchmark plan for an LIS bene, that was not discussed today, and I think that has to be a big feature of what we do. Because the more that we are empowering LIS benes to select a plan, that minimizes the differences for them.

I agree with Brian's comments that trying to do this through intelligent plan selection is probably not the right path. But beefing up our support for LIS benes and being able to do that, whether that's communication or other decision support, I think that is critically important, and it's not something that we should waste an opportunity to try to feature, especially if we're going to touch the auto-enrollment pieces. But I think regardless

of that, given the high proportion of benes who are going through auto-enrollment in the first place.

And then the last point I'll make is that I agree with Pat's what I will call wisdom here, that if the Affordable Care Act on the Part C portion of this has already changed something in a direction because of disruption, it gives me pause to think that we should now turn around and swing the pendulum the other way. So that's my last point.

I have one parting thought, which is it strikes me that there are a lot of moving parts here. I'm, in general, agnostic on the de minimis piece, because I think if we moved on the auto-enrollment that probably will mitigate some of those effects. But given that it's so complicated I think it would be nice to see some general simulations of some of the options here before we end up having to make concrete recommendations. Thanks.

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks, Dana. So once again, Eric, great work. I wasn't going to comment on this but Amol just raised the issue of improving the choice architecture, so I can't help myself. We did a study, a

Part D study, several years ago, just showing simplifying the information leads to much better choice. The information that's provided, that's found just playing around with the Plan Finder website, which is terrible, by the way. That won't surprise anyone.

So there's a lot of other levers here in our kind of set here that we could use actually to improve choice. And so, Amol, thank you for raising that.

Stepping back from that comment, however, I'm really excited, Eric, that we're working on this topic. Slide 6 is a clear indication that we have a problem. So I'm very excited we're going to move towards a recommendation here.

My comment kind of goes back to my Round 1 question about details. I guess given kind of what we know now, I think I'd come down on, similar to Jaewon and Amok and others, wanting to, you know, assign more auto-enrollees to lower premium plans, doing that thoughtfully. And I appreciate Brian's comment about some of the potential circularity here. And I think others have raised potentials of ultimately lowering competition, if we were to concentrate beneficiaries in particular plans. I think

we'd want to kind of keep an eye on that.

But my final comment is that I think all of this is predicated on details, and it's really hard right now to know kind of what's going to be impact on premium program savings, which of these drawbacks are we going to see kind of more turnover, are we going to see more reassignments, without kind of putting some more flesh on the bone here. So I hope, if we get another kind of bite at this apple, Eric, maybe there's an opportunity to kind of look at some greater specificity and think about it a little bit more, if we were to go this route we would minimize this particular drawback or this particular issue, like reassignment, for example. I would really appreciate that as a way to kind of think a little bit more about the alternatives here. Thank you.

DR. CHERNEW: Okay. I think, Larry, you have the last word.

DR. CASALINO: Ok. Thanks. Eric, I love what you wrote and your answers to people's questions has been even better.

You know, it's clear that we have a problem, and clearly, as we always find to be the case with Part D, it's

hard to understand. I think it's more important to get this right than to rush to have a recommendation. Unlike some of the issues we've faced, I don't see the same time urgency with this as for some others. So it would be great if we could get a recommendation this year, in this kind of round, but if we can't I think it would be more important to wait and get it right.

So that said, I do think that what Bruce suggested deserves more attention. And we've had enough discussion today to see that it is very complex and would need some real work for us to understand it and see how it might work out. But it seems to me, and it seems to some other Commissioners that at least it's worth looking into some more.

That aside, like others, at this point I like Option 1, auto-enrollment going in a weighted way to plans with lower premiums. And there have been some comments on how we might have to deal with adjusting the benchmark or number of plans, and obviously that's going to require some sort of modeling as well. I'm not going to make comments on that.

I will say that if I understand correctly there's

a kind of unintended consequence of, let's say we could get everybody to choose, and nobody had to be auto-enrolled. One might think, boy, that's great. That's the way things ought to be. But then that would take this option off the table, I think, as a way to get in more competition and getting premiums down. So I don't know what to do about that, but in the real world it's probably not a problem, because everybody probably isn't going to choose.

The last thing I'll say is, you know, de minimis, I think, is a smaller issue than the issues we've been talking about. My feeling coming into this meeting was that we should just get rid of it. But I realized that I don't myself, and I'm not sure that the rest of us do, or all of the rest of us do, know how important the issue of auto-assignment for a beneficiary, auto-enrollment to a plan that has a different formulary, I don't know how important that is. So I am assuming that the specialty drug coverage is fairly good, and that Medicare doesn't allow plans where it isn't. But if that's not the case and you really could get hurt if you needed certain drugs and you couldn't get them if you were auto-enrolled in a different plan, then it is a big issue. And I just want to

point out that with certain drugs -- and this is not a rare thing -- even missing one month can mean life or death for some beneficiaries, and certainly can be a big deal.

So I would like to know more about how much difference is there between the plans, in terms of their formularies, and therefore, how big a deal is it if someone gets auto-enrolled to a plan different than they're in. Again, that there haven't been surveys or focus groups sounds like that would get a good sense of how beneficiaries feel about this. But it should be possible to have kind of objective evidence of how much the formularies differ in important drugs, if they do at all.

DR. CHERNEW: Okay. We have, as always, and magically, had both a wonderfully rich conversation and brought us right to time. So I will give my quick summary and we will then ponder this more. Maybe that's the first step.

There is certainly enthusiasm for going forward. Larry, I agree, we don't want to go forward with something unless we're confident in it. That may require us to be less ambitious or to wait. I'm not sure.

There seems to be general enthusiasm for the idea

of doing something with enrollment. There is a lot of concern about the MA. The details of that matter. There's a lot of concern about the role that MA might play, and we need to spend some more time thinking about Bruce's suggestion, which we will do. I have some concerns about how well risk adjustment works here and about how the differences between the LIS and the non-LIS populations are behaving, not just for clinical reasons but because the LIS plans effectively are more generous than the enhanced plans. But we will need to think through all of those things.

So we have a lot to do, including figuring out if we get another bite at the apple, and we will return to discuss this again, because I do hear there was general interest in pursuing this more.

So, Jim, do you want to add anything? I'm about to call the meeting to a close.

DR. MATHEWS: No. I'm good. Thank you.

DR. CHERNEW: So without further ado, thanks -- oh, I take it back. I do have to make one other announcement. For those of you listening at home, or wherever you may be, we really do want to hear your

comments on this, and anything else we discussed this afternoon. So you can reach out through a number of ways to talk to the MedPAC staff, on the website by email and other things. Please, please do that if you have comments to convey.

And now, having said that, I will call the meeting to a close, and we will reconvene tomorrow, I believe, at 9:30, and we're going to be talking, I think, about post-acute value-based payment. So everybody who's spent the day with us, or at least the afternoon, thank you very much. And until tomorrow.

[Whereupon, at 5:15 p.m. the meeting was recessed, to reconvene at 9:30 a.m. on Friday, September 3, 2021.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Via GoToWebinar

Friday, September 4, 2021
9:33 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
PAUL B. GINSBURG, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
STACIE B. DUSETZINA, PhD
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P R O C E E D I N G S

[9:33 a.m.]

DR. CHERNEW: Hello, and welcome everybody to our second day of the September MedPAC meeting for this cycle. I'm not going to give a long intro. We are going to start off with a topic that's really challenging, very important, which is the work we're doing on a post-acute value-incentive payment program, and I think Ledia or Carol -- who's starting?

MS. TABOR: Hi. This is Ledia.

DR. CHERNEW: Okay. Ledia. Yep.

MS. TABOR: Hi.

DR. CHERNEW: All yours, Ledia.

MS. TABOR: Great. Thanks.

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

This morning, Carol and I will present the first of two planned discussions regarding our mandated report to design a value incentive program for post-acute care.

We plan to incorporate your feedback from the discussion and return to you all for one more discussion on

the topic this coming January.

The Consolidated Appropriations Act 2021 requires MedPAC to report on a prototype value-based payment program that could be used in a unified PAC PPS. As a reminder, there are many elements that need to be developed before a unified payment system could be implemented.

This recently mandated report should consider design elements of a VBP, analyze the effects of implementing that program, and make recommendations as appropriate.

Our report is due March 15th, 2022. Given this tight timeline, we cannot accommodate the three meetings we typically use for making recommendations. Therefore, we do not anticipate making formal recommendations. However, the work we present here has a strong foundation in the Commission's past work and recommendations on value incentive programs.

Today I'll present the five elements of our proposed PAC VIP design. The elements apply to all four PAC settings, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

As I talk about these elements, they may sound familiar to many of you, which is great because they are consistent with the Commission's June 2021 recommendation to replace the current SNF value-based purchasing program with a SNF VIP.

Next, Carol will present results of illustrative modeling of this design and for PAC settings. Then we'll look for your feedback on the proposed design and our modeling findings.

The first design element is that the PAC VIP would score a small set of performance measures. Payments would be adjusted based on provider performance on a small set of outcome and resource use measures that are uniformly defined across settings. The measure set should be revised as other measures, such as patient experience, become available.

In our illustrative model, we scored three uniformly defined, risk-adjusted, claims-based measures: hospitalizations within stay, Medicare spending per beneficiary, and successful discharge to the community.

Second, the PAC VIP would incorporate strategies to ensure reliable measure results. A high reliability

standard would be used to determine the minimum number of stays required for a provider to be included in scoring.

