MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Thursday, November 2, 2023
10:17 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
JONATHAN B. JAFFERY, MD, MS, MMM, FACP
R. TAMARA KONETZKA, PhD
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD, MPH, MBA
JAEWON RYU, MD, JD
SCOTT SARRAN, MD
GINA UPCHURCH, RPH, MPH

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

AGENDA PAGE

P R O C E E D I N G S

[10:17 a.m.]

DR. CHERNEW: Hello, everybody. Welcome to our November MedPAC meeting. I think we have a terrific agenda. I'm not going to belabor it, but I do want to start us off with a topic that has been of great interest and importance to us, which is rural emergency hospitals. This is in response to a mandated report, but frankly we might do this report if it wasn't even mandated.

The rural emergency hospital program reflects some MedPAC thinking before it was put in place, and I think tracking where it's going is important. We have been quite concerned with care in rural areas and how to manage that system.

So I am now going to turn it over to Jeff to take us through the presentation. Jeff.

DR. STENSLAND: All right. Good morning. The audience can download these slides by clicking on handout section of the control panel, which is on the right-hand side of your screen.

In this session, we are going to discuss rural emergency hospitals, which are outpatient-only hospitals

designed to preserve access to emergency care in small rural communities.

The Consolidated Appropriations Act of 2021 created rural emergency hospitals and requires MedPAC to report on the program annually. We will fulfill our mandate by discussing REHs today and publishing a chapter in our March report.

The REH program allows hospitals to convert to outpatient-only hospitals beginning in 2023. However, because a full year of 2023 claims data is not yet available, our initial 2024 REH report will only discuss how the program works and describe the hospitals that have decided to convert to REH status. In future years, our reports will include an analysis of REH claims data.

In this session, we will start by discussing the history of Medicare's inpatient-centric payment policies. Initially, the enhanced inpatient payments helped reduce closures, but as inpatient volumes declined, the inpatient-centric policies became less potent. Closures rebounded somewhat in 2013. Due to concerns regarding closures and access to emergency care the REH program was enacted in 2021. Today we will explain how the REH program works and

describe REH hospitals.

Since the inpatient prospective payment program started in 1983, Medicare primarily supported rural hospitals by increasing inpatient payment rates. The sole community hospital program, the Medicare-dependent hospital program, the critical access hospital program, and the low-volume hospital program all increase inpatient rates to hospitals, and about 95 percent of all rural hospitals receive one of these types of special payments.

There are two programs that provide increased outpatient rates. The critical access hospital program provides cost-based outpatient rates, and the sole community hospital program provides a 7.1 percent add-on to outpatient rates. However, to receive those outpatient additions, a hospital must maintain inpatient services.

Tying Medicare supports to inpatient services is problematic due to the decline in inpatient services over time. Across all hospitals, there has been about a 45 percent decline in Medicare admissions per capita since the sole community hospital program was started in 1983. Rural volumes have declined faster than urban volumes in recent years as rural patients increasingly bypass rural

hospitals.

In 2022, the 300 smallest rural hospitals had an average daily census of less than three patients, and this count of three patients includes inpatient acute patients, plus observation patients, plus post-acute patients in swing beds.

Extremely low volumes can lead to high costs. Critical access hospitals had an average cost of $2,400 per post-acute day in 2022. This is five times the costs of competing SNFs. These high costs can lead to closure if commercial payers, Medicare Advantage, and Medicaid are not willing to pay rates high enough to cover these patients' costs plus the cost of the uninsured. The combination of declining volumes and constrained prices can result in closures.

For example, we examined all the 40 rural hospitals that closed between 2015 and 2019. On average, admissions declined by 54 percent at these hospitals during the decade prior to closure. We found that about one-third of the decline in admissions was due to a reduction in inpatient use by beneficiaries living in the market, but about two-thirds of the decline was due to beneficiaries in

the market increasingly bypassing their local rural hospital.

This graphic is designed to put current closures rates in perspective and highlight the relationship between Medicare payment policy and closures. On the left-hand side of the graphic, we see that after Medicare introduced the inpatient prospective payment system in the fall of 1983, there was an uptick in closures of rural hospitals. The hospitals with the highest costs per service tended to have financial difficulties.

Around 2000, the critical access hospital program started to grow and provided an option of cost-based payments for small, rural hospitals. After the CAH program expanded, the country saw a temporary reduction in rural closures. However, volume continued to decline. By 2013, rural hospital closures started to rebound modestly. The volume was simply too low for some providers to survive.

This rebound in closures led to a rebound in concerns about the loss of emergency access in rural areas. MedPAC then a way to preserve emergency access without subsidizing largely empty inpatient beds.

After our work was published, Congress enacting

the Rural Emergency Hospital program which started to roll out in 2023. Brian will now describe how the REH program works and discuss some examples of how the program has allowed some hospitals to avoid closure.

MR. O'DONNELL: Hospitals can apply to convert to an REH beginning in 2023. Hospitals eligible to convert are those that as of December 27, 2020, were either CAHs or PPS hospitals with 50 or fewer beds in a rural area. Converting to an REH voluntary, meaning hospitals can choose whether or not they want to convert. Hospitals that choose to convert to REHs are allowed to convert back to full-service hospitals, although REHs that want to convert back to CAHs will need to be located more than 35 miles from the next-nearest hospital or more than 15 miles away in certain circumstances.

Once hospitals convert to REHs, the services they furnish may change. One major difference between REHs and full-service hospitals is that REHs cannot maintain acute inpatient beds or swing beds. "Swing beds" are inpatient beds that can be used interchangeably for either acute care or post-acute skilled nursing care.

REHs must have an emergency department staffed

with a clinician 24 hours a day, 7 days a week and offer hospital observation care services. REHs also have the option to furnish other services, including distinct part SNF services and other outpatient services beyond ED services.

REHs are required to maintain an annual average per patient length of stay of 24 hours or less. This means that any particular beneficiary is able to stay in observation care at an REH for more than 24 hours, but the REH's average must be 24 hours or less across all their patients.

REHs must also have a transfer agreement with a Level I or II trauma center.

Moving from what services REHs can furnish to how Medicare pays for those services. First, REHs receive fixed monthly payments directly from Medicare. In 2023, these fixed payments were about $270,000 per month per REH, which equals $3.2 million annually.

These fixed payments do not vary based on the size of the hospital, which means that lower-revenue hospitals benefit more. In addition, the fixed payments disproportionately benefit hospitals with fewer resources

because, in contrast to cost-based payments, hospitals don't receive additional federal support if they are able to increase their costs by spending more money.

The monthly fixed payments increase annually based on hospital market basket growth and can be used flexibly based on local needs.

Moving on to number two, REHs receive 105 percent of OPPS rates for OPPS services. This includes emergency department visits, observation care, and other outpatient services, such as clinic visits.

And third, REHs receive standard rates for other services, such as skilled nursing facility services, lab tests, and RHCs services.

In terms of the costs patients face, beneficiary outpatient cost sharing will decrease substantially if an REH used to be a CAH.

Now, moving on to hospitals that have converted to REHs. From the beginning of 2023 until mid-October, 17 hospitals have converted to REHs. Prior to converting, hospitals often furnished a low and declining volume of inpatient care.

From 2011-2021, these 17 hospitals' average total

all-payer inpatient admissions declined 57 percent, and in 2021, these hospitals averaged less than 1 total all-payer inpatient admission per day. All but one REH is located less than 35 miles from next nearest general acute care hospital.

These findings suggest the new REH designation is aligned with the shift away from inpatient care that was already happening in rural communities.

This slide reviews a few additional characteristics of the 17 hospitals before they converted.

HOPD services were declining but at a slower rate than inpatient services. For example, from 2012 to 2022, fee-for-service outpatient volume declined at about half the rate of fee-for-service inpatient volume, and six hospitals had fee-for-service outpatient volume that was flat or actually increasing.

And in 2022, these hospitals averaged 12 fee-for-service outpatient visits per day.

These outpatient data suggest that some hospitals that provided little inpatient care were important sources of outpatient care for their communities.

Prior to converting, all but 1 hospital received

special payments from Medicare -- 5 were CAHs and were paid based on their costs. Of the 12 PPS hospitals, 11 received special payments based on being an LVH, SCH, and/or an MDH. But despite these special payments from fee-for-service Medicare, most of these hospitals were under significant financial pressure.

Prior to converting, the median total, all-payer profit margin of these hospitals was negative 13 percent in 2022.

Because a limited number of hospitals have converted to date, we interviewed and conducted site visits to three hospitals that were in the process of transiting to REHs to gain additional qualitative context. The hospital representatives we spoke with said their facilities would have closed without the option to convert to an REH.

All the hospitals had or planned to reduce nurse staffing costs by, for example, reducing the use of contract nurses or not filling open positions. This finding is important because it suggests that by removing the requirement to maintain an underutilized inpatient department, the new REH designation allows hospitals to

furnish care more efficiently.

The hospitals' plans to use their fixed monthly payments varied substantially across communities, ranging from investing in the physical infrastructure of their hospital to adding transportation services. This underscores that local control and flexibility is a key component of the REH designation.

While the response to the new REH designation was positive overall, hospital representatives noted a few concerns. Their communities' most prominent concern was the loss of inpatient services. This concern persisted even for hospitals that furnished a low volume of inpatient care and were relatively proximal to another full-service hospital.

One of the main goals of the REH program was to maintain access to care, so in addition to looking at hospitals that converted to REHs, which we did on the previous slides, we also looked at rural hospitals that closed instead of converting to REHs.

We identified eight rural hospitals that closed in fiscal year 2023. Three closed hospitals had more than 50 beds and were therefore not eligible to convert to an

REH. Of these three, two are planning to re-open. Two closed but news reports suggest they are exploring reopening as REHs. One hospital converted to a 24/7 ED but has not become an REH because state regulations are not in place for the facility to become an REH.

It's important to note that while federal regulations allowed REHs at the start of 2023, some hospitals are still waiting for the necessary state regulations to be enacted. And another hospital converted to an outpatient department of a neighboring hospital in the same system. And, finally, one hospital fully closed without plans to reopen. However, that hospital was only two miles away from another critical access hospital.

This analysis suggests that the new REH designation has reduced the number of, but not eliminated, rural hospital closures and that very few rural hospitals that would be considered necessary for emergency access have fully closed without plans to reopen since the REH designation was implemented.

In terms of next steps, a version of today's materials will be included in the March 2024 report to the Congress. Staff will analyze REH payments for the March

2025 report to the Congress. As part of that process, we will continue to monitor the development of the new REH designation.

For today's discussion, we would like to answer any questions Commissioners have about the work presented and seek feedback on any additional REH analyses you would like to see in future.

And with that, I look forward to your questions and I'll turn it back to Mike.

DR. CHERNEW: Great. Thank you very much. The program is new. It's really good to keep a track on it. It's really good to understand, and I think we will do more of this going forward, how it fits into the broader context of care delivery in areas that are rural. This is just one, as you pointed out, of many things as we care about the access in the areas through these many mechanisms.

But I won't belabor that now. I think we'll just start with the Round 1 queue, and I think Lynn is going to be the first in the Round 1 queue, and then Dana will keep it. Lynn.

MS. BARR: Thank you for this excellent report. I particular thought the background information was really

informative and helpful, and I'm really excited that 17 hospitals have signed up for the program. I think that's a win for MedPAC. So thank you very much for all the work you've done to build this model, and I think it's very informative in building future policy that we can build off of this.

I have a Round 1 question. Tell me about the ownership of these 17 hospitals. In Table 1, I want to know of those 17 hospitals in Table 1, could you add a column that says what is the ownership? Because I want to know how much of this is really smart people and systems going, "Well, I think you can make more money doing this than that, so I'm going to do that," and that ignores all of sort of the cultural and other issues that might be hidden in that.

Can you tell me what percentage of those hospitals are public, you know, not owned by somebody else?

MR. O'DONNELL: I don't have the numbers at my fingertips, but that's definitely something we can add. And I will say, just based on kind of knowing these 17, there is definitely a mix, so they're not all system hospitals. But we can put that column in there.

MS. BARR: Okay. It's particularly Table 1. It's going to help us really understand better, you know, motivation. I think that they are going to be two completely different groups, and so we might want to start looking at them separately.

And I think everything else was Round 2. Thank you.

DEPUTY DIRECTOR KELLEY: Betty.

DR. RAMBUR: Thank you. I echo the appreciation and I also support Lynn's comment.

I think this is a Round 1, and if not, you can bump it. But I was curious about behavioral health services. On page 15 it talked about how rural areas had often eliminated behavioral health because it was expensive or they couldn't quite manage it financially, and then there are these limitations on observations. So I was just curious if we have any information about access to crisis behavioral and mental health services, or is that information we can get?

MR. O'DONNELL: I think there are two things there. One is that I think we talked about when we were going out and speaking with folks, we did hear that was one

of the services, when they are living on a pure fee-for-service chassis, that they eliminated.

When you convert to an REH you have to specify what services you think you're going to add or maintain. So we don't know fully. REHs have submitted that information, but we don't know what they've been performing thus far.

We can update that information in the future, but the fixed payments should allow them, if there is a need in the community to furnish it, to furnish those services going forward.

MS. KELLEY: Larry, did you have a Round 1 question?

DR. CASALINO: I will pass, Dana. Thanks.

MS. KELLEY: All right. I will go to Jonathan, who has a Round 1 question. He asks, do we know how many institutions are in the process of considering changing to REH status?

MR. O'DONNELL: We don't. We know there are additional ones that are in the process of considering it but haven't and have officially been kind of defined as an REH. There is a whole process set up where HRSA funded a

technical assistance center, so we know hospitals are going to that technical assistance, looking at their costs, and analyzing how it will help or hurt them.

So we don't have a definitive number on how many are considering, but we know that there is an extra tranche that are currently considering it that are not in the 17 that we were able to identify.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. I just had a question about the $3.2 million fixed payment amount and any insight into how that was derived?

DR. STENSLAND: They did an estimate of how much, on average, that a critical access hospital gets more in terms of payments from Medicare than they would've gotten if they had been a PPS hospital. And so it was designed to be somewhat close to a wash on cost, though it's going to cost more because you have some of these hospitals converting from PPS to rural emergency hospital, and the ones that are converting are generally smaller ones that probably weren't getting as much extra payment and maybe lower-income kind of communities where they weren't getting as much extra payment because their costs weren't as high.

MS. KELLEY: Greg.

MR. POULSEN: Do we have a sense for whether, among the 17 or any of the others that you may have become aware of that are in the next tranche that you talked about, are they viewing REH as the endpoint or is this a path to get somewhere else for them, either to return to full-service status or maybe to depart from the market, that this is a way to sort of hold out for another year or two?

DR. STENSLAND: I think they all think of this as an endpoint. This is going to keep us going and we're going to be this into the future.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Jeff and Brian. I definitely want to echo the great work and the importance of the topic.

I have a few hopefully quick-ish questions. The first one is, has CMS, I guess either as we had done some of the earlier work here at MedPAC, probably more importantly as CMS actually launched the program, were there particular expectations of how many REHs would enroll, or how many hospitals would convert to REH?

MR. O'DONNELL: I can let you follow up, but I don't think there were explicit expectations from CMS. You know, we follow the academic literature, and it ranged from 50 to 600. So there are a lot of different projections on who would benefit.

But I also think it's important to think about it on a long-term basis, because as inpatient volumes continue to decline, this designation could look increasingly positive for hospitals going forward.

So there are a lot of point-in-time simulations, but it's also kind of a long-term process, for sure.

DR. NAVATHE: So related to that, this is a program, essentially, that hospitals can make these transitions in perpetuity. There is not like a, you have to enroll by X date or something like that. Is that correct?

DR. STENSLAND: Yes.

DR. NAVATHE: So the other question relates to something that you had in the slides and the reading materials which is some hospitals seem to have already closed and then are considering transitioning to REH status. Is a time window in which they have to consider

that or is that something again that they have a sort of almost like perpetuity on that?

MR. O'DONNELL: I believe the statute says that if you are in existence as of December 27, 2020, then you can convert to an REH. Now there are benefits to still being an operating hospital when you convert, so the process of transitioning to an REH, for example, you don't have to get resurveyed if you're an open hospital. So if you shuttered and have to open back up there is an additional process of getting resurveyed.

I don't think that there is a kind of clock that shuts off, but I do think that if you are shuttered and then you open back up as an REH it's probably harder.

DR. NAVATHE: Got it. Okay. Last question, so thank you for that. From the interviews that we've done I was just curious; do we have a sense of how much of a friction point it is that once you convert to REH you can't go back to your grandfathered critical access hospital status?

DR. STENSLAND: I think there is. In the places that we talked to, I don't think they thought it was a big issue because they thought, well, if we don't do this we're

probably going to close, and we have very few admissions anyways.

In terms of the broader community out there, I think it is a concern for some of these smaller rural places. Maybe they don't completely trust that this is a permanent program. They also might wonder, well, maybe we're going to grow later and we'll want to convert back.

For the people who have done it, it was probably not a big deal, but the people that are maybe considering it, it can be a big deal.

DR. NAVATHE: Great. Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. Great presentation. I had a few questions, just to understand this a little bit better. I think one you've also clarified for me, which is that when you convert to an REH you can use some of that unused space and repurpose it for other services. Correct? Great.

And then the other question was why was 50 beds selected? I'm just curious about that because if space can be repurposed there are some advantages in a hospital with, say, 75 beds, being able to utilize their space in a

different way to meet community needs.

And then third question -- and like I said, the first one you had already answered -- the third one has to do around the low volumes, and were those low volumes related to declining populations in those catchment areas or not.

Thank you.

DR. STENSLAND: With the last one, generally, no, they weren't. When we looked at closures we found, before hospitals closed, their population declined by an average of 1 percent, but their admissions had declined by an average of over 50 percent. So it's not so much that the population is shrinking. It's that the people there are going somewhere else for care.

MR. O'DONNELL: On the 50-bed thing, I don't think that there is a particular logic to picking 50 beds as opposed to 75. What I would say is that historically 50 beds has been used as a shorthand for small rural hospital. There's a similar criteria for RHCs.

So I don't think there's a particular logic, and as you can kind of see in our writing, when we're considering going forward, whether that makes sense. But I

don't think there's anything magical about 50, to answer your question.

DR. CHERNEW: Actually, let me just jump in and make one point on Robert's first question. This analysis is really a lot about the hospitals, but a lot of what happens when, say, some have more bypasses than others, a lot of that is because of the context of the markets and where they are. At some point we're going to begin to think holistically because it's not the case that every hospital should stay open or we should have an REH in some places. And some of them shut services, which sounds problematic, and I agree. But a lot of it depends on where the substitute services were and what's happening from the beneficiary perspective.

We just have to get there. Right now we're really talking about what's happening in this program for these hospitals. But at the end of the day there's this how is this program fitting into the tapestry of care for people in a bunch of areas, and that's why you see more bypasses in some places than other places, in my opinion. Sorry.

MS. KELLEY: Wayne.

DR. RILEY: Brian and Jeff, great work. In the chapter you have a great description of the characteristics of rural emergency hospitals. What can you share about regional characteristics? You know, we have objective evidence in upstate New York that there is population decline, which probably tracks population decline to Medicare beneficiaries. But are we seeing that in other parts of the country? Your anecdotal reports of rural hospitals closing in the South as well. Is there anything that you could add to the characteristics regarding the regionality question?

MR. O'DONNELL: We can add more statistics on this in the next round. I think we were somewhat careful about, you know, we have 17, so we can look at 17 with a microscope. So we were kind of a little cautious about making a conclusion based on 17.

But to your point, they are concentrated in the South. I think Texas has 5, and that's the highest state. So they are concentrated right now in the South, although not exclusively. Going forward we can add some of those stats. But we just wanted to keep in mind that the first tranche might look different than the second tranche.

MS. KELLEY: Scott.

DR. SARRAN: Thanks, guys. Great work for sure.

Building off a little bit Betty, Mike and Wayne's questions around broadly contextualizing this work, given that many of the communities in which hospitals have either pursued or are considering an REH transition, given that many of those communities have really poor health outcomes and health status, I'm wondering if we or anyone else has teed up a parallel body of work around evaluating health status and health outcomes over time, sort of the pre-post conversion, to see what impact the conversion may or may not have had.

In the ideal world, the conversion should enable a refocusing of resources around community need, which should lead to better health status and outcomes. So I am just wondering, again, if anyone is looking at that broader picture.

DR. STENSLAND: I think no one has done it yet. That could be something we could do in the long term, once we have a big enough sample size that we can draw some conclusions. And we'll probably also have to do some work on coding in rural areas. It's different because the

incentives for coding are different in different markets in rural areas whether you're getting paid cost or whether you're getting paid on your codes. So it becomes a difficult exercise that would take a fair amount of data.

MS. KELLEY: That's all I have for Round 1, unless I've missed anyone.

DR. CHERNEW: That's all I had too, so that's great. Now we're going to start Round 2, and if I have this right, Lynn is the first person in Round 2.

MS. BARR: All right. So 17 hospitals converted, 8 hospitals closed. If we hadn't had this, potentially we would have had 25 closures this year. That's a pretty big number compared to previous years. What are you thinking about that?

MR. O'DONNELL: I would just say that we don't know that all of them would have been closing this year. They may have hung on, but clearly given their financial state a lot of them would've closed in either this year or the coming years.

MS. BARR: Got it. Is this a post-pandemic bubble?

DR. STENSLAND: Part of that is going on. There

was a very low level of closures in 2020 and 2021, because rural hospitals got a lot more money than the actual cost of the pandemic, so the closures went way down. So you would expect a little bit of a bounce-up, actually more of a bounce-up than we saw, and the bounce-up was probably contracted because some of these would've closed and instead, they converted.

MS. BARR: We've just got to keep looking at that. I mean, if we have another year of 25 closures, or potential, it's a bigger number than we've seen in a long, long time, so I'm a little worried. But I agree it could be the other part.

Outpatient versus inpatient. What percentage of these hospitals' business is outpatient? I believe, anecdotally, rural critical access hospital, 75 percent of their business is outpatient, right? So we keep talking about hospitals, but these are outpatient centers that really -- we're fixing an outpatient problem. We're really not fixing an inpatient problem. There is plenty of access to inpatient beds, but there is no access, or limited access, to outpatient services.

So I was curious, and unfortunately you only have

five CAHs -- I'm really concerned that this was really targeted towards struggling critical access hospitals and yet it's 12 PPS hospitals and only 5 CAHs. So I'm very concerned about what's going on there.

So the thing that I think you're fixing, that I'm most excited about this, is pricing in the outpatient market. We all know, in 2009, prices in outpatient CAHs were 2.5 times the price that they would pay in an OPPS hospital. And we've seen in our data, like for Medicare Advantage, all these zero-premium policies. Seniors are extremely sensitive to price.

So could we, in the CAH cohort, where we are really affecting price, can we start tracking volume and see if their volume -- let's look a few years back. We should be able to see that pretty quickly, that if the community starts moving back and using the hospital this is going to be a very important piece of data to inform our policies on pricing. And are we driving people out of rural hospitals because pricing, which is, of course, my opinion.

And that is the end of my comments. Thank you.

DR. STENSLAND: Just to clarify, when you say

pricing, what you mean is the price paid by the beneficiary, in essence their co-insurance?

MS. BARR: No. So it's not just the co-insurance. There is price transparency, right. I live in a rural community. They can't actually tell me what it costs because it's critical access and they don't know. But they try to estimate. And if seniors are as cost sensitive as people say, I'm going to look at that price and then I'm going to look at the price in the urban area, and I'm going to go to the urban area just because the price is lower. They don't even understand the copay issues a lot, and we found this a lot with the care coordination.

And so with care coordination, if we wanted to enroll them in care coordination, they had to pay an $8 a month copay. And because of that, more than half refused. We were like, you don't pay the copay. You've got supplemental insurance. I don't care. I'm not paying that copay. So they are extremely price sensitive.

I don't think, if they know the price they want to go to a lower price. So I don't even know if it's the copay issue as much as a pricing issue. But certainly

price affects it.

DR. CHERNEW: I just want to follow up on both those points quickly. The first point about closure, I agree that's important but I would emphasize there's another outcome, which is merger, particularly being acquired by an outside system, so they might stay open. It's a complicated issue which relates to the second point I want to make, which is about this bypass.

There is a big issue in some other work I've been doing about capital investment in different places. One possibility is they're getting enough to stay open but not enough to really, really invest. And so people increasingly find the place they travel to a more attractive facility, cost aside, because of how that's playing out. That may not be bad, by the way, but I'm just saying I think the dynamic of bypass is actually quite complicated and cost is part of it, perhaps. There's a lot going on with bypass.

MS. BARR: Okay. But we don't have any data.

DR. CHERNEW: No, I agree with that point.

MS. BARR: We have data that says patients are sensitive to the cost, and we have overwhelming data about

that. And what frustrates me is every time I bring this up people go, "Oh, it's because of quality," or it's because of this, or it's because of that, and I we don't have --

DR. CHERNEW: Yes, I --

MS. BARR: -- other than we know they're price sensitive.

DR. CHERNEW: Yes. And I think understanding the broader point I was trying to make is I think it's worth understanding more the dynamics behind bypass, which certainly includes cost and a bunch of other things.

MS. BARR: I would be so supportive of MedPAC doing a comprehensive study, what is causing bypass in rural hospitals, because we pay more for people that bypass because we still pay the fixed cost to the hospital.

DR. CHERNEW: Yeah, that's spot on.

MS. BARR: So I would love to see that work.

DR. CHERNEW: I agree. That's spot on.

MS. BARR: Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you so much for this excellent work. I especially want to compliment you on the history of the payment reforms and the way that you set up

the chapter. It was so clearly done and really pointed to a need for these policies.

I also think the deep dive into the -- you know, going to those hospitals and also digging into the ones that closed and why was incredibly helpful.

I want to just ask if it's possible -- the chart that you showed in the materials on hospital closures over time I think is really valuable, but I wonder if it's also possible to add the openings or mergers or just have a better sense of the availability of hospitals in those areas. I feel like having that would round it out so we would know -- you know, I think it would still be alarming, but would provide maybe a little bit more contextual information about what access is still there since those things have changed.

This is a little bit responding to Jeff's comment earlier about the number of people considering transition or number of hospitals considering transition, but I actually was wondering, is it possible to know how many would be eligible at all? And I think you guys mentioned 50 to 600 is the range in the literature. But do we have a sense at least of how many possible that we could be

talking about? We've seen 17 already convert. We know there's more coming. But what's the denominator as best we could capture it?

MR. O'DONNELL: Yes, so you'll see different estimates out there, including one from Amol, I believe. I think it's around 1,700, that's kind of the rough number. When you think about it, any CAH is allowed to transition, and so there are 1,350 of those, and then a few hundred rural PPS hospitals that have fewer 50 beds, so about 1,700.

DR. DUSETZINA: That would be really helpful, when you mentioned the 17 and then what's coming, just kind of put it in the context of what is the potential reach of the program.

Another thing that just struck me when you were talking about the payment, and I think in the presentation you mentioned kind of an average monthly and then the 3.2 million per year. Is it 3.2 million at a lump sum? Or is it actually a monthly payment?

MR. O'DONNELL: It's a monthly payment. It sums to 3.2 million.

DR. DUSETZINA: Okay. So basically if your

hospital -- you know, they tried to convert to save themselves, but then they still went under, you just stop the payment at the time that they are no longer functioning. Okay

MR. O'DONNELL: It's a monthly check, yes.

DR. DUSETZINA: Okay. And then my last question was related to the -- you know, it's clear from the chapter that hospitals can choose to use the payment how they want to support the services. Is there a plan to audit for beneficiary access to and use of those hospitals? Just to make sure that, you know, the money that's being spent to preserve access is actually -- you know, that we still see people going and getting services.

MR. O'DONNELL: Yeah, so I think, you know, we're mandated to study this every year. I think HHS also gets a few mandates in the legislation. And, also, as part of their plan to transition, hospitals have to submit an action plan. So they have to delineate what they think they're going to do, and so they'll be able to audit that in the next, you know, four or five years once they actually transition.

So I think there are plans to study it going

forward, but I don't think anything has happened to date because it's so new.

DR. DUSETZINA: Okay. Well, great work. Thank you.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. I appreciate this great chapter.

A few comments on the issue of bypass. I would just also add that there's also the Gucci factor where people want to go to the big facility, and also questions about the volume. Is enough volume being done?

I wanted to add the Round 2 question to my Round 1 question in terms of I really think it would be important to keep track of mental health services that are chosen, because many divested of that capacity because of finances and other reasons, but I can't imagine that there won't be need in all the areas.

I wanted to give a shout-out to Amol about this issue of being able to switch back. Having spent much of my life in western North Dakota where there's a lot of frontier counties, and then Vermont, which started rural but is much more populated, and now Rhode Island, that's a

city state and actually thinks it's rural. Every rural place is really different, and in very small rural areas, the issue of the responsibility to your community is so profound because you're taking care of your family members and your neighbors and your uncles and your cousins and your godparents. So I think that that trust in we can do this but if it doesn't work, I can still go back to caring for my community is really huge.

I also wanted to comment on -- I think this is a very important program, but I also think it's a solution for some and not all. There was an article in the Washington Post awhile back that exactly mirrored my experience in that the nurse in this area isn't just sitting with low volume inpatient. They're working the ED. They might be doing home visits, et cetera, et cetera. So when you cut out some of the services, you're not really cutting out all the costs. So this is a very specific solution and an important one. And I'm wondering if, since we can't get to the full issue that Scott raised about the broader picture, could we just have a little text box about some of the initiatives that are happening, like Pennsylvania's rural initiative, but I'll also just share

the Rough Rider clinically integrated network of 23 critical access hospitals that was just formed in North Dakota. And not have a ton about that, but I think it would be important for, you know, the readers and Congress to see. This is one very important endeavor, but there's others.