In our illustrative modeling, we used a reliability standard of 0.7, meaning 70 percent of the variance in a measure's results was attributable to actual performance differences, not random variation, so providers can be meaningfully differentiated. This standard translates to a minimum of 60 stays for each measure. Like the SNF VIP, to include low-volume providers in the program, we scored three years of performance.

Third, the PAC VIP would establish a system for distributing rewards with minimal cliff effects. A simple scoring approach would be used that awards points for every performance achieved with minimal use of thresholds, or cliffs. A continuous performance scale would result in every provider having an incentive to improve.

The initial PAC VIP design scores providers within their settings because the performance differed across settings. After implementation of a unified PAC PPS with consistent regulatory requirements, transitioning to common performance targets could be appropriate.

In our modeling, performance is assessed against

a national distribution within each setting. The scales convert performance to points so that every achievement is recognized.

Fourth, the PAC VIP accounts for differences in patients' social risk factors using a peer-grouping mechanism, if necessary. If providers with populations at high social risk are disadvantaged in achieving good performance, then the PAC VIP would stratify providers into peer groups based on the social risk of their patient populations to counter those disadvantages.

A payment adjustment would be made to each provider based on its performance relative to its peers.

Our illustrative modeling uses peer groups to distribute payment incentives, if warranted. Performance scores are not adjusted. Rather, we adjusted the payments associated with performance.

Fifth, the PAC VIP would distribute a provider-funded pool of dollars in its entirety. All withheld funds would be distributed back to providers based on their performance.

The illustrative model used a withhold of 5 percent of payments that are all distributed back to

providers. Though not explicitly designed to achieve program savings, improved provider performance could, however, lower program spending; for example, by having fewer readmissions.

I'll now turn it over to Carol to discuss the modeling results.

DR. CARTER: To determine if peer grouping was needed in each setting, we assessed the relationship between performance and the measure of social risk using correlations. We examined two measures of social risk. Consistent with our past work on such programs, one set of analyses used a provider's share of fully dual-eligible beneficiaries as the measure of the social risk of a provider's patient population. This proxy considers patient income and is calculated for the specific patients treated by each provider.

A second set of analyses uses the Area Deprivation Index, or ADI, as the proxy of social risk. In your discussions on the SNF value-based purchasing program, some Commissioners asked us to explore the geographically based measure of social risk. The ADI captures a variety of characteristics of the communities where a provider's

patients live, such as the average income of residents in the area, resident access to a car or phone, and educational attainment. However, the measure is not specific to the beneficiaries treated by a provider.

Both measures have some evidence linking them to health outcomes, and both are calculated from administrative data.

We found that providers treating patients at higher social risk did not consistently have worse performance. The relationship between social risk and performance varied by setting and measure of social risk. So peer grouping may not always be needed.

Each row shows in this chart shows the measure of the social risk, and the columns indicate how performance was related to it. The pale blue cells indicate when peer grouping may not be needed, and the green cells indicate when peer grouping may be needed.

In the first row, looking at duals share, the LTCHs and home health agencies with high shares of fully dual-eligible beneficiaries had better performance, so peer grouping may not be needed for them. In contrast, SNFs and IRFs with high shares had worse performance, so peer

grouping may be needed.

In the second row, we look at providers with high ADIs, where a high index indicates more social risk. Here we see that LTCHs and IRFs with high indexes had better performance, suggesting no need for peer groups. In contrast, SNFs and home health agencies with high indexes had worse performance, so peer grouping for those settings might be needed for them.

These results are complicated. We found that two settings, SNFs and LTCHs, had consistent results for the two measures of social risk, and two settings, IRFs and HHAs, where the link between social risk and performance depends on the measure of social risk. These results suggest that peer grouping may not always be needed and raise questions about how to decide when to use peer groups. I will come back to these questions in a minute.

So let's unpack these results a bit by setting. For SNFs, both measures were inversely related to performance. That is, providers with patients at high social risk had worse performance. The link between performance and social risk was stronger for the duals share measure compared with the ADI measure.

Using either measure of social risk, peer grouping would help counter disadvantages some SNFs face when treating patients at high social risk.

Policymakers would need to decide which measure of social risk to define peer groups. One idea we had was to base peer groups for institutional providers, such as SNFs, on duals share because it is specific to the beneficiaries treated by the provider, and then to use ADI measure for home health agencies because it captures a broader range of risks that may be more relevant to home-based care. And I'll say more about that in a minute when I review the home health results.

For IRFs, the results varied by measure of social risk. IRFs with high shares of fully dual-eligible beneficiaries had slightly worse performance, but IRFs with high ADIs had better performance. These results are hard to interpret, and policymakers would need to decide which measure to use in assessing whether peer grouping is warranted.

Peer grouping based on the duals share would counter the modest disadvantages some IRFs face in treating patients at high social risk, but the paper notes that the

benefits would be small. It is possible that CMS's criteria for IRFs may limit the complexity of patients they admit and may reduce differences in performances across providers, even after adjusting for clinical differences in the patients they treat.

In deciding which measure to use, again, one idea is to use the duals measure because it is specific to the patients treated by each IRF, and like SNFs, institutional care may be less susceptible to the risks of the community.

Turning to long-term care hospitals, we found that both measures of social risk were related to better performance. This suggests that peer grouping may not be needed for LTCHs.

Again, similar like to IRFs, it's possible that the qualifying criteria for LTCHs may help ensure that they treat complex patients, which may reduce differences in performances across providers, even after risk adjustment.

For home health agencies, the results varied by measure of social risk. Agencies with high shares of dual-eligible beneficiaries had better performance, indicating no need for peer groups, but agencies with high ADIs had worse performance, suggesting that peer groups based on

this measure would be beneficial for these agencies.

In contrast to the institutional providers, peer groups based on the ADI may be a better measure for home health agencies because it captures the diversity of risks that may factor into home-based care. While risk factors may affect any provider's ability to achieve good performance, home health agencies may face additional challenges because the communities' risk factors are also relevant to the home environment where beneficiaries are treated.

For example, as I mentioned before, the ADI includes a measure of a resident's access to a car or telephone. This could capture whether a family member can transport a beneficiary to a follow-up medical appointment or could easily call and get medical advice or refill a prescription, and these factors could affect outcomes such as hospitalization rates.

In summary, our modeling illustrates that a value incentive program could be implemented with a mix of common and setting-specific features. Common design features would score a small set of performance measures, incorporate strategies to ensure reliable measure results,

establish a system for distributing rewards with minimal cliff effects, and distribute the entire provider-funded pool of dollars. However, other features comparing performances across the providers and accounting for patient social risk factors, if needed, should be setting-specific.

Our results raise two important questions about peer grouping. How do you approach peer grouping if the relationships between social risk measures and outcomes differ? How do you determine which is the right measure of social risk to use?

Our results suggest that two measures of social risk capture different dimensions of risk that are important in assessing provider performance. Our analysis underscores the need for further work on measures that capture a wide range of social risk.

We'd like to get your feedback on the design elements and results, and look forward to your discussions about the questions on peer grouping that this work has raised.

That concludes our presentation, and I'll turn things back to Mike.

DR. CHERNEW: Okay. There is so, so much there. We are going to start by going through the Round 1 questions. I think Amol will kick it off, and Dana is going to be handling the queue. So, Amol?

DR. NAVATHE: Great. Thank you. Fantastic work and very interesting content here.

I had, hopefully, what is a very quick question, which is when you -- so, if we go to Slide 10 and do that analysis looking at correlations, am I right in understanding these are truly correlations in the sense that we did not adjust for clinical risk in any way or adjust for any other factors? So this is purely just correlation?

DR. CARTER: So these were correlations between the risk-adjusted measures of performance and the measure of social risk. So the total performance score for a provider would have been risk-adjusted.

DR. NAVATHE: Oh, I see. Okay. So we're risk-adjusting the performance score first, and then we're looking at the correlation between that and these social measures?

DR. CARTER: Yes.

DR. NAVATHE: Okay. Thank you. Thank you for that clarification.

MS. KELLEY: Dana?

DR. SAFRAN: Thanks. So thanks for this really important work.

I do have a number of questions, some related to the risk adjustment but also more broadly. So the first question is in testing that's been done so far on a unified PAC PPS risk adjustment -- I'm not talking about our measures at the moment but the methodology for the payment -- what do we know about the testing of the risk adjustment methodology to assess its adequacy? My question about that just relates to what you've pointed to and what we know are really significant differences across these settings in terms of the populations that they take care of, and I think whatever we know about the adequacy of risk adjustment on that side will carry over to our thinking about risk adjustment on the measures side.

DR. CARTER: The risk adjustment for the PAC PPS is pretty -- well, I wanted to use the word "complete," but no risk adjustment is perfect. It has a lot of factors in it. It does include sort of the primary reason for

treatment. It has two or three different measures of patient complexity. We have a measure of patient frailty. We have a measure of the severity of illness of the patients. We use things like the ICU length of stay if there was a preceding hospital stay. Those are the ones that come immediately to mind.

But, if you're asking sort of if I have a measure of the accuracy, I don't have that off the top of my head.

DR. SAFRAN: Okay. Thanks.

And then, in addition, in terms of the measures that we're modeling here, we have three measures that we're proposing for the VIP, and I know this is meant to be just illustrative, but the chapter itself also comments on the fact that, you know, a broader measure set is almost certainly going to be needed. And I'm curious what, if anything, you all know about the additional measures that are under development or potentially might be used because I'm questioning -- and I'll save it for Round 2 -- some additions that we could make to the chapter that really call out the need for additional measures, but some may be already under development or well under way. So I'm just curious what, as you picked these there, were you picking

from, you know, a very broad set and these were the best or a very thin crop and, you know, this was all there was? Just can you give us a read on that?

MS. TABOR: Sure. So I think because we wanted to have uniform measures across all four PAC settings, we did have more narrow sets. We also wanted measures that were consistent with the Commission's principles, so focused on outcomes, preferably calculating the administrative data.

I will say the IMPACT Act a few years ago did require the Secretary to develop some measures, quality measures, but many of those are not consistent with the Commission's principles. There's things like medication reconciliation, which is provider-reported, which Carol and my work back in 2019 found that measures that are provider-reported, you know, are not consistently reported. So we have issues with those measures, and then patient experience, I think, as we mentioned in the paper, there are patient experience measures available for home health agencies but not for any other setting. So we, you know, again, considered what the Commission's principles would want to encourage development of those, so it could be

added to those kind of measure sets.

DR. SAFRAN: Yeah. Okay. A couple more questions. One is -- you know, and this goes to the heart of what you're asking us to speak about -- the lack of concordance in the findings for ADI versus the duals adjustments is, you know, troubling at best. And I guess I want to -- first of all, I really applaud the work on, you know, identifying the ADI and incorporating that into our testing. You know, we, as a Commission, really wanted to advance beyond measures that are just duals, knowing that that's really a weak proxy, and really been interested in measures that use nine-digit ZIP, and it seems that you've found one that looks quite complete.

So I guess for Round 1 I have maybe two questions about that part of the work. One is, I just wanted to confirm that the way that you used the ADI was you used it at the beneficiary level, like each beneficiary would have their ADI score based on their neighborhood, and then a provider would get an ADI score for its population, based on those individual level scores of its patients. Is that correct?

MS. TABOR: Yes. I will say that the ADI is --

the way it's calculated by the developers, actually for every single census block group they create a ranking based on all of the inputs into the ADI. And then they crosswalk the census block group, so the nine-digit ZIP code. So every nine-digit ZIP code basically has a ranking. And we took the ZIP code of each beneficiary and for each provider that calculated an average. So each provider has an average ranking of where its beneficiaries reside.

DR. SAFRAN: Okay. So I'll just hand it back to make sure I'm clear. For every nine-digit ZIP we have some ADI index. And so every beneficiary, based on their nine-digit ZIP we can attach that index, and then that becomes the basis for scoring a provider's ADI mix, let's call it. So it is quite analogous to duals. It is measured at the person, even though it's geographic indicators. Yes? Yes. Okay. I gotcha. Thanks for that.

And then I guess a couple of just final questions. I realize I'm taking a bit of time, but there's so much here. Do you have hypotheses about what possible reason -- for example, in LTCH, what possible reason there would be that social risks would be associated with better performance in that setting?

DR. CARTER: Not really. The range, particularly in duals scores, for LTCHs is pretty narrow. And the performance scores for LTCHs is pretty narrow, particularly compared to, say, SNFs and home health. So you're just trying to explain differences in performance, which are narrow, with, at least on the duals side, a pretty narrow range of differences in social risk. But why they're positively correlated I don't have a great explanation for it. We do think that CMS's criteria, where they're limiting the types of patients that go to LTCHs, may play a role in limiting sort of who is getting admitted, but we don't have good explanations about the correlation.

DR. SAFRAN: Okay.

DR. CHERNEW: Dana?

DR. SAFRAN: Yes.

DR. CHERNEW: I just had one for context here, and I think your question is extraordinarily reasonable. I know you know this. I just want to emphasize for the audience. This presentation writ large, and your questions in particular, really illustrate there is a statistical dynamic to performance measurement, just as much as there's a substantive dynamic. And it's just clear through a lot

of this -- and I think Carol and Ledia did a great job of this -- is they're managing both. Sometimes it's obviously with the reliability and sample size things, but that doesn't solve some of the complex confounding and other issues, statistical stuff that you've spent a ton of time thinking about.

So we're going to keep going there, but I hope that's helpful.

DR. SAFRAN: Yeah, it is, and I'll make this my last question. It's sort of a question and possibly edging into Round 2. But I didn't see in any of the tables any information about sample sizes, and I think that would be extraordinarily helpful in every one of these tables to really understand. Because I know I struggled to understand how much of the, I'm going to call it "wonky mish-mash" of relationships, you know, between the two different measures of social risk with settings, that I personally couldn't come up with hypotheses for why that would be happening other than either we've got a lot of noise, because of very small sample sizes, especially across the strata, or that, you know, there's something really troubling about the validity and reliability of

either some of our outcome measures or some of our social risk indicators.

So in order to try to nail that down I was going to come back in Round 2 but I will say here, it would be very helpful to incorporate sample sizes into all the tables, as well as an indicator of whether the tables are adjusted or unadjusted in the results that are being shown. For example, Table 1, I was not clear whether those were adjusted or unadjusted results, in the chapter, I'm talking about, not on the slides.

So let me stop there and I'll come back in Round 2 with some thoughts. Thank you so much.

MS. KELLEY: David.

DR. GRABOWSKI: Great. Thanks. Carol, Ledia, great work as always. I have, I think, one relatively narrow question. We had a presentation, Carol, I think you led, a couple of years ago, on sequential PAC stays and that being frequent. How do we treat that here in terms of the measures? You can imagine community discharge being influenced by that, Medicare spending per beneficiary. Are we taking just initial PAC stays or are we thinking about this interrelationship, because there's a lot of

discharges, obviously, from institutional to home health? Thanks.

DR. CARTER: So in this work we didn't glue stays together. So each PAC stay is considered on its own.

DR. GRABOWSKI: So you would model a home health stay, that's a unique kind of observation, even it was preceded by LTCH or SNF, for example.

DR. CARTER: Yes.

DR. GRABOWSKI: Got it. Thanks.

MS. KELLEY: Okay. I have Larry next.

DR. CASALINO: So really nice work, great report, and the slides really made it simple to understand some complicated things.

I was going to ask the same questions as Amol, but let me probe a little deeper on it, because I think this is so important. And really I think the issue of how the correlation was done and how the conclusions or results, in terms of relationship between risk and score, social risk and score, how this was done, I think it's so important that I would suggest that the report include considerable detail on it, including the kinds of things that Amol and Dana were asking about.

Let me push a little further on this. Conceptually, I think your explanation that an area of deprivation, area of risk might be more important for something like home health agencies, where the patient is still in the community than for patients who are institutionalized for a considerable length of time. So, you know, that's an interesting hypothesis and plausible conceptually for why we might find ADI more important than dual eligibility in home health.

It's hard to understand why dual eligibility would be associated with better performance, in any setting honestly. And maybe it is, but I think because it's so counterintuitive and the rules are inconsistent, I think that real scrutiny of the methods, and explanation of the methods in the reports is indicated.

So in terms of, well, the methods, if I understand correctly you calculated a performance score for each beneficiary, and this was risk adjusted but not for social risks. Then you calculated an average score for each physician and you correlated the average score, performance score, for each physician with the average social risk, whether it be dual eligible or ADI. Is that

correct?

MS. TABOR: So we actually, for each provider, so let's say for SNFs, for each SNF we calculated each of the three measures. So we calculated within a hospitalization rate that is risk adjusted for clinical factors only. And then so each SNF basically has three measured results that we then averaged to create a total performance score.

DR. CASALINO: And then correlated that with the average social risk by one or the other measure of the provider's patients. Is that right?

MS. TABOR: Correct.

DR. CASALINO: Why did you choose to do that instead of just a beneficiary-level analysis, which would put, for each beneficiary of a provider, you know, whether they had an undesirable outcome or not, or, you know, there's various ways that that measure could be calculated. But then on the predictor side have all the risk adjusters that you have, and then just in a variable for dual eligible or not, and then in a separate regression the continuous variable, I guess, for the ADI score, and then look to see if the ADI or the dual eligible coefficient was positive or negative or significant? Why do it the way you

did it in the second way, which would be a way that I, at least, would be a little more familiar with?

DR. CARTER: Well, we were trying to measure a provider's performance, and so we thought that calculating these rates at the provider level, which is how we measure provider quality of care and outcomes sort of in all of our work, was the way to go. So that's just in general, it's consistent with how we've measured provider performance.

DR. CASALINO: Okay. That's all I have to say, except I think to emphasize again that I think as much detail, even if it's just footnotes, and probably should be in footnotes, can put into the report about the method used and the rationale for it, to better, I think.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you so much. This was very fascinating, and I have some really basic questions, and I apologize of these are probably obvious to you. Three quick questions.

I was curious about the measurement burden with the ADI. Does the nine-digit ZIP code serve as a proxy for all those other factors or are they somehow gathered separately? That's my question.

MS. TABOR: They are based on the ACS, American Community Survey results that are determined at census block group level. So there is no provider burden, I guess, associated with the calculation.

DR. RAMBUR: Say that again. I'm sorry.

MS. TABOR: There's a group of researchers who calculated.

DR. RAMBUR: All right. Thank you. And then is discharge to hospice part of discharge to community? I'm assuming it's not but I just wanted to know for sure.

MS. TABOR: It is not.

DR. RAMBUR: Okay. And then finally -- go ahead. Sorry.

MS. TABOR: Beneficiaries who are discharged to hospice are taken out of the measure calculation, basically.

DR. RAMBUR: Okay. Thank you. And then another -- and I know these are really basic questions, but I'm trying to wrap my brain around this. On page 18 it talked about the ten-point scale spans larger differences in two of them than the other. So less in SNFs and home health and larger inpatient rehab facilities and LTCH. And I

can't quite wrap my brain around what that would actually mean in terms of the scores that these facilities or services receive.