Just briefly, you know, disclosure, I've been working with the nurses in the state of North Dakota, so how do they think about critical access hospitals taking on full risk with low volume for traditional and how we can think about that. So not to segue away from this important work, but I think it would be helpful. This is one of many things, because there are many rural areas in America. So I think it's really important work.

MS. KELLEY: Tamara.

DR. KONETZKA: Thanks for this excellent, really interesting work. A couple of things.

One, I was really struck by what's going to happen to post-acute care going from, you know, $2,400 day swing bed payments to SNF PPS payments, which are obviously a lot lower. So I would just encourage you, I guess, as you start to evaluate this and get the claims, to look at

post-acute care access and see if there are any unintended consequences there. You know, a lot of the references to sort of distance from other hospitals, I think, you know, is about inpatient care and not about post-acute care. So that would be something we'd want to keep an eye on.

And then the question I would hang onto that is: In your interviews, did the issue of post-acute care and the elimination of the swing beds come up at all? Or was that sort of -- did that play into the thinking about these trends, these conversions at all?

And then the final thing I would say is that I would also echo Scott's suggestion to look at the broader picture. I love that you already looked at hospitals or started to look at hospitals that closed as well, because I think that's a great comparison and was a great addition to the chapter. And I think that's just sort of one step in looking at the broader picture of the hospital care and the post-acute care available in these marks.

Thanks.

MS. KELLEY: Go ahead, Lynn.

MS. BARR: I just wanted to give a plus one on Tamara. I was thinking about Surprise Valley Hospital up

in the northern part of California, and their only patients are swing bed patients. But there is no skilled nursing facility for them to go to within, God, probably 50 to 75 miles. So if we -- you know, it's something to really consider, is that by not allowing them to use swing beds, which doesn't really make any sense -- right? -- and they've got an empty bed, they could still bill it as a SNF day, right? But they have to have a distinct part SNF, right? They can't just -- so this -- I'm so glad you brought that up, Tamara. I can think of ten hospitals right now, remote critical access hospitals, frontier critical access hospitals will not be able to adopt this program because they have no alternatives for skilled nursing.

MR. O'DONNELL: Yeah, and the only thing I'll say -- and I'll let Jeff jump in here -- is that, you know, this issue is clearly on our radar. We've taken a look at it thus far a little bit, but keep in mind that only five CAHs have converted thus far. So most swing beds are at CAHs, although PPS hospitals can do them.

You know, one thing we're looking at in the future is, you know, kind of how hard is it for rural

hospitals to create a distinct part SNF, and so we actually spoke with one who was quite small that did it, but we've heard concerns that it's quite difficult. And so over the next year, one of the things that we're going to do is talk to folks and understand better on a state-by-state basis of how hard is it to open a distinct part SNF, because I think, you know, like you said, if they're getting paid the SNF PPS rates, I think that's our kind of number one, and then the next thing is how hard or can they do it.

MS. KELLEY: Brian.

DR. MILLER: I love this chapter. I think it was -- I want to plus-one on the comments about the back story in the chapter. That was extremely helpful. And thinking about the REHs amongst the menu of options for rural facilities, CAH, Medicare-dependent hospitals, sole community hospital, low-volume hospital, I think many people forget those other designations, so having that there is quite useful.

A few thoughts. On the tax-exempt versus taxpaying hospitals, I think that that information is important, noting that at least economically speaking those entities tend to behave the same way, which is to seek a

margin.

As for systems and local ownership, I agree that local ownership is important. I also think that there are advantages to systems. Not every sole community hospital is going to have the resources or the ability to necessarily get good access for their beneficiaries to things like neurosurgical care, plastic surgery, burns. So having REHs that are part of systems is actually extremely important to make sure that rural beneficiaries have equitable access to specialty care. And so I think we should note that.

I think in terms of expanding access and then also thinking about loss of access, I liked it that you mentioned that the average census was 2.4 patients per day, which is clearly very low. It's important, but there is a volume-quality relationship which is well known in all medical specialties and probably applies to all technical trades from carpenters to hospitalists to plastic surgeons. And I think most of us can agree that at 2.4 patients per day, we might unfortunately be offering rural beneficiaries lower-quality care, and so having those facilities change and essentially functionally transform into a freestanding

emergency room with 24/7 access and then send those beneficiaries to other hospitals ensures that they have access to the emergency care that they need or even urgent care, but that they also have equal access to high-quality inpatient care.

In that vein, I guess the question I had about this policy is: We're talking about converting facilities that are going to close, and I noted the distance of 15 to 35 miles, also as someone who has lived in a rural area, I can see 15 miles on a two-lane road in December in a blizzard is very different from 15 miles in, you know, suburban Las Vegas.

So why don't we allow health systems -- and thinking about the future of this policy, maybe consider putting a line in, talking about allowing health systems or allowing physicians to open facilities that could qualify as REHs to expand access in rural areas? Right? Health systems could potentially do this and create -- expand a network of care in rural areas, and physicians could also do this and expand emergency access in rural areas, noting that during the public health emergency we allowed freestanding ERs widely to do this for three years. When

the public health emergency ended, that access closed because they were not allowed to participate in Medicare.

If we're worried about abuses in emergency -- what is functionally a freestanding emergency room, we could also think about making those two lowest level acuity payments on the physician fee schedule and that would sort of disincentivize abuse of very low acuity care in REHs.

And I think, you know, one other thing that I want to congratulate all of us on is that this is a recommendation that we made to Congress that was enacted, and now we are talking about a program that MedPAC recommended that we are now evaluating the program that we recommended creating, which is great. I think in that vein, actually, it would be great if MedPAC evaluated its performance on all of its recommendations, which is something that the Federal Trade Commission's Office of Policy Planning does with its advocacy, and I think that that would help us as an organization become even more efficient and effective.

A long way of saying I love this chapter and lots of great ideas for the future.

DR. STENSLAND: I would just add, when we made

our original recommendation, we had a distance requirement of 35 miles, which is if they were more than 35 miles away, they needed that to convert, and the idea was that if somebody was closer than 35 miles to another hospital, they could become an outpatient department at that hospital. But that also -- we did not have any restrictions on who could become a new REH. So if you were an isolated community and you're more than 35 miles from any hospitals and you thought you needed this kind of emergency care, you could have started your own emergency room under our recommendation. It was enacted a little bit differently when it went through the Congress.

DR. MILLER: Then we should probably note that we'd still like that recommendation, because that massively expands access for rural beneficiaries, and it's a great recommendation, which even though I wasn't on MedPAC at that time, I would support and vote in favor of it.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you very much for this chapter. It was great work. You know, given that this is a new model, I think there's a lot to learn about the performance of this model and whether it's achieving its

objectives. So I'm going to plus-one on several things that other Commissioners around the table have said.

I think it's going to be important to track volume and try to break that down in terms of what types of services are being provided.

I would also support trying to better understand whether this shift is preventing migration or bypass. Does it help mitigate that problem? And if people are still bypassing, what are they bypassing for?

I'll plus-one on Tamara's comments about swing beds and really trying to understand the implications of that.

I would also encourage continued learning in terms of how they are going to spend the dollars, since there's a fair amount of flexibility here, and I think it would be important to learn about that.

And then I'm really interested in trying to understand margins. So does this help improve their financial performance and by how much and whether the support that's provided here, the structural dollars provided by Medicare are sufficient or are additional resources required and whether other parties, such as

states, need to come to the table to help support access in rural areas?

And, relatedly, if the margins say swing from -- what did you say? -- negative 13 percent to positive, does this then put these entities in a better position from the standpoint of larger health systems wanting to then step forward and consolidate with them?

MS. KELLEY: Jaewon.

DR. RYU: Yeah, I also really appreciated and enjoyed the chapter. A lot of comments have already been made. But I especially like the analysis around the 40 places that had closed. I thought that was really informative, and for several reasons, and I think there are a couple areas I'd love to see a little bit deeper analysis.

I think we have to understand bypass better, and I agree with some of the comments that have been made. It's multifactorial, I think many different reasons that contribute. The one that concerns me though is programmatic deterioration. And some programs I think very appropriately should not be in these low-volume environments. I think Brian made that point. I think we

would all agree. You know, transplant might be an example of that. But some programs are fairly foundational. You might even call them bread and butter. Maybe it's something like cardiology.

And so there are certain programs that I think, to the extent they're deteriorating, I think it does speak to access or, you know, lack thereof. And I think Lynn's point is also important to remember. Yeah, the average daily census on the inpatient side may be low, but really when a program dies, it doesn't die just on inpatient. It dies on outpatient. And I think that's the larger access concern that I would have.

The other just quick comment is I think this does inform some of the discussions we have every year in the cycle around payment adequacy and access, and we say, you know, we should be as targeted as possible in our interventions, and I agree with that. But rural -- and maybe safety net would be the other area -- are two areas where, you know, this notion of deteriorating programs I think were trailing. And we've talked about the leading versus trailing, lagging indicators. I think the program demise is something that is not picked up well in the

criteria we use every year around access.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. This is a great topic, great discussion. Just to piggyback on some of Mike's comments during my Round 1 question, yeah, I think we have to think about this a little bit more holistically as well. I think this is, in part, a quantitative analysis but also a qualitative analysis. I like the idea that you actually went and spoke to a few of these facilities that have convert.

You know, market force isn't just evolving changes, and communities may necessitate certain inpatient beds closing down, and I think many of us understand that.

I'm also concerned about how we can repurpose that space in a positive way for the community based on their health care needs, and that we don't have a handle on. It would be good to really understand, of these facilities, did they take advantage of actually creating health care needs of their community outside the inpatient arena. Did they preserve radiology services? Did they preserve laboratory services? Did they expand outpatient and primary care? Did they have to convert into a couple

of ambulatory surgery areas to be able to do procedures?

Likewise, not everything needs to look like an inpatient space. So when we think about rural areas, they also have acute needs for residential treatment centers, based on mental health needs or substance abuse. Was there an opportunity to actually convert space for those types of community health needs as well? And if they couldn't but had to close down, what was the reason? Because often when you have to repurpose your health care facility for something new it requires an infusion of capital, and therefore you have to look for another partner, another health system, or your local or state government would need to help infuse those dollars in order to do the facility redesign that's necessary to repurpose the area that you need.

So I think we're just scratching the surface of this, which actually is a good thing. I think this is an exciting project, and I think there's a lot to learn here and a lot that can be offered with additional analysis.

Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. I'm going to make a specific

suggestion. It largely builds off comments from Betty and Tamara but especially Cheryl and Robert.

Given that what we want is not just, call it first-order measures around access to quality care, quality and affordable care, but what we really want at the end of the day, sort of call it a second order set of outcomes, which again is improved health status and health outcomes. And again, no need to reiterate but it's probably worth highlighting in the chapter how many of these communities are extremely problematic in their current health status and health outcomes, hugely disparate.

So the suggestion is in understanding that hospitals aren't the sole arbiter or driver of those outcomes, they still are an important lever in many ways. So we want to magnify the use and point, the use of that lever.

So here is the specific suggestion, that we consider recommending that a requirement for a conversation to a rural emergency hospital or de novo rural hospital designation would require a formal health needs assessment of the community and not just around access to services but around what are the problematic health status issues,

health outcomes issues for that community, and how will that hospital use the change in designation, particularly the money they're getting, that's not attached to a specific fee-for-service type encounter, how will they use that money and the other flexibilities to reshape from a programmatic and bricks-and-mortar, their outpatient assets? How will they use that to address those problematic health status, health outcomes issues, and how will they then -- finally, how will they then measure and monitor the impact of that?

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Jeff and Brian. Like Brian, I really love this work. I think it's really fantastic, very on point.

I think many of my comments are in echo of several of the Commissioners. One thing I wanted to add to that is I think the interviews were really fantastic, and to the extent that we have been with and are constrained doing interviews in the future as part of this work it might be helpful to try to interview some of the hospitals that are considering, that are in the process of submitting, or maybe considered and decided not to do REHs.

Because I think right now, we're getting obviously a selection bias of what we're hearing, and it's going to be better to get sort of a comprehensive, qualitative view of the considerations.

I wanted to a couple of quick plus-ones. I think understanding the bypass issue piece is good. I think understanding the range of services, what Betty and Jaewon said, I think is also going to be really helpful, especially because either communities thinking about this in the context of staffing employment, kind of access more broadly, I think will be great. I know that you all are probably planning to look at some of this stuff already.

And then I was curious, I have a Round 1-ish question as well. In some sense I think as I read some of the early materials on this it seems like there was a theory on the cost structure whereby not having an inpatient cost structure would help the financial issues that Cheryl and others have highlighted. And I was wondering if these REHs continue to submit cost reports, and if they do then that's something that we could probably look at going forward, and I think that would be very helpful, especially because a lot of the care that they do

provide is in the outpatient setting, and I wonder if that is actually going to play out in the way that the theory, at least, would have said. Thanks.

MR. O'DONNELL: They are required to submit cost reports, so that's something we can look at.

DR. NAVATHE: Great. Thanks.

MS. KELLEY: Gina.

MS. UPCHURCH: This will be quick and partly a Round 1 question, I believe. The $3.2 million -- and I loved the chapter. It was super helpful laying the groundwork -- the $3.2 million, is that promised for a number of years, so that they can plan these community changes?

DR. STENSLAND: It goes on forever and it increases every year with inflation.

MS. UPCHURCH: Okay. So there's the assumption that it's going to continue on so they can play.

So then the second one builds off an earlier comment that Betty made, concerns about mental health parity. And I really appreciate Scott's question of having community assessment and having people respond in this conversion to the community needs. I am very worried about

mental health parity, particularly thinking about Medicare Advantage penetration, because I'm noticing with Medicare Advantage plans that there is not a lot of mental health parity in terms of the cost sharing the beneficiary pays.

So I'm just curious if there's more MA penetration, is that creating more problems for rural communities in terms of mental health services, because I am very concerned about mental health parity in rural communities. Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Two, about things that I think could be tracked or maybe should be tracked, but also, I'd be interested in hearing comments that you guys have today.

The first is just really quick, and you briefly mentioned it in your report. The local physicians, of whom there aren't probably going to be very many and probably most of them will be primary care physicians, they may not be that happy -- and you say this -- with losing the ability to hospitalize locally a patient with mild to moderate pneumonia or mild congestive heart failure, the kind of things that are common. And it's not really a big

revenue producer for the physicians but it could be a career satisfaction issue.

So it would be interesting to see, over time, if this has an effect on the supply of physicians in rural areas, because it's possible that it could hurt it. So I think we're tracking it but also if you've heard any comments about it. Well, I guess you did because you put it in the chapter.