MS. TABOR: So as you said, because SNFs and home health agencies have more variation across the measures, the way that this would translate, looking at Table 1, is for a SNF, for the all-condition hospitalization within stay, if a SNF received 23 percent they would get zero points, but basically for IRFs, no IRFs scored that poorly so the zero points would translate to 11 percent for IRFs.

DR. RAMBUR: Yeah. I mean, I understood that but it was hard for me to think about that as a policy, what's the significance. So I'll just leave it there. Thank you.

DR. CARTER: And I did just want to point out, because of these differences is why we wanted to use setting-specific comparisons, at least initially. And some of these relationships reflect current payment policy. A provider would be more likely to have a higher hospitalization rate if their lengths of stay are twice as long, as a simple example, or the Medicare spending per beneficiary with home health episodes are a fraction of institutional care. And so if you put them on a common

scale, home health agencies would always look like they're better performers, regardless of really how they stack up against their peers.

DR. RAMBUR: Thank you. That's helpful. Thank you.

MS. KELLEY: Pat.

MS. WANG: Thanks. I was wondering whether you have seen or have a view on the correlation between dual status and the score of the Area Deprivation Index and how much those two actually agree with each other. That's the first question, because if those are large, you know, and so the ADI is calculated so, of course, it's a good thing to use, but I wondered whether there are -- so there are some researchers who are looking more at the census tract level, which are smaller populations within ZIP codes, obviously, for things like social vulnerability indices, things like that. And I was just curious whether you could even consider using a smaller population or geographic set. But, you know, that's kind of the nature of my questions.

MS. TABOR: They are. The measures of duals and ADI are actually capturing different aspects of care, because we did run a correlation and they, except for SNFs,

are not related. So, you know, that goes to show that they are calculating different results, or kind of measuring different concepts.

And then to your second question, we did actually kind of the smallest level you can get down to, which is the nine-digit ZIP. We had explored measures using indices that are based at the county level, and we said that's just not representative enough, especially since we're trying to capture -- you know, get as close to the beneficiary as possible. This ADI, which is calculated at the nine-digit ZIP is basically as small as you can get.

MS. WANG: The work on census tract around social vulnerability index and things like that are not -- you can't use them on a broad scale.

MS. TABOR: We can follow up with you afterwards on this, but the nine-digit ZIP was actually smaller.

DR. SAFRAN: Yeah, and just to verify. A nine-digit ZIP is basically equivalent to what's called a census block group level, much, much smaller than a census tract.

MS. WANG: Okay.

DR. SAFRAN: I think the work that you're talking about is the work that's happening using census block

group-level data, and nine-digit ZIP is really analogous to that.

MS. WANG: Thank you. Thank you. Ledia, can I make sure I understood the response to the first part of the question, when you said there was not a correlation between dual status and ADI. Is that at the individual level? I mean, you know, just very simplistically, is it likely that somebody with dual status lives in an ADI that indicates a high level of area deprivation, or are those two factors not correlated? Because you're giving scores for dual status and scores for ADI. I mean, obviously they must diverge, to explain the different results that you got for these outcomes, but I was just curious if, you know, we can gain more understanding of the contours of what each thing is measuring. So for the individual who is dual, how likely is it that they are living in a nine-digit ZIP that has been identified as being high in area of deprivation?

MS. TABOR: So I believe that we ran this at the provider level, but I don't want to misspeak. Carol, do you know? Or, if not, we can just follow up with you exactly on the methodology.

DR. CARTER: Yeah. That would have been my

guess.

But I guess I did want to just point out that given that the ADI is at the area level, it's true that a bene could be living in a high area with a high index, but that doesn't necessarily mean that that individual beneficiary has those characteristics.

We've tied each beneficiary to where they live, but it doesn't mean that that characteristic describes that individual.

MS. WANG: Mm-hmm. Thank you, and thank you, Dana, for the explanation.

MS. KELLEY: Okay. Mike, that's the end of Round 1. Did you want to jump in here? Oh, I'm sorry. Lynn, did you have something? Go right ahead.

MS. BARR: I join the other Commissioners in thanking you for trying to find a way to do this type of work, and I realize how painful it is.

But when I look at ADI and the definition of ADI, I'm concerned about its applicability to rural settings. A lot of it is about housing density. You know, do you have a car? I mean, everyone in rural has phone and a car because that's the only way they can survive. They're on a

party line, maybe, but, you know, they've got a phone and a car.

I wonder if this may not be a suitable measure for rural and would like to have some feedback on that from you. That's my first question. Then I have a second clarifying question.

MS. TABOR: I will say I want to look into this a little bit more. It's an interesting question that I haven't thought about, and I would also wonder if the developers of this ranking system have thought of it. So we can follow up with your afterwards or look into it for the January meeting.

MS. BARR: Thanks. And it's almost a joke because, like I say, you know, my last four of my ZIP code is my P.O. box number. There is no differentiation for me or anyone else in my community, right, because of -- you know, we all go to the post office.

But, at any rate, the second, as I was thinking about peer groupings, I remember from the QIO work and when they were looking at -- you know, they do a lot of work with SNFs, and I want to speak specifically about SNFs. As I recall, about half of the low-quality SNFs in the country

are located in rural areas, and that seems like a peer group, literally, the one- and two-star SNFs, and they're also very small. So the quality -- almost all of the efforts of the QIOs are focused disproportionately on trying to support rural. I think they could make a very interesting peer group amongst themselves, and that would particularly allow us to start to understand are the interventions that the QIO is making in these rural SNFs actually having any impact. Is this getting better, or does this cohort just continue to be really devastating quality?

Thank you.

DR. CHERNEW: Okay. I think we are now going to move to Round 2. My guess is many of these themes are going to be continued, but, Dana, if we're done with Round 1, can we get on to Round 2?

MS. KELLEY: Yes. And Dana Safran is first.

DR. SAFRAN: Okay. Thank you.

So just a couple of points here. So that previous discussion was extremely helpful, so I think I can be quite brief her.

First is I do think it is important in this

chapter to emphasize the utter inadequately of existing outcomes-oriented measures available for PAC care and to suggest what you view as priority gaps in the measures and measure concepts that are available for PAC. So I would urge you to include a section about that. If there are promising measures that are under development that you're aware of, by all means, let's include that, but I think this is critically important to the task we've been asked to do, which is to write about how a PAC VIP could be incorporated into a unified PAC PPS.

Second is that this lack of concordance around the ADI and the duals indicators is really troubling because it's clear to me right now that currently we don't understand why that's occurring. We don't understand whether that's truth that these are just two very different indicators or whether there are methods effects going on. So I think before we can send a chapter in response to the congressional request for this report, we really have to get a good handle on that.

So I would suggest that we begin by just creating for each of the indicators and each setting, a conceptual model for how we think that dual status or an area of

deprivation, living in a deprived area could conceptually -- like, what is the pathway by which that relationship could occur, and is the finding that we have plausible? And we may either want to incorporate a couple of those diagrams into our chapter, just to show the conceptual thinking about how these relationships can unfold.

It's also quite possible that -- and I think you make this point in the chapter. I would say I'm not ready to cede yet that the ADI is picking up aspects of geography that are divorced from the person, and therefore, the duals, which is absolutely an indicator of the person, is just a tighter, better indicator. That might be true. I'm not ready to cede that yet, but I think that's at the heart of what we have to figure out here.

What I'll say is that in some work that I have been involved with myself, we have found that nine-digit ZIPs or census blocker data are an extremely good predictor of what the individual status is. In particular, some work -- and this goes back now 15 years. I don't think things would have changed on this indicator. I could be wrong.

Knowing area poverty levels for 65 and over helped us to oversample seniors who were living in poverty,

and we were able to validate that when we did a survey and seniors told us their income level, but there are other indicators. And I'm aware of some work right now on race and ethnicity that's calling into question how well nine-digit ZIP can actually help give us a proxy for individual race/ethnicity. I know race/ethnicity is not in the ADI. I'm just giving you an example of where sometimes the area really gives you a very tight indicator of the person and what the person would say, and sometimes it doesn't. And I think we have to figure out the things, the 17 things that are in the ADI, you know. What do we have?

So I will be happy offline to share with you a couple of experts that I know are doing work in this very area because of health equity measurement efforts, and I think they might be very helpful to our efforts here to sort out the validity of the ADI as a person-level indicator of deprivation.

And then I think my final piece would just be to ask if we could include a table that would show both deprivation indicators, so duals and ADI, within a setting with the strata, so that we really can see side-by-side how similar or different are the results. All the information

was there, but it was very hard to put it together. And so a table, for example, like Table 7, which right now is focused just on the ADI results for -- I believe it was SNF. What I'm asking is, can Table 7 also incorporate the duals results for SNFs so we can see how duals and ADI do or don't align at the strata level?

So those are my thoughts, but honestly, this is truly such important work and so timely and relevant, not just because of our efforts around PAC PPS but also because of all we're trying to do around health equity and the importance of getting it right with respect to what the indicators are, because at the end of the day, if we aren't able to find good geographic-based indicators that can be excellent, reliable proxies for the person, that has very important implications for data collection that CMS is going to need to do so that we get actual person-level measurements. So this work, honestly, couldn't be more important around health equity and our work around PAC PPS. So thanks so much.

MS. KELLEY: Lynn?

MS. BARR: So, as this goes, just following on the talk about potential measures, as we're thinking about

a VIP set, I think we need to think about access as well, and this may not go across all -- you know, access may not be an issue everywhere, but it's certainly an issue in home health. There's a particular issue related to this in that home health agencies, when they say, "I deliver services in this county," then the rural health clinics cannot provide those services themselves, and so it blocks the local providers from providing home health.

And if you look at rural home health utilization, we're in anywhere between the bottom decile and the bottom quartile in access, in use of home health, and we're way above in SNF because we have no access to home health because of this problem.

So I would suggest, particularly for home health, that providing access to care in all of the ZIP codes in the counties they request, because a home health agency cannot -- it's less profitable the further they drive. It's pretty simple as to why they don't want to drive to remote locations to see one patient, but that's fine. Then don't claim the county. So, if we measured access and they would be limited to only claiming the areas that they actually use, then we would be able to provide access to

rural beneficiaries to the home health benefit, which today, like I day, they're somewhere between the bottom decile and bottom quartile.

Thank you.

MS. KELLEY: David?

DR. GRABOWSKI: Thanks, Dana.

So let me start by saying I'm really excited we're undertaking this work. It's really challenging work. Maybe from yesterday, this is also super-challenging work, but super important work.

Very bluntly, if we're going to have a unified PAC payment system, we need a unified PAC VIP system as well along with unified regulations and lots of other kind of dimensions as well.

So I wanted to touch on sort of three points in my remarks, and I'm really happy to follow Dana because she kind of hit on these, and she's really the perfect person really to talk about the quality measures and the social risk adjustment. But let me start with the quality measures. As somebody who does research in this space, I was a little embarrassed even that this is the state of play in terms of quality measures that we use.

I will say, though, with readmissions, successful community discharge, Medicare spending per beneficiary, these are used a lot with SNF and home health agencies. I've seen them a lot less with inpatient rehab and long-term care hospitals. I think during the Q&A, I think it was you, Ledia, that said there's just a much more narrow range in terms of these measures for LTCHs and IRFs. That's a question of how well -- I know these are the measures that are available across the three sectors, and I believe they're valid for SNFs and HHAs, or at least we've been using them for a long time, unless certain kind of -- especially around readmissions with LTCHs, it's hard to think about, well, it's already a hospital, and how are we thinking about a discharge back to the acute hospital? so something to think about there.

And this kind of came up as well during the Q&A, but I worry a lot about the size of these sectors and just the noise with these different measures. We have a few hundred long-term care hospitals in this country, about 1,200 inpatient rehab facilities, but then 12,000 home health agencies, 15,000 skilled nursing facilities. So kind of the performance of these different measures are

going to be very, very different across these sectors, and so some of this isn't perhaps that surprising that we don't quite see the variation we might expect for LTCHs and IRFs.

Shifting gears into a second point, and that's really around the social risk adjustment, similar to other Commissioners, I didn't know what to make of this difference across the duals and ADI. Ledia and Carol, I felt a little bad. For years, we've been pushing you to move past the duals measure, and then you finally do, and it turns out we can't make heads or tails of what you found.

I do, however -- and I was going to make a similar comment to what Dana offered. The one part of the chapter I really didn't like was kind of taking the data and saying, well, we can apply this measure here but not to this sector. I like that Dana pushed you around a conceptual model to kind of guide or work. This idea of kind of after the fact saying, well, the duals measure doesn't perform well for LTCHs, so we'll just dismiss it, I didn't like that approach. So I think, once again, some of that is the noise with LTCHs and IRFs, just with the small numbers there, but I would encourage the staff to sort of

think about how we might conceptually forecast this risk adjustment to work and then apply it systematically rather than kind of after the fact.

The final point I wanted to make was around maybe some additional text, maybe it's a text box to just sort of takes us from -- and Dana, I think, started you down this path already of how do we -- what is this data play now, and what are the steps that need to happen to get us to this kind of unified system? Even in the chapter now, you talk about we don't really combine and compare home health agencies against SNFs or SNFs against LTCHs. What's going to need to happen to get us to that sort of unified PAC VIP that I think we all envision where we can't actually make comparisons potentially across sectors? What do we need to do in terms of quality measures? What needs to happen in terms of the social risk adjustment? Maybe laying that out, I sort of have a sort of schematic in mind. Maybe I could talk more offline about that, but I would like to be systematic about what needs to happen because I think this is really important work, but I worry that there's a lot of obstacles in our way to kind of get to that harmonized model, and I just want to think about some of this, as Dana

said, about a patient satisfaction measures and whether we can grow the measures set. Some of this is about social risk adjustment. So I would appreciate that kind of roadmap. Maybe it's not in the chapter, but maybe it's just for us to sort of think through.

But, anyway, once again, great work, and I look forward to further work on this issue. Thanks.

MS. KELLEY: Stacie?

DR. DUSETZINA: Great work.

As I'm looking at these measures, the Area Deprivation Index, one thing that, as a person trained in epidemiology, I am compelled to ask is about thinking about categorizing the ADI. I know that that is one way that it can be used to create these kind of coarser groupings of risk, and I wonder if maybe trying to check to see if you categorize these, put people in buckets, is there more of a threshold effect? Do you see things that kind of make more sense or more consistency across these different settings of care?

I think the only other point I wanted to make, as I was reading through the design elements, I definitely understand the desire to get away from threshold effects

when it comes to words, but when I read the question that had been asked about do we want a floor on who came get a reward, it just sort of seems like, yeah, absolutely. We don't want to be giving rewards to low performers or very low performers, and it makes sense to me to think about setting a limit on you have to reach a certain level of quality to get a performance-based reward, but I realize that kind of gets into this cycle of if we can't adjust well enough, we don't want to penalize people.

But is struck me, you know, like you could say you have to reach a certain level of quality and then also combine something about improvement from prior performance, so that you can really acknowledge the fact that some sites are really trying to get better, even if they are still below some threshold of performance, just kind of recognizing that you could combine both of those elements.

That's all I have, but great work on this report.

MS. KELLEY: Brian.

DR. DeBUSK: As always, thank you, Ledia and Carol for a fantastic report. I always enjoy reading your work on PAC.

I wanted to echo something that David pointed out

earlier, which is, you know, I was just excited to see some alternative definitions for the peer groups. And so congratulations. I mean, I think the first attempt didn't work out as we hoped, but I do hope that we, as a Commission, will always encourage exploration there. And when you bring a result to us that, you know, as in this case doesn't seem to be an improvement or produces a nebulous result, you know, my one thought was great work and please keep trying.

I think the criteria that we ultimately use -- well, first of all I think it will be evolving, but I think the criteria we use may be completely non-intuitive. I don't know that the criteria will be that obviously to us when we're done.

The other thing that I wanted to circle back to, I realize that functional improvement measures have a lot of issues, particularly when they're subjective and provider reported. You guys have done an excellent job of documenting those limitations. I hope, just like you explore some of these alternative peer grouping criteria, I hope we will periodically revisit the functional improvement measures. Hopefully something new could be

developed there. I have trouble letting that particular item go, because largely that is the purpose of PAC, is to improve function.

So hopefully periodically we can revisit that as well, but again, great work, great read, great chapter, and I'm so glad we're doing this. Thank you.

MS. KELLEY: Betty.

DR. RAMBUR: Well again, thank you so much for a fascinating chapter. The request was for Commissioners to weigh in sort of where they're at, so I'm briefly going to just highlight areas that I strongly agree with and some that I have questions about. And some of this is redundant but I wanted it to be on the record so you know at least what I'm thinking.

I strongly agree with a smaller set of measures, particularly if they don't add to measurement burden. I also strongly support the need for more granular public reporting, which is mentioned in the report. I strongly support the evolution of the measures to include the patient and family experience, because in so many of these settings the family experience is very key.

In terms of low volume and the fluctuation I do

support the weighting. I think it was a three-year average with the heavier weight being on the third year. I thought that was important.

Stacey, I appreciated hearing your thoughts on the minimum, because I was sort of landing that there shouldn't be a minimum. But if there is a minimum or a performance, I think that can be positive.

I agree that there needs to be a ramp-up so that the incentive to participate is large enough to really focus on improving these measures and the outcomes, and I strongly support the full redistribution so that we could really maximize quality in these settings that take care of so many very vulnerable people.

In terms of the conversation about the risk adjustment, that is fascinating, and I look forward to hearing more and learning more so I can be more clear on where I would land on the best way to proceed.

So thank you all so much for your work, and Commissioners, for your thoughts and comments.

MS. KELLEY: Paul.

DR. PAUL GINSBURG: Yes. I've got two issues I wanted to bring up. One of them is focusing on you found

that peer groups appear to be needed or useful for some types of providers but not for others. Has anyone thought about, you know, what is the kind of upside and downside of not using peer groups when you should have used them. And we do think about that a lot, but do we also think about what happens if we are using peer groups but, in effect, it's not accomplishing what we want? In a sense, how much harm can that do, because that may be relevant to a decision as to whether to just be bold and using peer grouping to be able to address social determinants, or do we want to have a strong case before we do use them, and we would be much more cautious? That's just a question that I hope we can think about.

The other thing is that, you know, given these findings, and I think the chapter does say that this is not ready to have a uniform assessment of quality throughout the four provider types -- we should be using this within each provider type -- and really, you know, raise concerns about whether we will ever actually get to uniform payments, or even uniform quality standards across the four provider types. I think a significant accomplishment to standardize the approaches to risk adjustment, to quality

measurement, et cetera, across the four provider types to the degree that it is useful, but in a sense it's another big step to actually pay the same or have the same actual quality adjustments that we are rewarding or not rewarding. Thanks.

MS. KELLEY: Amol.

DR. NAVATHE: Carol and Ledia, I also echo the prior Commissioners' comments that this is really important work. I think you've taken us down a really important path, and so thanks for leading us in this direction. As David pointed out, super, super important, super, super challenging. I'm trying to add my supers in.