The other point is a little more complex. I think that the relationship of these rural emergency hospitals and systems will be a really important thing to think about going forward. Mission area work consolidation can be a good thing, I think. I think Brian's point that it could really help patient care in a lot of ways in these rural communities if the rural emergency hospital has a formal relationship where it is owned by, let's say, a system. And it might be more attractive for a system, I think, to own a facility that has a rural emergency hospital than to own a money-losing, quote/unquote, "full service" hospital.

So will this lead to more ownership of the rural emergency hospitals by systems, because as I say, it could

be a very good thing. I think that's worth tracking. It could become quite a large phenomenon perhaps.

To downside, potentially, I think an ownership by system could be what Robert and Scott especially have emphasized. Like where is $3.2 million going in terms of helping the communities and repurposing the physical space even. I could imagine that that's an area where that could be really important actually. It could be at least as important as the emergency department services that the community gets from this. But I could imagine that local control of the hospital, local people might have both more motivation and more knowledge to repurpose things and use that $3.2 million effectively than system administrators a long way away.

So on the one hand I can see the system is very beneficial, but on the other hand it might not be as good for what's done with the $3.2 million locally. So as others have said, tracking what happens with the $3.2 million, and then kind of the intersection of all this with system ownership or not I think would be useful.

MS. KELLEY: Greg.

MR. POULSEN: I know we're short on time so I'll

try and be quick. We've talked about this in the past, but I think technology relationships and telehealth broadly is tremendously important to this whole discussion area and to all of the components that we're talking about. And it doesn't necessarily require ownership to make those kind of things work. To Larry's point, we have a dozen rural hospitals that are part of our organization but we have 65 that are not, and they've all seen significant improvements in their bypass ratios, their profitability, and the other capabilities that I think would benefit performance, whether or not they become REHs or whether they are simply upscaling their facilities in order to keep people.

Because I think Larry's point is important. There are things that are nice to have locally, especially when their distances are long. If this is a dozen miles it's not as big a deal as if it's 100 miles from a local area, whether it's OB or community pneumonia, et cetera.

So I think that as we're seeing technology, we need to continuously reevaluate this in the context of technologies that become more and more capability every year and that allow places that are geographically remote to not be intellectually remote from all of the services

and capabilities that are increasingly available.

MS. KELLEY: That's all I have in Round 2, Mike, I believe.

DR. CHERNEW: And that's all I have in Round 2. And as the miraculous talents of the Commissioners demonstrate that no matter how little time we have left, we seem to ultimately end on time. So I'm very grateful to all of you.

I won't give a broad summary of this, but I will say the following. There is widespread enthusiasm for this work and appreciation of it. I want to emphasize the combination of quantitative and qualitative analysis I think is particularly appreciated and really provide the context that's important, that I really want to call special attention to that.

The second thing I will say, and I think maybe the main theme of this which we will continue to think through, is how we place all of these programs in the context of a whole range of other things and how we continue to both have the institution perspective, which again we largely saw here, and how we build in the, I'm going to call it the community or the area perspective, to

understand how it's working in different places.

I do think that we care about both for a range of reasons. We care about the nuances across different types of services. I think that as technology drives care outside of hospitals, outside of inpatient care towards outpatient care, this changing production function just becomes problematic in some areas. So we need to continue to strive to figure out how to support them. I think the rural emergency hospital was one manifestation for how to do that, as was pointed out. There can be some tweaks to it that we can discuss in the future. But there also can be other programs one might wrap around it in a range of ways.

So again, we're going to continue to focus in this area, both on this program and on this sort of broad topic, and I appreciate all the comments. I think it really has been a productive way to help move us to the next steps in this work. So to Jeff and Brian, thank you guys tons.

We're going to take a five-minute break and we are going to be back at 11:35 for our session on D-SNPs.

[Recess.]

DR. CHERNEW: Okay. We're back. One of the areas that we are perpetually interested in is this sort of interaction between Medicare and Medicaid, and one place where the policy in that regard is particularly salient is the D-SNPs, and there is a lot of stuff, a lot of programs to try and encourage this type of integration across the programs. We are mandated to report on this on a regular basis for roughly the next decade, and we will.

And I think Eric is going to lead our discussion. So Eric, I'm turning to you.

MR. ROLLINS: Thank you and good morning. Today I'm going to present a mandated report on dual-eligible special needs plans, or D-SNPs, which will appear as a chapter in our March 2024 report to the Congress. Before I begin, I'd like to remind the audience that they can download these slides in the handout section on the right-hand side of the screen.

D-SNPs are a group of specialized Medicare Advantage plans that serve beneficiaries who qualify for both Medicare and Medicaid. These beneficiaries are commonly referred to as dual-eligible beneficiaries. The Bipartisan Budget Act of 2018 requires the Commission to

periodically compare the performance of D-SNPs and other managed care plans that serve dual eligibles, but vary in the extent of their responsibility for providing Medicaid-covered services. This is our second report under the BBA mandate.

Let me start with a little bit of background. About 19 percent of all Medicare beneficiaries, now about 12 million people, are dually eligible at any given point in time. When beneficiaries have both Medicare and Medicaid coverage, Medicare acts as the primary payer for any services covered by both programs, such as inpatient care or physician services. Medicaid covers long-term services and supports, such as home- and community-based services or custodial nursing home care, plus wraparound services that Medicare does not cover, such as dental care and transportation.

Dual eligibles are often divided into two groups: those who are "full benefit" because they qualify for the full range of Medicaid benefits covered in their state, and those who are "partial benefit" and only receive assistance with Medicare premiums and, in some cases, cost sharing.

Compared to other Medicare beneficiaries, dual

eligibles are more likely to be in poor health and they have per-capita costs that are, on average, more than two times higher. Policymakers have long been concerned that dual eligibles may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs.

Like other beneficiaries, the share of dual eligibles enrolled in MA plans has grown rapidly in recent years. The graph on the left-hand side shows the share of dual-eligible and non-dual-eligible beneficiaries that were enrolled in MA from 2012 to 2022. Historically, dual eligibles were less likely to enroll in a plan, but that pattern reversed during this period, and the share of dual eligibles enrolled in MA is now higher than that of non-dual-eligible beneficiaries.

Within the dual-eligible population, as shown in the graph on the right-hand side, partial-benefit dual eligibles have consistently been more likely than full-benefit dual eligibles to enroll in MA plans. Between 2012 and 2022, the MA participation rates for both groups more than doubled, but the growth for partial-benefit dual eligibles was particularly rapid, and more than 70 percent

of them are now enrolled in MA plans.

Dual eligibles also tend to enroll in different types of MA plans than other beneficiaries. In 2022, among beneficiaries who are not dually eligible, 75 percent were enrolled in conventional plans and another 23 percent were in employer-sponsored plans. In contrast, among dual eligibles, 62 percent were enrolled in D-SNPs while 34 percent were in conventional plans and only 1 percent were in employer plans.

Full-benefit dual eligibles were particularly likely to enroll in D-SNPs instead of conventional plans, 71 percent versus 25 percent, while partial-benefit dual eligibles were split about evenly between the two plan types. As we noted in your mailing materials, partial-benefit dual eligibles who receive assistance with Medicare cost sharing are much more likely to enroll in D-SNPs, while those who do not receive assistance with cost sharing are much more likely to enroll in conventional plans.

As an aside, while D-SNPs are specifically designed to serve dual eligibles and account for most of the dual eligibles enrolled in plans, I wanted to mention that Medicare also has two other types of plans that

primarily serve dual eligibles because they target beneficiaries who need long-term services and supports, for which Medicaid is the largest payer. These plans are MA institutional special needs plans, or I-SNPs, which currently have about 110,000 enrollees and largely focus on beneficiaries who are already living in nursing homes, and the Program of All-Inclusive Care for the Elderly, or PACE, which currently has about 60,000 enrollees and focuses on frail beneficiaries who still live in the community but need the level of care provided in a nursing home. Almost all of the beneficiaries enrolled in these two types of plans are dually eligible.

There are actually three different types of D-SNPs defined in statute, so let me briefly describe them for you. I apologize in advance for all the acronyms.

The first type is known as a coordination-only D-SNP. These plans must notify the state about admissions to inpatient hospitals and skilled nursing facilities for at least one group of "high-risk" enrollees, and they are the least integrated because they don't have to provide any Medicaid services.

The second type is the highly integrated dual-

eligible SNP, or HIDE SNP. These plans must have a capitated Medicaid contract, either on their own or through an affiliated plan, to provide LTSS and/or behavioral health services. You can think of these plans as having a moderate level of integration since they do provide some Medicaid services, but the range of services isn't as broad as it is in more integrated plans.

The third type is the fully integrated dual-eligible SNP, or FIDE SNP. These plans must have a capitated Medicaid contract to provide LTSS, acute care, and primary care services. Starting in 2025, these contracts must also cover behavioral health, Medicare cost sharing, home health, and durable medical equipment. These plans are the most integrated since they cover a broad range of Medicaid services.

The extent to which D-SNPs must integrate the delivery of Medicare and Medicaid services has evolved over time. Starting in 2021, all D-SNPs have been required to meet one of three standards for integration. Under the first standard, plans operate as a coordination-only D-SNP. These plans account for 57 percent of D-SNP enrollment. Under the second standard, plans operate as a HIDE SNP or

FIDE SNP, but do not have a feature known as exclusively aligned enrollment, which means that all enrollees also receive their Medicaid benefits from the same insurer. These plans account for 36 percent of D-SNP enrollment. Finally, under the third standard, plans operate as a HIDE SNP or FIDE SNP and also have exclusively aligned enrollment. These plans account for a small share of D-SNP enrollment, about 7 percent.

Turning now to the specifics of the mandate, the BBA requires the Commission to periodically assess the performance of D-SNPs. Under the mandate, we should make this assessment using data from HEDIS, which is a set of clinical quality measures developed for health plans by the National Committee for Quality Assurance. We can also use other data sources, like the CAHPS patient experience survey that was developed by the Agency for Healthcare Research and Quality or plan encounter data, if feasible.

The mandate also says that we should compare the performance of five types of plans that serve dual eligibles: three types of D-SNPs divided based on the integration standards that I just described, the Medicare-Medicaid Plans, or market maker programs, that operate

under CMS's financial alignment demonstration, and other MA plans. For the other MA plans, we're looking only at the dual eligibles enrolled in those plans.

Finally, we must provide a report every two years from 2022 to 2032, and then every five years starting in 2033. This is our second report under the mandate.

We analyzed HEDIS data using an approach that was similar to the one we used in our first mandated report. We analyzed person-level data for measurement year 2021, which was the most recent available when we performed our analysis, and calculated scores for a total of 38 measures. We focused on measures that are calculated using administrative data only. We excluded so-called "hybrid measures" that can be calculated using a mix of administrative data and information collected from a sample of enrollee medical records, because the sample is chosen at the contract level and is too small to generate reliable plan-level estimates.

We then identified any instances where the score for a particular plan type differed from the scores of the other plan types by at least 3 percentage points. Our goal was to identify instances where one plan type clearly

performed better or worse than the others. CMS has used this threshold in some of its HEDIS analyses to signify when scores are meaningfully different.

The results from our HEDIS analysis were mixed and did not clearly favor one plan type. This table shows how often scores for a given plan type were noticeably better or worse than the scores for the other plan types. There's a table in your mailing materials that has the scores for each individual measure, which will also appear in the final report. As you can see, most plan types performed relatively well or poorly on one or two of the 38 measures, but in most cases the differences between scores were relatively small.

Of the five plan types, we found that MMPs had the largest variation in performance. They performed noticeably better on 3 measures, such as screening for potentially harmful drug-disease interactions in older adults and follow-up after a hospitalization for mental illness, but they also performed noticeably worse on 4 measures, such as breast cancer screening and osteoporosis management in women who had a fracture.

Overall, these mixed findings are consistent with

our first mandated report.

For this report, we also looked at results from the MA version of the CAHPS patient experience survey. This analysis is new and did not appear in our first mandated report. We used results from the surveys that plans conducted in 2022, which are the most recent available.

We focused on scores for six so-called composite measures, which combine the scores on groups of closely related individual measures. For example, one composite measure looks at the ability to get care quickly while another looks at customer service. We also focused on scores for five measures where enrollees give an overall rating of a key feature of their health care experience, such as their personal doctor or health plan. Finally, we adjusted survey responses to account for differences in case mix, using the same factors that CMS applies when it adjusts CAHPS responses to calculate the MA star ratings.

We found that the coordination-only D-SNPs, as a group, performed slightly better on many CAHPS measures, including all of the composite measures and some of the enrollee ratings. In contrast, MMPs had slightly lower

scores on several composite measures and enrollee ratings. This finding is somewhat counterintuitive since the level of integration is relatively low in coordination-only D-SNPs and high in MMPs.

However, the differences between the highest- and lowest-performing plan types were relatively small in absolute terms and may not be very meaningful for beneficiaries, even if they pass a test of statistical significance. For example, across the five plan types we compared, the scores on the composite measure for getting care quickly ranged from 73 to 76 -- these are on a 100-point scale -- and the average rating for an enrollee's personal doctor ranged from 89 to 91. This pattern was consistent with other analyses that have found that CAHPS scores for many measures tend to cluster within a narrow range.

Although our HEDIS and CAHPS analyses did identify some differences across the various plan types, we think it is difficult to draw broader conclusions about plan performance because there could be other factors that contribute to the variation in scores. For example, more highly integrated plans like FIDE SNPs and MMPs are not

widely available, and about 85 percent of the enrollment in each plan type was in just 5 states. This variation means that differences in scores across the five comparison groups could be influenced by factors such as regional differences in state Medicaid eligibility requirements and physician practice patterns.

Another factor that might have played a role are structural differences between MA plans and MMPs, which performed worse on some HEDIS and CAHPS measures. MMPs are part of a demonstration and differ from MA plans in several ways. For example, many states passively enrolled some beneficiaries in MMPs and plans may have had more difficulty engaging with those enrollees. In addition, MA plans and MMPs have different quality incentives == for MA plans, it's structured as a bonus, while for MMPs it's structured as a withhold -- and they are largely evaluated on different measures.

In our HEDIS analysis, we found that MA plans performed better than MMPs on measures that are used in the MA star ratings, while MMPs performed better than MA plans on the measure used in the quality withhold. Similarly, in our CAHPS analysis, most of the composite measures and

enrollee ratings are used in the MA star ratings but not the MMP quality withhold. Some of the differences between MA plans and MMPs may thus reflect differences in plans' financial incentives to focus on certain measures over others.

Looking ahead to the next report in this series, which will be due in 2026, we plan to supplement our HEDIS and CAHPS analyses with information on ambulatory-care sensitive hospitalization rates, which we plan to calculate using a combination of plan encounter data and hospital discharge data.