So a few points. I agree with Larry that I think, in the write-up, I think we have to give more details on the methodology there. I think it was a little bit hard to know exactly what was going on, and I think definitely the spirit of what was going on was conveyed clearly. But in this case, I think as Dana and others have highlighted, the devil obviously is in the details. It's helpful if we can maybe spell this out just a little bit more.

The second point that's somewhat related is I

think we would benefit from just digging deeper into the analysis and looking at simple correlations without risk adjustment, simple correlations with risk adjustment, and then also looking at the relationships between clinical risk and social risk themselves for each of the settings, for the beneficiaries themselves. I think that would be helpful.

And then also, kind of like we do as part of the payment updates work, where we're looking at the characteristics of the SNFs, the geographies of not just the SNFs but the facilities, I think it would be helpful here, again, to try to really unpack what we're observing, especially because it's varied by different setting, what the characteristics of facilities are that are high performing, what are the characteristics of facilities that are taking care of disproportionately social risk benes, disproportionately clinical risk benes. If we can lay this out and try to understand, to some extent, is what we're observing -- in some sense a kind of a feature of the data and not really a feature of how service is provided, or is this really a feature of how service is provided and kind of collapsed into specific facilities by setting.

A third point here, I generally feel sort of a sense of discomfort or at least not fully convinced when we're seeing the discrepancies, particularly between the share of duals and ADI measure. I think that's part of what's giving me pause in saying I think we should push forward or dive deeper into the data. I think you guys have already started to do that, so I think we have a good staff holding from which to leap off and keep going further.

I would echo Paul's points and others around the conceptual basis here by setting. I think you guys have actually started to do that already in the writeup, and I think in the paper, and that was helpful. But I think in some sense a priori would be helpful to have some discussion before we are touching the data.

And I think the macro point that I have, that I'll leave with, and I think Paul started to hit on this a little bit with what are the dangers of doing peer grouping when peer grouping conceptually may not really make that much sense, I think the kind of natural point here is we definitely want to follow the data, and at MedPAC we do a good job of that, generally speaking. You guys have

already taken us in that direction. But I think we also want to be a little bit careful of following what might be some idiosyncrasies in the data and finding a narrative to fit that data.

And at least when I was thinking through the home health piece and the discrepancy between share of dual and ADI, I felt like, you know, are we potentially vulnerable to doing that here versus do we really have a good conceptual basis or are we really finding a true feature of how services are delivered that can accommodate in the design?

So I think we're off to a great start here. I really thank you for this work. I think it's really important. And like Brian said, I think especially as we kind of pave new ground or move into different directions not everything is going to work out in the first try. So I'm not discouraged by that at all. I'm very optimistic that we can get there, and thank you so much.

MS. KELLEY: Jon Perlin.

DR. PERLIN: Well, Amol really set my comments up very well. First let me start by adding my thanks to Carol and Ledia. This is really terrific work. It's important

work. And from our discussion its obviously provocative work.

Let me also, in the spirit of questions you actually asked, give my plus-one to Betty's comments. This really builds on Dana and David's points, and it takes me back to really the beginning of my career on the first principles of performance measurement. The question is fundamentally this: what is the question that we're trying to answer, and we're trying to understand how social risk vulnerability plays into outcomes, on a number of dimensions of outcomes -- clinical outcomes, and for the entities that are providing service, their performance outcomes.

And so I think all of us are united in the spirit that we really want this to work. But we're trying to compare two rough proxies, and Amol just made the comment that we're trying to extract a narrative from proxies that have a number of embedded elements, some of which add another level of, quote, "truth" may correlate very strongly, and others which may add noise. And we find ourselves in this situation where we're compelled to use these rough proxies because they're available, and this is

the classic trap in performance measurement. You grab a measure because it's available. This is the old saw about, you know, why do you look for the keys under lamppost -- because that's where the light is. And that's not wrong. That's what we've got. But I think it compels some higher order of questions.

And so we don't have to answer this now, but for people like David and Dana and others, if other choices of data were available would we know, or would we have better performing metrics for adjusting for social risk and possibly clinical risk as well?

And it leads to a question for staff, and for us as a Commission. Have we reached the point where we need to clearly ask CMS to find mechanisms to collect different source data, so we're not using rough proxies, so we're actually using a set of variables that actually predict the outcomes that are of interest? And, you know, I'm glad we framed the discussion around unifying the four elements of PAC, but fundamentally these questions come up, and in acute care as well, and so has the time come for really seeking these more fundamental data more broadly?

So I throw that out, and I know that it's sort of

terrifying in terms of its ambition, yet there's a point where these are the sorts of data that may actually help the program evolve to be more effective. And as we sort of move into a next generation of performance measurement, ubiquity of health records, et cetera, these are the sorts of factors that need to become part of the picture of a beneficiary to really give them the best care and for the program to be scored most effectively.

Again, terrific work. Many thanks.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. So much has been said, and much of which I agree with. Let me just emphasize three points.

I am not going to comment on Jonathan Perlin's last point, although I think it's really important. And there could even be a whole set of work devoted to should better data be collected and how, about social risk.

So I have three things. One is, there's so much in this report in terms of design elements, and we've been very focused on social risk, I think appropriately. But we haven't, except for Betty, had much to say about the design elements. In my case, I'm not concerned about that because

I actually agree with them. I think they're terrific and extremely well explained. But I wonder whether we should assume that because we haven't discussed them, other Commissioners are also in accord with them. So that's my first point.

My second point is I just want to emphasize what David said earlier. It's one thing -- or my interpretation of what he said, or gloss on it -- it's one thing, I think, to say let's have identical design elements across post-acute settings, and I agree with that and I think the report is pretty successful in convincingly putting out the design elements that could and should be used. But the report does also mention that something we'd like to be able to compare performance across post-acute settings, but doesn't really say much about, as David pointed out, about well, what would need to happen for us to get there. So it would be nice to know a good more about that.

But also it doesn't really say anything, I don't think, about why would we want to compare across settings? I think, actually, in other things that MedPAC has published in the last couple of years there have been some discussions about why it would be desirable to compare

performance across settings, and pretty sophisticated discussions. And if that's the case, or even if it's not, I think either way it would be great to have some of that in this report. Why would we want to compare across settings, and then what barriers would have to be overcome? So that's my second point.

My last point is, again, on social risks, that we've spent so much time on -- and I'm really just repeating what I said around [inaudible], just to emphasize it -- first of all, whatever we do we should have more explanation in the report, I think, of what actually was done methodologically to try to look at the association between a measure of social risk and a measure of performance.

But secondly, this is so consequential. If MedPAC comes out and says well look, in some cases if you're dual eligible you are more likely to get a good outcome than a bad outcome. You know, that could be true, and if it's true it's really important. But if it's not true, then putting it out there is really quite harmful, both to the world and to MedPAC's reputation, I think.

So I know that staff is quite sophisticated

methodologically and very careful and much more familiar with the details of the subject matter than at least most of the Commissioners. But I do think we want to make sure if we put things out, like we have in this current draft, that the methodology used to make the comparison, or to determine the relationship between social risk and performance by setting, that it's really best available, ideally, and if not the very best available at least completely bulletproof. And I'm not the best person to evaluate this but just listening to others' comments as well I'm not yet convinced that we're there. So I would just encourage the leadership and staff to think hard about that.

MS. KELLEY: Bruce.

MR. PYENSON: I want to congratulate staff for just really terrific and thought-provoking work. And I agree with what my fellow Commissioners have said, but I have a different context in mind for this chapter, which is a population health context and a broad accountability context and a unified PAC context. What we're doing here is evaluating particular silos within PAC, whereas most of our thinking, and we're required to do that based on the

limitations of the data and so forth, but most of our work has been thinking about broader accountability, which also better tracks with health outcomes. And I think it would be fine to say that it's really hard, and of limited value, to create a system that reflects what we want to reflect within these silos. I think that would be a successful outcome of this chapter, and to say the right way to do this is to look more broadly and hold a whole community of providers accountable for the continuum of care.

So I, of course, have lots of suggestions of what might improve the fit of the regression models and so forth. But as I thought about it I really want to spare staff from those suggestions, because I think what we're finding in a certain sense supports our broader vision that the right way to do this is on a broader accountable basis that takes into account more of a continuum of the care and the circumstances of beneficiaries.

But I think that the richness of the conversation has really been a credit to the staff in creating this work.

DR. CHERNEW: Okay. Again, we are almost perfectly on time. This has been a very rich discussion.

Bruce largely stole a lot of my wrap-up, which will help us stay on time, but I'll make a few simple points.

First, this is a mandated report, and it will come out because it's a mandated report, just so you know.

Second, I have heard, I am sure the staff has heard, I'm sure all of you have heard, the statistical issues here are enormous in a whole range of ways, and there have been a lot of discussions about things we could do, might do, should do, would want to do, a little of plotting of the academic community for not having solved it in the first place. I blame Grabowski.

In any case, this is really hard. Issues of how to adjust for social determinants, what that means is challenging in any one sector, let alone in a unified way. Just to manage expectations, we will have bandwidth issues. So I'm glad that this is my second, not my sixth, cycle. It will be something we will continue for a while, and just so you know, there is related work being done at CMS and other parts of the government. I'm sure NQF, Dana, will be thinking about how to measure a whole range of these things, and we will certainly borrow from expertise

outside, as needed, but understand we do have a mandate, and we do have bandwidth issues.