Switching gears a bit, I'd like to spend a few more minutes talking about the MMPs. As I just mentioned, these are demonstration plans, and they have been part of a broader effort by CMS and states to develop new models of care for dual eligibles. With the MMPs, they've been testing whether capitated health plans that integrate Medicare and Medicaid services can reduce program costs and improve quality. These demonstrations have had a number of distinctive elements, such as the use of passive enrollment and a payment system for MMPs that shares the savings that were expected to result between participating states and

the federal government.

The MMPs have been one of the largest demonstrations targeted at dual-eligible beneficiaries. Overall, a total of 10 states have conducted demonstrations. They started between 2013 and 2016 -- the specific dates varied by state -- and most of them are still under way, so we now have several years of experience with the MMP model. At their peak, the MMPs had between 400,000 and 450,000 enrollees.

CMS has conducted evaluations of each demonstration that assess their impact on areas such as program costs and service use. The evaluations that have been released so far typically cover the first three to five years of a demonstration. Overall, the evaluations have found that most MMP demonstrations, 7 out of 11, have increased Medicare spending. There is some evidence that the demonstrations have also increased Medicaid spending, but these findings are less conclusive because researchers have been unable to estimate the Medicaid spending effects of 6 of the 11 demonstrations due to various data limitations.

One key question about the demonstration had been

whether MMPs could achieve more desirable patterns of service use, for example, reducing the use of higher-cost services like inpatient care and nursing home stays, and expanding the use of lower-cost services like primary care and home- and community-based forms of LTSS. However, the evaluations have found mixed effects on service use, with some evidence of higher use of physician E&M services but no clear patterns for other services like emergency room visits and long nursing home stays.

Having said that, the findings from the evaluations are challenging to interpret because researchers compared the dual eligibles who are eligible for each demonstrations, whether or not they actually participated, with similar groups of dual eligibles in other states. The participation rates for many demonstrations have been lower than expected, often between 20 percent and 40 percent, making it less clear that any differences between the demonstration-eligible and comparison populations are due to the demonstration instead of other factors.

CMS announced last year that it plans to end the MMP demonstrations by the end of 2025, and will work with

states to convert those plans into D-SNPs.

That brings us to the discussion. As a reminder, this mandated report will appear as a separate informational chapter in our upcoming March 2024 report to the Congress. We'd now like to get your comments and feedback on our draft report.

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

DR. CHERNEW: Great. We're ready for Round 1.

MS. KELLEY: I think I have Stacie first.

DR. DUSETZINA: Thank you. This is a question about in the materials on Table 4, one of the things that kind of stood out to me is that the HEDIS measures looked like they were mostly only different in the MMP group, and I wondered if some of that was driven by sample size.

MR. ROLLINS: So for the HEDIS measures that we used -- and we touched on this I think briefly in the report -- they're measures that you can use based on basically administrative data, so claims, encounters, things like that, and measures where there is actually some sampling involved, where they are using a sample of medical records.

The only measures that we used in this report are based on that administrative data. So it's not a sampling per se. When you were talking about those measures, the plans are reporting information for every enrollee that they have. So in that sense, it's not a sample.

DR. DUSETZINA: Okay. Thank you.

MR. ROLLINS: But as we note, there may be reasons why MMPs perform differently than MA plans, sort of go beyond sort of sampling issues.

DR. DUSETZINA: I wonder if you're able to include at least the number of observations that are being used from the claims at the top of the table just to get some sense of the relative size of the group that's being used to poll those measures.

MR. ROLLINS: I can do that. It would approximate the total enrollment in that plan type, so for an MMP, your order of magnitude would be 400,000 enrollees.

DR. DUSETZINA: Okay.

MR. ROLLINS: Obviously not all of them are getting measured for each individual measure, but that's sort of the size of that plan population.

DR. DUSETZINA: Okay. All right. Thank you,

Eric.

MS. KELLEY: Lynn.

MS. BARR: Thank you. I have a question about the difference between partial and full benefits, and we talked about in partial, the patient pays the co-pay; in full, Medicaid pays the co-pay. But we've talked previously about Medicaid not paying the co-pay. So I'm a little confused. When it's full, is Medicaid actually paying the co-pay or the patient isn't paying the co-pay?

MR. ROLLINS: So if you're a full-benefit dual eligible, I'm going to give you an answer that's a little -- not exactly the answer to the question you ask. So, by and large, a full-benefit dual eligible is not going to be paying cost sharing. There are instances where Medicaid programs are allowed to impose nominal cost sharing on a particular service, so it might be $1, $2, $3, sort of that order of magnitude. So for certain services in certain states, you might see that. So that might be something that the actual beneficiary is expected to pay.

Separately from that is the state where it is expected to pay the cost sharing, does the state pay the full amount of the cost sharing? The states have

flexibility under Medicaid law that they can tie the amount that they are going to pay either to what Medicare's payment rate is or to what the state uses as its Medicaid payment rate for the same service. A lot of times, the states will use the lower of the two to reduce the amount they have to spend on cost sharing. It's what known as "a lesser of policy." So just as a rough numerical example, if you have a physician E&M visit and Medicare's payment rate is $100, normally the beneficiary would pay $20 of that. If you have a state that says, well, we're going to tie how much we pay for cost sharing to our Medicaid rates, in a state where it's $85, the state might pay just $5. If it's a state where the Medicaid payment rate is $70, they won't pay anything. And so obviously in a lot of cases, Medicaid's payment rates are going to be lower than what Medicare will pay; and since most states use these "lesser of" policies, the state itself is usually not paying the full amount of the cost sharing. But in those cases, the beneficiary cannot be balance billed. So essentially the provide just has to eat it.

MS. BARR: In those states, is the co-pay also reduced for the beneficiary? So if it's a partial benefit

plan, are they paying a lower co-pay or is it just the same as everyone else?

MR. ROLLINS: It's going to be whatever is governed by -- so, again, it gets into a question of what does the Medicaid program impose as co-payments.

MS. BARR: Got it.

MR. ROLLINS: But for the partial dual population, there are -- you can divide them roughly into two equal size groups. Half of them, the only help they're getting from Medicaid is the Part B premium. Other than that, they pay the same Medicare cost sharing as anybody else.

MS. BARR: Okay.

MR. ROLLINS: The other half do get assistance with both their Medicare premiums, Part A and Part B, and with their Part A and Part B cost sharing.

MS. BARR: Okay, great. Could you clarify that? Because it sounds in the thing like Medicaid's paying the co-pay and it's actually -- it's a little more complex than that.

MR. ROLLINS: Sure.

MS. BARR: Thank you.

MS. KELLEY: Brian.

DR. MILLER: Hats off on doing this highly technocratic chapter. I have a question or two which probably will reveal my ignorance, so I apologize in advance.

On page 14, the sample of 411 enrollees, do we know why that number of 411 was chosen? And if we don't know why CMS is doing that, that would be also good for us to know, because it's highly specific.

MR. ROLLINS: My understanding is that CMS determined that that was a sufficiently large sample size that the sample errors were tolerably small.

DR. MILLER: Okay. And it probably would be helpful for us to maybe note that in a footnote and cite a reg or some sort of document, because I saw that and I was very confused.

Another thing, looking at the HEDIS measures, I noted that we did do statistical testing. We should probably describe just for clarity and transparency what those statistical tests were, noting that they were or were not significant. And then my question is: Did we adjust for multiple comparisons like Bonferroni?

MR. ROLLINS: We did not do any comparisons like that.

DR. MILLER: Okay. We probably should put those in. Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Nice work, Eric. Two questions.

One, I think it was 73 to 76 percent was the general range for getting care quickly in the CAHPS. Is that correct? Then I guess the question is: Is that a good number or a bad number? And so it's a good number as long as you're not one of the 27 percent who isn't getting care quickly, I guess. But, remind me, how do those percentages compare with other data that we've seen in the past for getting care quickly, essentially? The questions are probably different in different surveys.

MR. ROLLINS: Well, if you're using CAHPS, that's a question that is asked in different versions of the CAHPS survey. Off the top of my head, I don't have sort of what the number is in other sectors, which I guess probably in this circumstance, Larry, are you asking other people in MA who are not dually eligible?

DR. CASALINO: Well, I guess I'd be interested in

other settings in which CAHPS is administered, but also in the Medicare beneficiary survey, if there is a similar enough question, it would be interesting to see what the percentages are there compared to this.

MR. ROLLINS: We can look into that.

DR. CASALINO: And for fee-for-service beneficiaries. That was the first question.

And the second and last is: Could you say -- I love the names of these different kind of D-SNPs. They're not highly revealing. But could you say a little bit more about the coordination only -- coordination only is a funny phrase in itself, but coordination would sound pretty good to me in medical care, actually. But can you say a little bit more about how these actually work and how they compare to just conventional MA plans and how they differ from conventional MA plans? Do they, for example, use prior authorization and have provider networks and so on? Just a little bit more about them, because those are by far the ones with the most numerous dual-eligible beneficiaries enrolled.

MR. ROLLINS: Sure. So generally speaking, a D-SNP is required to meet all of the requirements that every

other MA plan is required to meet, so they're not different in that sense. They do have some additional requirements. For example, like other -- all special needs plans have this. They have to have a model of care for sort of how they take care of the specific population that they serve. That has to get sort of approved. In the case of D-SNPs, they have to have a contract with the state Medicaid agency that meets certain requirements which are laid out in the mailing materials.

In terms of specifically what the coordination-only plans do, we don't have great insight into that yet. There are roughly -- I've seen some data that suggest, you know -- and it varies by state. The state can decide what is the group of high-risk beneficiaries that they would like to get this information on. In some states, that might be all of the plan's enrollees. In other cases, it might be only people who are enrolled in certain HCBS waiver programs or who have certain conditions. And so I don't think we know what impact that reporting requirement is having, and I think we said this in our comment letter when they were implementing the BBA provision that we were somewhat skeptical that it was going to do a lot, because,

you know, literally the plan is sending information to some place at the state government of person X just got admitted to the hospital or just got admitted to a skilled nursing facility.

I think we do have a great sense of sort of what, if anything, the state is doing with that information once they have it.

DR. CASALINO: More broadly, I think this is a topic that's really important, but yet a lot of people, including me, don't know that much about. And I don't know if it's possible to put in the chapter this time around or next time. But I think just more information for people, very basic, yes, these D-SNPs do what they're supposed to do, what MA plans in general do, so they do have prior authorization, they do have limited networks. But what else do they do? And how does that differ among the three types or five types or however you want to break it down?

To the extent that you can comment on that, just, you know, qualitatively, I think that would be helpful.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you for taking the deep dive, and you think the acronyms HIDE, FIDE are tough. How

about SLMB, QMB, MQBE, QI? It gets more complicated.

My question is -- or two questions. When you're looking at Table 4 with the HEDIS measures or Table 5 with the CAHPS, do you think it would make any difference or could we look at partial eligibility, partial full dual -- partial dual and then full dual? Partial dual, I mean the state is paying the Part B premium and/or if it's MQBQ, they're paying the cost sharing, getting at Len's question, or MQBE, which is a state decision usually just to pay the Part B premium, versus people who are full dual. Do we think that the responses from individuals would be different based on if they're partial or full?

And then I think you've written about this, but just to make sure I understand, so FIDE programs, you have to be full dual to be in a fully integrated plan? Is that true? Or does it not matter what level of Medicare savings program or Medicaid you're in to be a HIDE, FIDE, or coordination-only?

MR. ROLLINS: Off the top of my head, I can't immediately remember if it is a specific regulatory requirement, but at a minimum, in practice, the FIDE SNPs are just for full-benefit --

MS. UPCHURCH: They're just --

MR. ROLLINS: Yes. So to your first question, would these results differ if we just looked at full-benefit dual eligibles versus all of them, we did do that for HEDIS because that was sort of one thing we wondered about, because like in your first group, your coordination-only D-SNPs, roughly half of those enrollees are partial-benefit dual eligibles, and you have other categories like the MMPs, you have the FIDE SNPs where it's basically zero. And so we did -- we essentially ran the same results only for the full-benefit dual eligibles, and the basic story didn't change in the sense of there might be a measure or two for each plan type where they tend to do a little bit better, maybe a little worse, but we were basically left in the same place when we just looked at the full-benefit dual eligibles.

MS. UPCHURCH: Great. Maybe just write that down, let people know that that analysis was done. And maybe it was in there and I missed it. But great work. Thanks.

MR. ROLLINS: Sure.

MS. UPCHURCH: Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks, Eric, for a great chapter. I had a question on Table 5, just to make sure I understand how you did the calculations. So you're doing the comparison against an overall average, so is that an enrollment weighted average or is it a simple average of the numbers in the columns?

MR. ROLLINS: I think for this situation we used a simple average of the five plan types.

DR. DAMBERG: Okay, because you may want to think about enrollment weighting it. And building off of Larry's comment, you know, I think it would be helpful to include a column to show what the performance is on the non-duals just as another comparison point. And it would be helpful to have the overall average on the table.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks for this great work. A quick question. My understanding is that there are some states that are doing some auto assignment to D-SNPs, and I was curious if you could tell us a little bit more about that and how that relates to what we're seeing in terms of the results here and also how that may differ from what we

call "passive enrollment" for the MMPs.

MR. ROLLINS: Sure. So for D-SNPs, they are allowed to use what they call "default enrollment" in a very specific circumstance, which is people who have been on Medicaid and are becoming eligible for Medicare, either because they're turning 65 or because they've reached the end of their two-year waiting period for disability benefits. And in those cases, if you are in a Medicaid Advantage care plan offered by Company X, and Company X also offers a D-SNP product, with the state's approval, those people can be default enrolled so that when they become Medicare-eligible, they're not immediately starting in fee-for-service, they're starting in the D-SNP offered by the same company they've already been in. The argument has been that this is actually probably a way to preserve continuity of care and stability on the argument that the plans' provider networks probably look about the same across the two products, and the providers they've been seeing in their Medicaid plan are probably going to be also in the D-SNP product. So that's sort of what D-SNPs can do know. And there are numbers -- I don't have the numbers in my head. Some states are more aggressive about using that

than others, but I think it is slowly becoming a more popular option over time.

That only affects a slice of your dual-eligible population. Roughly speaking, half of the dual eligibles start out as Medicaid and then pick up Medicare; and the other, it's the reverse. And so default enrollment is only looking at the folks who have Medicaid first and then they pick up Medicare later.

For the MMPs, they could use passive enrollment more broadly, so they could also take people who had been in Medicare fee-for-service, for example, and passively enroll them in an MMP product. And we talked about this when we did a deeper dive on the financial alignment demonstration in some of our June reports. This was a very controversial feature, the demonstrations, and there were a lot of -- so they used passive enrollment, but they allowed the beneficiaries to opt out, and they could opt out either before they got -- before the enrollment in the MMPs took effect, or they could disenroll very quickly thereafter. And there was a lot of opting out and disenrollment in most of the demonstrations, and as I noted in talking about the evaluations, this is one thing that's made it hard to sort

of interpret the finding. The evaluations are dealing with demonstrations and ended up being much smaller, I think, than were initially envisioned.

DR. CASALINO: They were opting out and moving to Medicare fee-for-service? Or they're opting out and staying in the regular MA plan?

MR. ROLLINS: They could do either one.

DR. CASALINO: Do you have a sense of percentages?

MR. ROLLINS: I don't have a sense. We did site visits to a number of states. This was particularly controversial in situations where people had been in fee-for-service for many years, and my rough sense -- and it's a rough sense -- was that they were largely going back to fee-for-service.

DR. NAVATHE: Are we able to identify the beneficiaries, for example, in the states that do the default enrollment, as to whether they are default enrolled or not?

MR. ROLLINS: In theory that data does exist, yes.

DR. NAVATHE: I see.

DR. CHERNEW: That wasn't a yes or a no, by the way.

[Laughter.]

MR. ROLLINS: No, I don't think we have the data, but obviously I think CMS has to have that information to process the enrollment transaction. And there is some evidence to suggest -- I think the two states that had historically done default enrollments in a more systematic fashion were Arizona and Tennessee. And in those cases, most of the default enrollments are accepted. The beneficiary is not trying to switch out, which I think makes sense when you realize it's a much less disruptive arrangement than what you're talking about when you had some of the MMP demonstrations taking people who had been in fee-for-service for many years and were getting put in a managed care plan.

DR. NAVATHE: All right. Okay. Makes sense. So, in other words, it wouldn't be easy for us to stratify the results by something like that if it's not available to us.

MR. ROLLINS: For this report, I think that is correct.

DR. NAVATHE: Okay, thanks.

DR. CHERNEW: And that was the end of Round 1, I think.

MS. KELLEY: Gina had one last --

MS. UPCHURCH: Yeah, just a follow-on question --

DR. CHERNEW: Round 1.5

MS. UPCHURCH: -- to what Larry said. So we have any ideas -- obviously there's lots of marketing of Medicare Advantage plans in general. Do we have a sense if agents and brokers are paid more for enrolling people in D-SNPs versus regular Medicare Advantage? Say a person is eligible for one, say they have an MSP, Medicare savings program. Do we know if agents get paid more for enrolling them in these plans --

MR. ROLLINS: Versus other MA products?

MS. UPCHURCH: Versus other MA products. Or you can say versus original Medicare.

MR. ROLLINS: My understanding is that CMS does have limits on the commissions that brokers can receive. My understanding is they do not differ between regular MA products and D-SNPs. So there's that. The commissions they earn, my understanding is they will be higher for

enrolling somebody in an MA product than they would be in a Medigap plan. Obviously, for a dual-eligible population, Medigap is not much of an issue.

MS. UPCHURCH: Thanks.

DR. CHERNEW: Okay. And now we're going to Round 2, and we're going to Scott.

DR. SARRAN: Thanks, Eric. Great work. I've got three comments and one recommendation, and all of this is in the broad context of what the spirit and the promise of the SNP program or programs, broadly defined, were intended to achieve.

Comment 1. Based on my experience building population health models across MMP, dual SNPs, C-SNIPs, I-SNPs, institutional equivalent SNPs, and by population health I mean the integration of network medical management, utilization management, pharmacy program benefit design, my single biggest take-home is to achieve excellent in this space it requires, first and foremost, segmentation and focus on a specific population's needs. And one of the strong take-homes I have is that dual population is not homogeneous. There are very definite pockets of populations with very different needs and

challenges, and therefore different ways of addressing those.

Comment 2. I'm going to hone down and talk about the long-term institutionalized population specifically. But what I'm saying about that population applies to several other, you can call them sub-populations, within the broader D-SNP space, each of whom have some similar characteristics in terms of their types of needs and focus.

The institutionalized population, I think, is important because, for its population size, a million or so beneficiaries, horrible clinical outcomes versus any other population of beneficiaries, and the Medicare program is truly failing those beneficiaries as the Medicare program is executed today across both fee-for-service and MA. And you can simply look at the outcomes under COVID, which were just horrendous, look at avoidable, ambulatory care sensitive, ER visits or admission, look at quality of life measures, look at polypharmacy and problematic prescribing of inappropriate medications for geriatric population, look at end-of-life care, et cetera. Any measure you use, it's not just an opportunity for improvement. It really should be an imperative for improvement.

It's a population that's also really important because the fee-for-service program is not just unhelpful, it's just perverse, particularly in the interactions between Medicaid and Medicare funding, for so much for a beneficiary living in a long-term institution.

And it's a population to whom we should all believe -- and I do think we do all believe -- that we owe a special duty by virtue of being a population that frequently lacks advocates, that's frail, that's cognitively impaired at the end of their life. So if we don't owe a duty to that population, to whom do we owe a duty, right?

Comment 3. The SNP programs, broadly defined, really offer us, in 2023, here, the best set of solutions to address the population needs. And again, whether we're talking about institutionalized population or we're talking about other key populations, I might mention institutional equivalent, those beneficiaries living in the community but receiving the LTSS services. I could mention beneficiaries with serious mental illness. There are other populations where the same key points apply.

The SNP programs offer us our best solutions.

Why is that? First of all, there is plenty of money in the SNP program to take that money and use it to drive what we're talking about here, improved and specific clinical programs. Whether there is overfunding or not, I think it's a different discussion, but I think the key take-homes are certainly adequate funding to do really excellent work and address population needs.

And then SNP programs give us, by definition, an accountable entity in terms of how we construct -- broadly "we," not MedPAC -- we construct stars, how we oversee the requirements around models of care, how plans are audited. I mean, there are all sorts of accountability levers built in.

And last in the comment, this is exactly what we want from the SNP program, broadly defined. This is why the SNP programs were set up, is to meet specific populations' needs whose needs would not be presumed to be adequately addressed in a broad MA population, or a program.

So the recommendation. That all as background, my recommendation -- and understand we're not driving at a lot of change in this chapter -- but my recommendation as

we write next iterations is that we simply tee this up. And what I'd like to see us do is tee up, first, the heterogeneity of the populations, sub-populations, within the D-SNP program and their needs. Let's just highlight that, and there are all sorts of ways we can do that.

Let's note then, that the SNP programs do have some pockets of success that have been demonstrated. For example, there are recently well-done published studies on I-SNP programs driving improved outcomes, broadly defined, for institutionalized populations. So let's note the heterogeneity of the population. Let's note that there have been true successes in this space through the SNP programs. And then let's note that we can achieve population success either through a D-SNP entity, if that D-SNP entity includes appropriate programmatic segmentation and if the measurement and oversight of that D-SNP by CMS includes some appropriate subtypes of measures, or sub-populations' sets of measures, appropriate subtexts within the models of care around specific populations' needs.

The outcomes we're all looking to seek could be achieved within a D-SNP entity, but equally -- and I would maintain more easily achieved -- within a specific program

other than a D-SNP, a product other than D-SNP, such as an I-SNP, an institutional equivalent SNP, or a C-SNP. And again, what we would want -- and again, this is not about making a strong recommendation because I know we're not driving at that, but just to sort of highlight what I think there is good agreement on -- is we want to see key population segmentation with an understanding of key populations' needs, key programmatic execution, so they're going to be undertaken to address those populations' needs, and maybe highlight that within the context that to date we're not getting this. We're not seeing that type of segmentation and population success within the D-SNP program.

So there's lots of room for improvement. Whether that occurs in the D-SNP set of products and/or occurs via other SNP products.

MS. KELLEY: Tamara.

DR. KONETZKA: Great. I thought this was a really excellent chapter. I enjoyed it. My comments were almost exactly the same as Scott's, my list of comments, but I do want to add a few things.

First of all, one of my main points is also about

heterogeneity of this population. And I know that any issue we look at we're looking at heterogeneous populations. So it becomes hard in terms of power and stratifying, just because you could do hundreds of these stratifications.

But to me the most important distinction among the duals, that a lot of the literature follows, is to look at the younger-than-65 and older-than-65. So those who qualified for Medicare based on a disability and are also on Medicaid versus older adults.

So I think some of these programs, the effectiveness or what they are aimed at and the policies that they implement may be very different for a middle-aged adult with mental illness or substance use issues who is a dual versus an older adult with osteoporosis and dementia. And I don't know the extent to which some D-SNPs really kind of specialize or not, but I think there might certainly be heterogeneous effects, depending on how they implement their programs.

So that, to me, would be the one stratification or the one piece of heterogeneity that's really critical to look at.

The second thing. In terms of the outcome measures, I was very happy to see, at the very end of your chapter and in the slides that you're going to look at hospitalization rates because that's really just the classic issue or the classic consequence of misaligned incentives or conflicting incentives. And I say this is sort of well-known in the nursing home literature, where if somebody gets ill it's just easier to hospitalize somebody because Medicare is paying for that hospitalization if that person's stay is normally paid by Medicaid.

But it's also true in the community. We see over and over again in home and community-based populations where a lot of state Medicaid programs have expanded home and community-based care, which is great for a number of reasons, but Medicaid programs think they're saving money on this, but that's because they're not accounting for the fact that equivalent individuals in the community and getting HCBS in the community and in an institution, the people in the community get hospitalized much more often. So they're not accounting for those costs.

So when I looked at the CAHPS and the HEDIS analysis, you know, to me those outcomes didn't seem to get

centrally at the point as much as the hospitalization rates were. So I agree completely and I am really happy to see that you're going to look at hospitalization rates as well.

But about getting at this issue of what they're actually doing and the context, first of all, I agree with Scott that looking at this model, these D-SNPs, these coordination measures, is sort of the direction we should be going. It does sort of offer the best kind of solution. I often say that not just about the duals but in the long-term care world, certainly, we've been sort of going in the opposite direction of many payment policies where we're just getting more and more prescriptive and more and more prescriptive, and sort of paying for some kind of outcome or some kind of staffing level, et cetera. And I don't necessarily think that's been a success, as we saw in some of our discussions last time.

So going towards some of these models where we're going to hold somebody accountable, I think is really critical. So I'm very interested in these models and very excited to see what comes out of them.

At the same time then, my final point is what does coordination actually mean in this sense. Some of you

are asking for more context, but I think it's even a more fundamental question that that D-SNPs that are coordination-only, I wouldn't call them even coordination-only. They're lack of coordination, in a sense.

So I wasn't surprised at all to see that, whatever, that we didn't see wonderfully positive results for some of these models, even the ones that are more fully integrated. I would love to know more, and this is sort of a long-term research thing, I know, that we probably won't go into this time.

But I would like to see two things as sort of a longer-term investigation of this. One is to actually dig into what even the fully integrated ones are doing. Like if you're not aligned and you're sort of trying to coordinate across two different insurers in a program, what do they actually do and how do they try to achieve that? Do they achieve more coordination? So I'd like to know more sort of qualitatively about what they're doing in each of these cases.

And second, I'd love to move toward a sort of taxonomy of what coordination actually means, like what kinds of coordination are essential. What seems to be

working in terms of what some of these programs have implemented.

And then, finally, I'll just plus one to Scott's suggestion to look at the institutional population. I really would love to see more analysis done about I-SNPs, because I think that's really a growing population, a growing model, and one that really gets at many of the sort of cross-subsidization issues that come up in this Commission over and over again.

Thanks.

MS. KELLEY: Brian.

DR. MILLER: I really appreciate this. I'd say plus-one to all set of preceding comments. I do think that I-SNPs deserve their own focus from MedPAC. I agree with my colleagues.

A few thoughts. One, I think the important context that's missing here, which I think Cheryl hinted at earlier, was the fee-for-service duals comparison. I'd like to see that discussion in here. These populations -- and I say "these populations" because duals is multiple populations, the folks who have Medicaid who then end up aging or having a disease-specific entitlement and qualify

for Medicare, or Medicare benes who spend down their money and assets and then qualify for Medicaid -- when they remain in that sort of framing, I think if they remain in fee-for-service they have massively uncoordinated, not integrated care, which doesn't go well. They could go into a variety of programs, including the various flavors of D-SNPs, which we talked about, that the coordination-only D-SNPs might not have. That might be a name as opposed to an operating principle, which is a concern.

We should also probably enumerate some policy goals. I feel like in this chapter that might be helpful for policymakers. If we want integrated, coordinated care with population goals for the dual-eligible population it seems like HIDE or FIDE SNPs might be a better vehicle, even if in their current execution might not necessarily be meeting the goals that all of us sitting around this table want.

Risk-adjusted capitation, there are many problems with risk adjustments. Shall we say far from perfect, as we have discussed. But as a principle, having a budget paying for a population adjusted for health status with population-level goals is a good thing, I think. And I

think most of us would agree with that, that for a population like this, some of whom live in long-term care facilities, some of them, some of the patients are undomiciled, you know, high burden of chronic disease, high burden of mental health concerns, I think that we should enumerate that specific policy goal and make it clear that that's what we think and want for this population.

Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: I had four comments. Given the growing enrollment in this space, I do think we need to strengthen our ability to track performance, and to that end I would concur with the need to expand the sample sizes to allow reporting at the plan level. And I recognize this comes at a cost to the plans, but I think that cost overall is small relative to the size of spend and the payments to plans in this space.

The second point I'd like to make is as you think about the work for this cycle and in the future, I think it would be helpful to unpack variation in performance across the contracts. We know that they perform differentially. There is heterogeneity. And I think some of the plans that

serve 100 percent duals actually do better than those contracts that don't serve duals. And it would be important to not only follow up this quantitative look at heterogeneity with trying to drill down in these contracts that do especially well with these populations, to try to understand what they're doing to succeed and perform well.

The third point I'd like to make is that I do think this space could benefit from some more context, particularly around state waivers. I'm seeing this unfold in California, where they are moving all the duals into exclusively aligned plans over the next several years. And tracking sort of where that's happening and how that's going to shift enrollment, I think would be helpful.

And then lastly -- and I think this builds, to some extent, on Tamara's comments about separating the disabled from the non-disabled -- I do think there would be benefit from doing qualitative work directly with D-SNP enrollees, whether that's through a focus group or some of their mechanism, and I think that would enrich our understanding of what is and isn't working for this population.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you. Before I launch into my comments, I do want to restate that I do think D-SNPs are particularly helpful. I'm with the SHIP program, so we do insurance counseling for folks. So D-SNPs are particularly a really good product for people who have Medicare savings programs only. They're allowed to get into one of these plans, because they have much less cost sharing for the individuals, so it's better for them in that way.

So here are the comments. The coordinating-only, it really is a misuse of the words, as Tamara just pointed out. It really is a lack of coordination. So I'm wondering if a recommendation from us could be, at least on the Plan Finder tool, so those of us who are with SHIP or anybody trying to help your mother or grandmother, it would be really clear, you know, lack of coordination or whatever, FIDE/HIDE. I mean, some words to tell people what they're getting into. Are they in a plan that is truly trying to coordinate benefits between the Medicaid and the Medicare programs? Some symbol that tells us that.