The one thing I will say -- and I think this is very much in the spirit of what Bruce says -- first, I thought Bruce was going to be making a case for alternative payment models thinking about things on a population basis. He never actually said that, but it was pretty close to kind of what he said. So maybe -- there, he's shaking his head. So I'm going to take that as a yes, and I agree, by the way, Bruce. That's probably not surprising. One of the reasons why I like population-based payment models is they allow you to think along the orientation for these type of issues that you are outlining. I think that's true. We have another sector, another set of chapters to deal with that.

Secondly, what's very clear is we actually have to remind folks, we have what I consider to be a very successful body of work and chapter on SNF VIP that we've done, where I think we would all agree that in that particular context, it was working. And what I take from this is what is really challenging is extending those principles and the measurement issues to other areas. So I

don't want to imply that the SNF VIP is all perfect or doesn't face challenges, but we have a lot to do to get to these other areas, and they all seem to have their own separate things. And we really struggle with these case-mix adjustments, particularly when there are selection issues across all of these different sites. So, for some patients, these are substitutes. For some patients, they're not, and that raises all these statistical issues.

So where we are in my summary is I'm going to close with a thank-you to the Commissioners and a thank-you to the staff for both the substance and for recognizing all the really hard work that's gone into addressing this super-challenging topic.

We will continue along this path and come back to you with an update, having heard all of your comments, and hopefully, we will be able to create the tone that matches, I think, what many of you said, which is we are an agency that relies heavily on the analysis, and we, therefore, want to make sure that when we draw a conclusion, it is the conclusion we are comfortable drawing. And that, in many ways, is the bar. We will continue to do that and adjust our tone as needed as statistical challenges arise.

So I will stop there with a deep breath, and I think now we are going to transition to another somewhat complex area for a different reason, which is our work on the home health prospective payment system, and Evan is going to go through what we -- again, this is a mandated report, and you will see why, for reasons really that are no fault of our own, it is a particularly challenging report to write.

Evan?

MR. CHRISTMAN: Good morning. Thanks, Mike.

Before I begin, I'd like to remind the audience that they can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

In 2018, Congress mandated two changes to the home health prospective payment system. Those changes included a new 30-day unit of payment and the elimination of therapy visits as a payment factor in the case-mix system. These changes were implemented on January 1, 2020. The BBA 2018 requires MedPAC to provide an initial assessment of these changes by March 15, 2022.

Before I turn to our analysis under the BBA

mandate, I want to remind you of two issues we've noted in the past. The first issue is the high level of payments. Medicare margins for home health have averaged better than 16 percent in the 2001-to-2019 period. For many years the Commission has recommended payment reductions to address these overpayments.

The second issue was an incentive in the payment system. Prior to 2020, the PPS used the number of therapy visits provided in an episode as a payment factor. The Commission recommended the removal of therapy as a payment factor in 2011, and the BBA 2018 mandated this change be implemented in 2020.

The patient-driven groupings model, or PDGM, is the new case-mix system implemented to meet the statutory mandate. There is more detail in your paper on the system, but note that PDGM pays for based on diagnosis, functional debility, and certain service-use factors.

PDGM pays on a per-visit basis when 30-day periods include a low number of visits. These are referred to as low-use payment adjustment, or LUPA periods, and they are about 8 percent of the periods in 2019, with the remaining 92 percent receiving the full case-mix adjusted

payment.

The 2020 policies are the most significant changes to the PPS since it was implemented. Understanding how the delivery of home health care changes under it will be important to the Commission's oversight of the benefit.

However, identifying the impacts of PDGM will be challenging because the COVID-19 public health emergency also disrupted home health care in 2020.

PDGM was implemented on January 1, 2020, and the PHE was declared later that month. As a result, agencies experienced significant disruptions to the demand for home health care at the same time that they were implementing PDGM. The number of inpatient stays declined, particularly in spring of 2020, and there were also reports of beneficiaries declining care because they wanted to isolate at home.

Conversely, there was also a reported uptick in demand for home health from beneficiaries seeking to avoid a stay at a skilled nursing facility.

These disruptions could have affected the amount and mix of home health services provided to beneficiaries.

CMS and the Congress also made several other

policy changes that may have affected agency operations -- next slide, please. CMS and the Congress also made several other changes that may have affected agency operations and the delivery of the benefit.

First, relief funds such as the Paycheck Protection Program made substantial funds available to home health agencies. These funds helped to compensate for lost Medicare revenue.

Second, several home health-specific policies were implemented in 2020. Broadening the coverage of telehealth was the most significant of these. Prior to the PHE, coverage was limited to remote patient monitoring. In March of 2020, CMS allowed coverage of virtual visits and later made this a permanent change to the home health benefit. The federal funds and other policy changes were intended to bolster access during the public health emergency, but they also may have had an impact on the delivery of care. These particular confounders, particularly telehealth, need to be considered when we analyze the data from the first year of PDGM.

This slide shows utilization in 2019 and 2020. Overall, the number of home health users declined by 11

percent, and the number of 30-day periods declined by 7 percent in 2020.

The share of periods provided in rural areas in 2019 and 2020 was unchanged at 20 percent for both years. This indicates that home health fell at a similar rate for urban and rural areas.

As you can see from the two lines showing monthly utilization, home health experienced a significant reduction to volume in April and May of 2020 but then later recovered to a level near 2019 utilization.

The timing of the decline in volume suggests that it was not due to PDGM and reflects the impact of the public health emergency.

Turning to patient mix, despite the interruptions of the public health emergency, the types of patients typically served in home health care did not change significantly. For example, in both years, the shares of 30-day periods from the hospital and the community did not change. Similarly, the share of periods that were initial or subsequent periods of home health care did not change, and the share of periods classified as LUPAs did not change. Most notably, the clinical mix of patients in 2020

and the 12 clinical categories used by PDGM was about the same as this mix in the prior year. This indicates that the public health emergency did not change the primary clinical reason for which beneficiaries received home health care.

We did see more 30-day periods reporting the highest levels of functional debility and the highest-paying comorbidities, but we have noted in the past that these indicators may be less accurate measures of patient severity.

Next slide, please.

Turning to the number of home health visits in 2020, the total number of in-person visits declined by about 20 percent, a decline steeper than the decrease in beneficiaries served and 30-day periods noted earlier. However, this decline should be interpreted carefully.

CMS's expansion of telehealth allowed agencies for the first time to provide virtual visits to home health beneficiaries. Our discussions with home health agencies and industry experts indicated that the use of virtual visits expanded significantly. One survey found that 71 percent of home health agencies reported expanding

telehealth in 2020. Despite the decision by CMS to expand telehealth, agencies are not required to submit any detailed information on the type of telehealth services they provide or the amount they provided. Including virtual visits would offset some of the decline for in-person services we report in 2020. The lack of information on telehealth makes it challenging to assess the impact of PDGM, as we cannot observe when agencies use telehealth as a substitute or complement for in-person visits.

Next, we will look at how the mix and number of visits changed at the level of the 30-day period, the new unit of payment. The total number of visits in 2020 fell by 1.3 visits for a 30-day period. Most of the decline was due to a drop in therapy visits. This should not be surprising because prior to 2020, the PPS incentivized additional services with higher payments. However, it is important to again note that telehealth services likely offset some of the decline for in-person visits you see here.

Next. Thank you.

The decline for therapy was concentrated in 30-day periods with relatively high numbers of these therapy

visits. The share of periods with at least one in-person therapy visit declined from 65 percent in 2019 to 57 percent in 2020.

Among those periods with at least one in-person therapy visit, the share of periods with six or more therapy visits declined from 57 percent in 2019 to 50 percent in 2020. The change in therapy visits in 2020 may reflect a variety of factors, including the PHE and the increase in telehealth, but it also likely reflects the elimination of therapy visits as a payment factor.

Staff will present an updated analysis of payments and costs in December, but we note that in the 2022 proposed rule for the home health PPS, CMS found that the PDGM base rate for 2020 exceeded the estimated cost of the average 30-day period by 34 percent.

Given the Commission's long-standing concerns that Medicare rates for home health are too high, this may not be surprising. The BBA 2018 did not reduce home health rates for 2020, and so it appears that the high payments we have observed in the past continue.

Despite the significant drop in utilization for 2020, the supply of agencies declined by only 1 percent, a

rate slower than the decline in prior years. The decline in supply of agencies was smaller than the drop in 30-day periods, beneficiaries served, and inpatient visits in 2020. In effect, there were roughly the same number of agencies providing significantly fewer services.

It is likely that federal financial relief such as the PPP helped agencies compensate for lost Medicare revenue and remain open.

In summary, it is difficult to measure the impact of PDGM in 2020 because of the many disruptions related to the PHE.

We can see that volume declined in April and May of 2020 but later recovered.

While the PHE disrupted the pipeline for referral to home health care, our review suggests that the type of patients served by home health care did not change significantly in 2020.

The number of in-person visits declined, but this decline was offset by an unknown number of telehealth services.

In-person therapy visits declined by more than other types of home health services, but this decline may

be a natural consequence from switching to a payment system that does not incentivize additional therapy visits.

CMS's analysis of payments and costs indicates that the home health base rate was 34 percent above estimated costs in 2020, suggesting that overpayments continue under the new system, and there was a slight decline in the number of home health agencies in 2020, but the rate of decline was actually lower than prior years.

Finally, I would also like to note that we will be presenting additional analysis in December that will assess other factors under our mandates.

This completes my presentation. I look forward to your discussion.

DR. CHERNEW: Great. My chat is not that big to see who's getting in the queue, but if I haven't missed anyone, we don't have a Round 1 queue. Dana, did I miss anything?

MS. KELLEY: I think Lynn may have had a Round 1 question.