Next, just referring back to our October meeting, where we heard concerns about post-acute care with rehab,

so you're in a D-SNP and you are told by the place where you're going, "We really need you out of that if you're going to get care here," so then they go back to fee-for-service, and then when they get out into the community, they may want those perks again or those extra benefits with transportation and food, so they go back to the D-SNP, and we see that. We see that a lot in the community. So I think we just need to keep an eye on that, and that's what's making it hard for you with all the data because people are in and out of plans. But I do think we need to keep them on that, because we really do put people between a rock and a hard place. They're just trying to get the care they need. They have Medicare and Medicaid, and they're just trying to get the care they need, but the institutions, you know, the systems are not set up -- these institutions are not set up to deal with the insurance that the people have.

And then the last thing I'd say, while I appreciate segmentation, in trying to help someone who's older than 65 decide between their insurance products when they have a Medicare savings program or even a full dual eligible, they do look at dental, vision, hearing. So

everything else is pretty much the same around, you know, primary care, specialists, you really have very little cost sharing, unless you're just a Medicare savings program, you may have a little cost sharing. But they look, they want to know how much dental, where can I go for the dentist, vision, and hearing aids, how much am I going to get for hearing aids. And then it's a whole new level of variables here. We've got these cash carts. This one is $320 a month. This one is $200 a quarter. This one rolls over from month to month or from quarter to quarter; this one doesn't. These are the kinds of things we spend time doing, helping people understand the cash flow that's going to come to them. And there are just too many variables to really make it a truly informed decision for people.

So while I appreciate segmentation, we have built a system, and like one insurance plan can have six D-SNPs in North Carolina alone, I know. So we need to rein it in a little bit, because it's really not consumer friendly. Thanks.

MR. ROLLINS: If I could just jump in -- and I probably should have done this after Brian's comments -- I didn't mention it in the chapter, but the Commission had a

recommendation -- I think it was in 2013. This was back at a time when the authorization for D-SNPs was temporary and they just kept extending it a few years at a time. The Commission's recommendation was that the only D-SNPs that should be continued were those with a high level of integration. And so the ones that didn't seem to really have that we thought should be discontinued.

DR. CHERNEW: If I remember, there were also recommendations on I-SNPs and C-SNPs at that time, and I think the general concern of the Commission then was there was too much segmentation to efficiently manage across these different programs, and we thought that MA plans broadly should be responsible. That might be different than some of the tone here. But I was on the Commission in 2013, but I am also old -- in part because I was on the Commission in 2013.

So, yes, there was a long history when we looked at this again about how to manage this issue. I think Eric probably knows better than I do.

MR. ROLLINS: Your memory is correct. That was particularly an issue for the C-SNPs, and concerns about, you know, and still true now, a lot of the C-SNPs focus on

conditions like diabetes or things like that. They're actually just very widely prevalent in the Medicare population, and I think the Commission's view was to simplify things a bit. You know, pretty much all Medicare Advantage plans should be good at taking care of people who have diabetes, and it's unclear that for a lot of conditions -- a C-SNP is really where you want to sort of cluster the expertise. And I think the only conditions we thought really didn't seem to have a clear need, I think it was HIV, ESRD, and I want to say behavioral health, severe mental illness.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. I enjoyed this chapter. I think it was a nice primer on dual eligibles in terms of revealing some of the structure and complexities around it. It's a good learning chapter as well. It also piques one's curiosity because when you hear terms like "coordination-only" and "fully integrated," you wonder if it's aspirational and just how fully integrated an actual plan might be.

With that being said, I just have a brief comment relative to the methodology, and I certainly think it's

quite reasonable to pull measures like HEDIS measures and CG-CAHPS measures to try to assess the different groups of dual eligibles. As with many process and clinical outcome measures in quality these days, many entities are clustering around the mean. And so all of a sudden when you're trying to apply that data across different groups or defined populations, all of a sudden, you know, the relative performance starts to lose its effectiveness and then you're kind of stuck.

So I agree with pivoting to something a little bit more different. The ambulatory care sensitive hospitalization rates I think is worthwhile looking at. And I also wanted to ask you a question to opine about that a little bit, because it's going to require pulling hospital discharge data, but also MA encounter data. And, of course, you know we've had all these conversations around encounter data and the lack of integrity, sometimes missing, you know, data around the encounter.

I was curious. In this particular population of dual eligibles, do you think that the data will be better and it will help you to be able to get what you need to be able to differentiate the different dual eligibles in a

much more optimal way?

MR. ROLLINS: I don't know that in this case the encounters for dual eligibles are more complete than they are for MA enrollees who are not dually eligible. In the specific case, we think that the combination of the inpatient information that's on the encounter data can be supplemented with the MEDPAR discharge data, and between the two, we think we can get a reasonably complete picture of sort of what's going on with inpatient stays.

DR. CHERRY: Great. And it will be interesting seeing the next iteration of this. Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Eric, thanks for this great work, certainly very important, certainly very complicated, and I think you've done a very nice job of synthesizing a lot of material into something that we could digest in advance of this meeting.

I had just a couple of thoughts. I think it seems a lot of these comparisons are challenging because there's heterogeneity in the population, as many other Commissioners have pointed out. And so I guess very generally speaking I would support the idea that we would

want to place a little bit more context, to the extent that we could, you know, relative to the non-duals, almost to some extent in the parent plan, the same parent plan for the D-SNP, to the extent that there is one, or in the context of fee-for-service, although I think that potentially has some other challenges. But, nonetheless, I think we need a little more contextual comparisons, I think, to really understand what might be going on here. And it strikes me that the outcome measures that we're looking at are perhaps a little too narrow in some sense because where we're seeing a lot of the -- the activity of the coordination is really on the LTSS, you know, HCBS side. And so the question is: How is that going to wrap in? That's why I was to some extent asking for comparisons relative to clinically apparent MA plan, because perhaps we're likely to see much more variation on the Medicaid services side, and the question is: How does that create benefit on the Medicare Part A/Part B services side?

I agree with others that it's going to be very interesting to see what you find on the hospitalization side because perhaps that is a more summative measure that's kind of capturing some of the interaction between

those two sets of services.

I know we typically haven't looked at Medicaid data, but I think it would be also interesting to see -- to the extent that we could do something like that, you know, look at some of the T-MSIS data on the Medicaid side to see what that might be able to tell us also happening on the Medicaid benefit side of things, without making, obviously, an overly expansive effort, that might be difficult to do.

So, overall, great work. I'm really looking forward to future work in this space, and hopefully by broadening the outcomes that we look at, we can get at more meaningful outcomes relative to where the variation truly is between the different types of D-SNPs.

MS. KELLEY: Lynn.

MS. BARR: Thank you so much. This has been a great discussion. I've learned a lot from this.

I just want to plus-one on a few things. I think the segmentation is critical. When all the data looks the same -- right? -- with everyone saying, well, these uncoordinated plans are just as good as these fully coordinated plans, the HIDEs and FIDEs and the N-IDEs, they're all the same, there's something wrong. I don't

know what those segments are, but it sounds like disabled, LTSS, behavioral/mental health might be just three broad buckets that we could classify people based on DRGs -- or based on diagnosis, and see if that vagueness continues in -- to talk about like enrollment of patients in plans, I want to know which MA plan is best at LTSS because that's who I am. I don't really care that, you know, you're really good at chronic disease management, because that's not really what I care about, you know. So I think the segmentation will really help the consumer.

And then the segments, I plus-one on the segment specific quality measures. Give me one or two things that are really important to that population, and then I can better understand who I should enroll where and where to send Grandma. And I love the idea of comparing to fee-for-service because -- and, again, you know, segmented, that may also tell us that we're spending a whole bunch of money and we're not actually getting anything, you know, and that we need a different approach that's more like a fee-for-service approach. I don't know.

And then in terms of outcome measures, certainly, you know, we talked about ambulatory sensitive conditions.

It seems like ED utilization almost crosses all of these and would be like the number one thing I would want to look at, is how often are these people going to the emergency room, and are we reducing that because that's where most of these people wind up if they're not well cared for.

Thank you very much for your great work.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. Great work and great comments from the Commissioners. I don't have anything to your already terrific remarks except for one thing. I just wanted to underscore Cheryl's excellent suggestion of qualitative interviews for D-SNP beneficiaries, and also add that it should include families as well, because they're often in so many ways bearing a lot of the impact. So I would say beneficiaries and their families.

Thank you.

DR. CHERNEW: Okay. So let me start my summary by saying thank you to Eric. This is really an outstanding body of work, and I can say with some confidence it will be continued. I have a few broad themes that at least I'd like to raise from this discussion and thank the Commissioners for all their comments.

The first one is there seems to be a disconnect sometimes between the promise and the execution, a lot of concern about how we deal with the execution of this, and the challenge is whether the failure of execution is something that we can really solve in a regulatory oversight framework, or if like many things it is just hard to micromanage. I think we will continue to monitor it, but it is a theme that I think is constantly important.

I think this point about the institutional population is an extremely important one in where we're going, and I think we will be spending a lot of time separately on how we think about what to do with the institutionalized population.

There's a number of measurement issues that arise in this conversation. I won't recap them all, but I think without belaboring them, they include things like the quality of the measures. I think a bigger issue is the overlap in the distribution across these things. So if you had like a plan-specific thing, is it really the plan type or is it just your execution within your plan type that matters? And so we need to think about that broad level of heterogeneity, not just across plans, which is what I was

just referring to, but also across beneficiaries, and because beneficiaries are complex in terms of their diseases and in terms of if they're institutionalized or not and, you know, functional status issues, it's just very hard to get to this level of targeting.

We certainly, I think, can think through, even if we didn't have a very segmented program, some more segmented measurement, but I think this is such a complicated -- it's a very complicated population, a very important population, a very complicated program in and of itself, a very complicated institutional setup between the program and, say, other programs that these people have, very complicated interaction between social needs and other needs. You know, it's just a lot.

And so we'll continue to monitor this the way we can in our standard MedPAC ways. We will continue to refine what we can say. Right now we're not looking towards big versions of grand reforming of how the SNP program works, and certainly how the SNP program works within the broader context of bigger MA. But as you all know; we are looking at bigger context of broader MA. So, with luck, we can both support the design of the program

that helps these beneficiaries get as much advantage as they can from what plans can provide, and we could help build a measurement and hopefully a policy framework around it. But we're going to be doing that -- that is a longer-run both measurement and policy development activity that we're going to have to undertake.

So Scott wants to say one more thing, and so, Scott, go ahead. And then I'm going to finish up.

DR. SARRAN: I appreciate a lot of excellent discussions, and it helped me in my own mind, I think, better organize some thoughts.

I think we might end perhaps on this comment around the need for a finite number of segmentations within the broad dual population as being key. And I don't know that we need to specify what those are. Simplistically they might be long-term care living, long-term eligible but community living/LTSS receiving/disabled, perhaps could lump SMI, housing unstable, substance use disorder into one, and then everybody else. That might be the simplest, but the point is people could refine the segmentation and keep the number of segments fairly finite.

And then the concept that it would seem to me

pretty low-hanging fruit for CMS to require that plans that are filing as D-SNPs and wanting to serve rather than potentially exclude some of those populations should address in their model of care their specific clinical programs to meet those populations' needs, speaking to a network medical management, utilization management, pharmacy and benefits, to meet those populations' needs; and that there be a very small number -- no more than three; ideally one or two -- outcomes, not process but outcomes measures that reflect those populations' specific current problematic outcomes. Perhaps that's a good way we could end up.

DR. CHERNEW: Thumbs up.

So that's actually quite consistent with this whole other body of work we think through about quality measurement, writ large. You know, we have a lot of challenges with quality measurement that pervades almost everything we do, and we struggle with how to do it. It is probably true that this is a particularly challenging population to measure quality in, but the principles you just laid out I think are not that different than the principles that were laid out actually before I became

Chair.

In any case, there's a lot to do, much more than you're going to see when this particular chapter moves ahead, so luckily, we will do them every two years. This is a much longer range, so don't expect you're going to see all of it done this cycle, but this has been very helpful.

I will say to those folks listening at home, please don't hesitate to give us your feedback on this session or the previous one on rural emergency hospitals. You can reach us at Meetingcomments@medpac.gov. You can go to our website and otherwise leave comments. But we do want to hear from those of you at home about your reactions to this.

And with that said, I will again thank Eric for his excellent work on this chapter. We are going to take lunch and we will be back I believe, if I have this right -- we will be back at 2:15 to talk about our work on hospice.

So, again, thank you all. We'll be back soon.

[Whereupon, at 12:57 p.m., the meeting was recessed, to reconvene at 2:15 p.m. this same day.]

AFTERNOON SESSION

[2:17 p.m.]

DR. CHERNEW: Welcome back. Thanks to you at home for joining us. We are going to start this afternoon with an overview of our work on hospice. Hospice remains a very important, although sometimes controversial, aspect, this implementation of hospice in the Medicare program. So we have a work plan about a range of things we are going to do, and I'm going to turn it over to Eric to outline that.

MR. ROLLINS: And I should just be clear, I am simply reading on Kim's behalf. Good afternoon. The audience can download a pdf of the slides on the right-hand side of the screen.

Today, we are going to discuss the hospice work plan for the upcoming cycle and beyond. Today's session will have 3 parts: first, background on hospice; then we'll discuss the work plan for four current or new projects; and then we'll conclude with Commissioner's discussion and questions.

First, background on hospice. The Medicare hospice benefit provides palliative and supportive services for terminally ill beneficiaries who choose to enroll. To

be eligible, beneficiaries must have life expectancy of 6 months or less if the disease runs its normal course. A physician must certify that a beneficiary initially meets this criterion and then must recertify their eligibility periodically. There is no limit on how long a beneficiary can be in hospice as long as they meet this criterion.

Another requirement of hospice is that the beneficiary agrees to forgo conventional care for the terminal illness and related condition outside of hospice.

Next, we have background on the hospice payment system. A couple points. Medicare pays a daily rate for hospice regardless of whether services are furnished on a particular day. There are four levels of care. For routine home care, the predominant level of care, Medicare pays a higher per diem rate for the first 60 days and a lower rate for days 61 and beyond.

There are three other levels of care -- general inpatient care, continuous home care, and inpatient respite care -- that are paid higher daily rates. There is an aggregate cap on the total payments a provider can receive which we'll discuss later.

Here's a snapshot of hospice in 2021. You've

seen these figures before. We will be updating them to 2022 at the December meeting. In 2021, about 1.7 million beneficiaries, including 47 percent of decedents, received hospice services.

Among hospice decedents, length of stay was 17 days at median and 92 days at the average, reflecting that many beneficiaries have short stays and some have long stays. Hospice patients received an average of 3.8 visits per week from hospice staff, with a portion of that total accounted for by nurse, aide, and social worker visits. Medicare paid hospice providers $23 billion in 2021.