DR. CHERNEW: Lynn, I can just like -- go on.

MS. BARR: Sorry about this, and I think people are starting to anticipate my questions here.

I'm just curious about what you're seeing. You said that basically the declines were similar in rural versus urban, and I'm just curious. There's such different patterns in 2020 of hospitalizations in rural versus urban areas and decline of service utilization. So is that still tied to the same level of discharges? Is that normalized for discharges? is my question, because it would surprise me that because rural has such an access issue to home health that if you put more financial pressure on those providers, how are they not going to -- I mean, the whole issue with rural is it's more expensive to give them care. So they're going to be looking to replace those funds. So I'm surprised that there is not any sort of differential, and I was wondering if you had any further comments on that.

MR. CHRISTMAN: I guess I can think about what you mean when you say normalized for discharge. I think I understand the issue that you're highlighting.

I think what I would note is that, in general, as you're well aware, there's a spectrum of utilization across rural areas. Some rural areas are the highest-using home health areas in the country.

MS. BARR: Exactly. Yeah.

MR. CHRISTMAN: Right.

So I guess I think what I was noting was that the benefit remained relatively stable through the emergency despite we saw a big decline in volume, but the attributes of patients and the services they received, with some exception for therapy, didn't change that much on average at the period level. And so I guess for me, the story of the rural percentage being the same fit the larger pattern we were seeing in other indicators that things were relatively stable.

MS. BARR: You bring up a really interesting point, though, because if you look at rural and include Texas, it appears to us in our data -- you know, no offense to folks in Texas -- that there seems to be a lot of overutilization of home health in Texas that's really shocking when you compare it to some of the other parts of the country, and there's other pockets as well.

So I don't know. You know, it's hard when you're dealing with relatively small numbers and then you have, like, these obviously sort of profiteers out there that are really working the system and seem to be immune to any kind

of market pressure. Have you ever looked at any of those?

It's so hard to look at rural data, you know, micropolitan versus rural. So any thoughts on that?

MR. CHRISTMAN: I think, you know, probably -- we've done a lot of different looks at rural. I would point to the report we issued last summer that showed -- you know, split it out by the different categories of county. I guess what I would note in general is that, you know, I guess there's probably 10 to 12 states where average rural utilization, the last time we looked at it, was higher than the urban utilization. So it's not just -- you know, I appreciate certain areas really pop up when you look for the most extremes of utilization, but there are a number of states where it's sort of normal business, for whatever reasons, the rural areas actually have slightly higher use on average. It's not just Texas.

MS. BARR: Yeah. That's interesting. Maybe we could talk sometime offline, and I could share what we're seeing in ACO data. It seems very skewed, and so maybe there's just differences with ACOs versus others.

Thank you.

DR. CHERNEW: Okay. I think I'm just seeing --

Dana, I don't think there's anyone else in the Round 1 queue.

MS. KELLEY: No, that's correct. Are you ready to go to Round 2?

DR. CHERNEW: I think that's what the agenda calls for, so, yes, absolutely.

MS. KELLEY: All right. David, you're first.

DR. GRABOWSKI: Thanks, Dana, and thanks, Evan, for this excellent work. They gave you a very challenging task here to evaluate the impact of this new payment model when it completely lines up with the timing of the pandemic. So I don't have any brilliant ideas of how to tease out the effect of the payment model versus the pandemic.

But I did want to raise a couple of issues. One, I was a little disheartened that we can't tease out what the claims -- what's -- you know, how much telehealth is being delivered, and I just wonder if there's a way to kind of -- I don't know if that's a recommendation or something to be more forceful in the chapter going forward. Is there a way to kind of detect or measure those visits? Because I think that would be really useful.

Home health for years has said they want to kind of expand delivery. How much of this is actually happening? You did a nice job of building in some reports from different companies and media stories, but it would be really nice to get systematic data on that.

The second point -- and this kind of fits more broadly with the evolution of payment and home health -- we've been trying to get this right going back to at least the '90s when home health exploded. We went from cost-based to the interim payment system to a prospective payment system and now to this current model. I think the big innovation was moving away from therapy towards paying for patient characteristics, really getting away from the overprovision of therapy in terms of the incentives, and just looking at that 34 percent figure that you presented is really disheartening.

You mentioned in the chapter, CMS already built in this 6 percent behavioral adjustment, that they didn't make it budget-neutral. They assumed that there was going to be upcoding and other behaviors on the part of home health.

So I think we have work to do in terms of

encouraging high-value home health care. This is maybe a highlight or a preview of the December discussion, but that 34 percent figure, I'll say it again. It's just really disappointing. So I thought this model would move us closer to kind of right-sizing or encouraging high-value care, and it seems like maybe this may be a step in the wrong direction.

Once again, I know we have a lot going on with the pandemic, and maybe some of this is hard to measure, but I was hoping that this wasn't what we were going to see.

So I'll stop there and just thank you once again, Evan, for this great work.

MS. KELLEY: Stacie?

DR. DUSETZINA: Echoing David, Evan, this is great work.

I was sort of thinking through how I would try to evaluate this, and there were just a couple of minor things. One is looking at your Figure 1 that you provided in the report, it's pretty clear you have this massive disruption, obviously, with the public health emergency, but then it kind of comes back to baseline. It looks

pretty good from July to December, and so I wonder if there's some opportunity to maybe think about segmenting out your time and maybe censoring those, like, public health emergency periods and thinking about how we can look at things when it was early days, per-public health emergency, January, February, ignore that middle part, and then look later on to see if you can kind of tease out anything that wasn't so much holding back on people allowing others to come into their homes, because I think there was so much disruption, as is obvious from those graphs.

The other thing that I thought was really interesting is in Table 4 in the report where you show the 30-day periods and the shift, this coding shift to these higher severity levels, and I do wonder if you would be able to show this by month and particularly what was the coding switch in January, what was the coding switch in February, before we move into this new public health emergency where now the service is needed or the illness might change, just to get an idea of that automatic upcoding of severity. It's pretty stark in that table what's going on with the coding switch.

Then echoing David and also in your report, it very clearly mentioned the lack of information on telehealth. That really needs to be available and especially for thinking about the adequacy of care. You know, there are some services that it seems like you could do quite well over telehealth and others that may be not as much. So I do think that asking for that to be a requirement would be really great moving forward, but excellent work on the report.

MS. KELLEY: Larry?

DR. CASALINO: Yeah. Evan, I think, in my mind, the relative lack of Round 2 comments indicates not a weakness but a strength of the work you've done. Pretty self-explanatory and Commissioners seem to agree with it.

I'd just make a couple of minor comments. The 34 percent, of course, speaks for itself. I'm not sure any more needs to be said about that, but I realize we're not making recommendations. Maybe just something along the lines of dryly saying that it's hard to know what's going on without knowing about the telehealth visits and requiring that information be provided about telehealth visits or information might be a good thing, again, not as

a recommendation but just pointing out that if there was such a requirement, then we would have telehealth data, and we'd actually be able to understand the program better.

The only other thing I would say is that the -- this may not be the way you intend the final report will look, but it ends kind of laconically, with the number of home health agencies participating in Medicare in 2020 specifically, and then I was kind of looking for some kind of concluding summary and didn't see it. Your last slide, Slide 14 -- I think it's the last slide, is it? Well, not quite last, but your summary slide, Slide 14. Something very much like that, I think, and it doesn't have to be much longer than that as a conclusion might be helpful for people who aren't really going to read the report in detail and it calls out the telehealth and the 34 percent among other things.

DR. CHERNEW: I'm pausing intentionally for a second, otherwise I am going to wrap up.

So I agree with Larry's point that this was really outstanding work. I think the reason the evaluation part is challenging is because of COVID, and, Stacie, I really do appreciate your comments. I think they are

correct. However, there's so much going on, even when volumes are kind of coming back and there's a lot of transitional things that are happening. The workforce in home health agencies has really changed. There's so many things on people's minds. The extent to what the agencies are going to respond, sort of in a steady-state way, in the midst of the COVID pandemic and the geographic variation is really hard to understand.

But, again, none of that matters at some level, and I think the -- maybe that's not the way I should have phrased that. The reason I say that is we are going to continue. This is not something we're going to do one time. As this payment model continues to be the way that home health is paid, we will continue as part of our normal course of business to do this type of analysis, and we will, as always, make recommendations on payments and a bunch of other things related to home health.

So my general view, my personal view is I'm not really ready to draw any conclusion about how the new payment model works, and honestly, I'm not so sure we need to even figure that out completely for 2020. We will have to make an update recommendation. We will have to continue

to monitor, and we will see where we go from there.

But this is one sector -- I know this is true of all sectors, but this is one sector where 2020 is just going to be, hopefully, a very, very unique year, and we will see what happens and how the numbers change going forward.

So, again, I'm going to pause.

[Pause.]

DR. CHERNEW: Hearing and seeing no one else getting in the queue, I think I will say thank you to all of you for all of your comments, and again, thank you to the staff for all of your work. And I will again remind those in the audience that we really do want to hear from you. We don't have the traditional public meeting, but that does not mean we do not want public feedback. There are a number of ways to give us feedback through the website. Reach out to us and let us know your thoughts on the topics we discuss.

We will continue to push forward the work we discussed today. Obviously, there is a lot to do, and again, I hope everybody has a healthy and happy and safe Labor Day.

So anything to add, Jim?

[No response.]

DR. CHERNEW: I'm going to take that as a no. You're covered by my chat box, Jim.

So thank you all, and we will be in touch.

DR. RAMBUR: Thanks, everybody. Bye.

[Whereupon, at 11:29 p.m., the meeting was adjourned.]