The next slide summarizes the hospice work plan over the next 18 months including four current or new projects. We will walk through each separately.

The first project is examining the effect of hospice on net Medicare spending. The most important benefit of hospice is its effect on patient care. Hospice offers terminally ill beneficiaries the option to receive end-of-life care focused on symptom management and to die at home or in another location based on their preferences.

When the hospice benefit was enacted, it was also thought that it would reduce net Medicare spending.

Hospice's effect on net Medicare spending is influenced by many factors.

It depends on what spending would be in the absence of hospice, which generally varies by terminal condition and increases the closer one gets to the end of life. It also depends on the timing of a beneficiaries admission to hospice and their length of stay in hospice.

You might wonder how the issue of hospice's effect on net aggregate Medicare spending fits into MedPAC's work. It is important to note that it does not factor into our assessment of beneficiary access to care and the adequacy of hospice payment rates that we do each December and January for the March report. Instead, it is a topic of general interest to policymakers, researchers, and stakeholders, so our work here is intended to contribute to that knowledge base.

Over the last couple decades, there have been a number of studies looking at the effect on hospice on net Medicare spending. The literature findings are mixed and partly vary depending on the methodology used. And there are a number of methodological challenges in trying to isolate the effect of hospice on net Medicare spending,

which we could talk more about on question.

In 2015, the Commission sponsored a contractor report to review the literature and do additional analysis. The 2015 study concluded that hospice did not reduce net Medicare spending in aggregate. More specifically, the study concluded that hospice likely saved for some beneficiaries -- for example, those with cancer -- but it did not appear to reduce aggregate net Medicare spending due to long stays among some noncancer patients.

Since that study, several additional studies have been conducted with varied results. Here are some examples to illustrate the varied literature, this not an exhaustive list. A recent working paper found that for profit hospice enrollment led to large savings for some beneficiaries with dementia. A recent industry-sponsored study reported hospice saved 3 percent in the last year of life, with savings for long stays across all diagnoses.

In contrast, some other studies show more mixed results. For example, several studies looking at spending in the last 6 or 12 months of life found hospice was associated with higher Medicare spending or no difference in Medicare for beneficiaries with dementia; lower Medicare

spending for beneficiaries with cancer; higher spending for beneficiaries with non-cancer diagnoses and stays exceeding 30 days; and higher spending for beneficiaries residing in nursing facilities.

Given the mixed picture in the recent literature, the Commission has decided to take a fresh at this issue and update its 2015 research. We've contracted with the Urban Institute to study this issue. The Urban Institute's study will include a literature review and assessment of methodological approaches and challenges and new data analysis with multiple methodologies, using recent data through 2019, and including Part D spending. Results from this work are expected in fall of 2024

Moving to the 2nd project. this is ongoing work related to the hospice aggregate cap. The cap limits annual aggregate payments to a hospice provider. This is not a patient-level limit. It applies to a provider's total payments across all patients. Hospices that exceed the aggregate cap have to pay the overage back to Medicare.

We have found that hospices that exceed the cap have long lengths of stay and high margins before application of the cap. Each year since March 2020, as

part of the annual update recommendation, the Commission has recommended that the cap be wage adjusted and reduced by 20 percent. The intent of this recommendation has been to make the cap more equitable across providers and focus payment reductions on providers with the longest stays and high margins.

We have a current project underway looking at the hospice cap and whether it affects patient outcomes. In particular, we are looking at admissions, discharge, and mortality patterns by type of patient across the cap year and across providers. Previously, we have looked at hospice length of stay and live discharge patterns, and like others, we have found that hospices that exceed the cap have long stays and high live discharge rates.

We are now conducting analyses of mortality rate data to see how mortality rates vary across providers. This work is partly in response to a recent working paper that reported a 2-percentage point increase in hospice patients' likelihood of death in the next year due to cap pressure. So we are conducting our own analyses of mortality rate data, and we will report back what we find.

The next ongoing project relates to uses --

[Fire alarm interruption.]

DR. CHERNEW: For those at home we've had a fire alarm, which now seems to have stopped, and we are checking on the status. But for now, I think, Eric, go ahead and we will adjust as we learn more information.

MR. ROLLINS: Okay. The next ongoing project relates to use of Medicare services outside the hospice benefit while beneficiaries are enrolled in hospice. Medicare payments to hospices are intended to cover all care for palliation and management of the terminal condition and related conditions.

Services for unrelated diagnoses are covered by fee-for-service Medicare or Part D.

CMS has not generally defined related versus unrelated services, but CMS has said it expects virtually all care needed by a terminally ill hospice patient would be provided by the hospice.

According to CMS, the Medicare program spent about $1.4 billion on nonhospice services for beneficiaries enrolled in hospice in 2022, and beneficiary cost sharing for those services was about $200 million. In addition, in our work, we've shown that the amount of nonhospice

spending varies across hospice providers.

Over the last year, a contractor and MedPAC staff conducted interviews with 12 hospice providers on the topic of nonhospice service use and spending for hospice enrollees. The providers we interviewed varied by size, geographic location and ownership type.

We discussed a range of issues as shown on the slide. For example, how hospices determine whether a service is related or unrelated to the terminal condition; factors that contribute to nonhospice service use for hospice enrollees. We also asked about the effect of CMS's new addendum policy that requires hospices to provide beneficiaries and families with a list of services the hospice considers unrelated and outside the hospice benefit if they request it

This next slide highlights a few of the key points that came out of the interviews. A number of factors appear to contribute to service use outside the hospice benefit for beneficiaries enrolled in hospice. For example, policy guidance on this topic is broad and the determination of what services meet CMS's criteria for related versus unrelated for a particular patient is

determined by the hospice clinician. We heard across providers mostly general agreement on what related versus unrelated means at a high level, but heard differences in across providers in how the policy was interpreted in some specific circumstances.

We also heard from hospices that there are logistical or technological barriers that sometimes contribute to spending outside the benefit.

In terms of the effect of the new addendum policy, the providers we talked with perceived that it had little impact on service use outside the benefit, reporting few requests for the addendum from beneficiaries or families.

We will include a more detailed discussion of the interviews in your December mailing materials.

Moving to the final item in the work plan. This is a new project to look at hospice and end-of-life care for beneficiaries with end stage renal disease. Beneficiaries who have ESRD are much less likely to use hospice at the end of life than other beneficiaries. In 2021, 28 percent of decedents with ESRD used hospice compared with 47 percent of all Medicare decedents.

In this year's hospice proposed rule, CMS indicated that they have heard anecdotal reports from beneficiaries and families that they believe Medicare does not permit dialysis once a beneficiary elects hospice. Some researchers and stakeholders have pointed to concern about terminating dialysis as one of the factors that may contribute to lower hospice uptake among beneficiaries with ESRD.

CMS indicated that dialysis would be covered under the hospice benefit for a particular patient if the hospice interdisciplinary group determined that dialysis was beneficial for that patient's symptom control. In that case, the cost of dialysis would be the responsibility of the hospice.

Given the lower rates of hospice use among decedents with ESRD, we are planning a new project to examine access end-of-life care for beneficiaries with ESRD. This would include aa literature review, interviews with clinicians, hospice providers, ESRD facilities, including programs that provide kidney palliative care, and we'd also take a deeper dive into the data to look at use of hospice among decedents with ESRD and characteristics of

patients, ESRD providers, and hospices. Based on what we find from this work, we could consider whether there are implications for beneficiaries' access to care and Medicare payment policy.

So, this brings us to the end of the presentation. In terms of next steps, your December mailing materials will have a summary of information from the interviews on nonhospice spending for beneficiaries in hospice and we plan to include that discussion in the March report chapter.

In terms of your discussion today, we welcome any questions on the projects in the work plan, or any feedback on the projects or other issues related to the work plan we should be considering.

DR. CHERNEW: Great job. Thanks, Eric. And now we're going to go to Round 1, and I think we're going to start with Gina, and I think, Kim, you're going to field the questions, so we're good. Gina.

MS. UPCHURCH: Thank you so much for this work. Obviously, hospice is a critical part of Medicare and does so much for Medicare beneficiaries and their families.

I just don't know this. What is the difference

between routine home care and continuous home care, because I didn't even think there was continuous home care. That's the first question.

MS. NEUMAN: Continuous home care is a special level of care that is used to manage a symptom crisis in the home, and to qualify as continuous home care and be paid at that rate there needs to be 8 hours of care in the home from hospice staff over a 24-hour period, and at least half of that has to have been provided by a nurse.

MS. UPCHURCH: Okay, great. Thank you. So my next question is, individuals with dementia, do we know if there is a hesitation with enrolling people in hospice with dementia, or more likely? Any sense of that, people with dementia? Are there different regulations for enrolling them or is it still that same regulations of less than six months?

MS. NEUMAN: It is the same regulations across all diagnoses, so prognosis of six months or less if the disease runs its normal course.

MS. UPCHURCH: Okay. And this is the last question. Because people can be enrolled, you've got the 90-day period, the 90 days and 60 days for recertification,

what's the incentive for a provider to doing a live discharge? I mean, I guess they're just saying they have less than six months to live. Do you find that happens much with people with dementia, or are they more likely to stay in the program?

MS. NEUMAN: Beneficiaries with dementia have a higher live discharge rate than the average hospice patient. There are a variety of reasons for live discharge that can occur. One is because the patient is determined to not meet the terminal prognosis criteria anymore. So that can be a reason why a beneficiary with dementia or a beneficiary with another condition who has wound up to have a quite long stay might have a live discharge.

There are other reasons as well. Beneficiaries may choose to revoke hospice. They may move out of area. They may transfer hospices. So there are multiple reasons, but prognosis would be a big component of the reason why we see that higher live discharge rate.

MS. UPCHURCH: Thanks for all those clarifications.

MS. KELLEY: Tamara.

DR. KONETZKA: So the spending caps seems to be a

really blunt instrument for cost containment, so I guess the question is do you know what the motivation was for instituting the spending cap as opposed to some other measure for cost containment. And the hospices that have met the spending cap, do they tend to have very different mix of diagnoses? Is the fact that they have these very long lengths of stay because they have more patients with dementia, for example, where the prognosis is less certain, or could there be some other way to address differences among patients that might make some patients under the current system lead to much higher spending?

Sorry. That's a roundabout way of saying that, but basically what was the motivation for the spending cap versus a lot of other things one might think of to sort of contain costs?

MS. NEUMAN: The spending cap was implemented when the benefit was enacted back in 1983, and it was, from what I understand, intended as a way to help ensure that the legislation did not lead to additional costs. So it was put in as a possible mechanism to control the total spending on hospice.

In terms of hospices that exceed the cap, you

asked about their diagnosis profile and their length of stay. Hospices that exceed the cap do have more patients who have diagnoses that tend to have longer stays. However, when you look within those diagnoses, they have much longer stays than other hospices. So among patients with COPD or heart failure or dementia, if you focus on that group, they will still have quite a bit longer stays than other hospices.

MS. KELLEY: Larry.

DR. CASALINO: I have a few questions. When I say "a few" rather than give the exact number, that's probably a bad sign -- not that I have a lot, but it just shows I may not be that clear.

So is it the case, Kim, that the hospice gets to decide whether a patient is eligible for hospice; is that correct?

MS. NEUMAN: When a patient first enters hospice, two physicians certify their eligibility usually: the patient's regular physician and then the hospice physician. After the first benefit period, then only the hospice physician certifies their eligibility.

DR. CASALINO: And if the hospice physician says

no the first time around, that's it, at least for that hospice. Is that correct?

MS. NEUMAN: I would assume that the hospice would not enroll the patient. I think it's hard to say about whether they would have a conversation about the patient is not eligible yet, but they may be in the future; in certain circumstances, you could come back to us. So I think it's hard to say what would happen if the hospice physician initially thought, no, the patient wasn't eligible.

DR. CASALINO: Is it fair to say, though, that hospices to some extent get to select their patients through this mechanism?

MS. NEUMAN: Hospices can select which types of patients that they enroll in certain ways; for example, there are certain settings of care where there tends to be patients with different kinds of diagnosis profiles or lengths of stay, so assisted living facilities versus referrals from a cancer oncologist. So by the way that you reach out to those in the community for referrals, there is the potential to focus on certain types of populations.

DR. CASALINO: But it's also the hospice

physician's decision a little bit about whether this cancer patient is eligible versus that dementia patient? I don't want to put words in your mouth, but that's true; is that correct?

MS. NEUMAN: The hospice physician would review the case to determine whether they thought the patient met eligibility criteria.

DR. CASALINO: So is there any attempt in the studies on hospice to account for the fact that there could be selection? I mean, we talk a lot about selection in MA plans, which is partly because MA plans arrange it that way and partly for other reasons. But is there any attempt with hospice to adjust for the fact that hospices have some degree of control over which patients they'll have?

MS. NEUMAN: Do you means in terms of how we pay the hospices?

DR. CASALINO: Studies of hospice -- like, for example, if you want to know if the hospice benefit is saving Medicare money, and one doesn't account for selection, that could be an issue. That's why I'm asking if there are attempts to adjust for that.

MS. NEUMAN: Right. So studies that are looking

at sort of the net effect of hospice on Medicare spending generally do try to control for different kinds of patients. They try to, to the extent possible, control for other kinds of characteristics that might influence spending that aren't related to hospice. It's not -- it's tricky, but they try to control for these different things, yes.

DR. CASALINO: One thing, just a suggestion for the chapter, I think this has been in earlier work that the Commission has published on hospice, but it's less clear on this one. Maybe be more explicit about which diagnoses can be more profitable for hospices and why. Basically you want people who are going to be long stay and not require much care for most of their time, like dementia patients. So we've said that before, I think, in other chapters, but it would probably be helpful in this chapter to just point that out.

My other question is: Why don't we -- if I'm understanding this properly, so ESRD patients, if they continue on dialysis while they're on hospice, the hospice has to pay for their dialysis? Is that right?

MS. NEUMAN: So if the dialysis is for symptom

control and the patient's primary terminal diagnosis is end-stage renal disease, then, yes, then it would fall under the hospice benefit, and the hospice would -- if the dialysis was provided to the hospice beneficiary, it would fall under the hospice benefit, and the hospice would bear the cost.

There are some beneficiaries who have a different hospice diagnosis that's not end-stage renal disease, something very separate, and in that case there are some beneficiaries for whom Medicare does pay for the dialysis as being unrelated.

DR. CASALINO: Why would a hospice ever take a beneficiary where the hospice is going to have to pay for the dialysis?

MS. NEUMAN: So we do hear anecdotal reports of concerns about the hospice per diem and whether it -- you know, how it matches up to what the cost of dialysis might be.

DR. CASALINO: Okay. Thank you. I guess just one other point. You mentioned that beneficiaries may believe that they're not eligible for hospice if they're on dialysis, and that's an important point, I think. But the

other side of the coin would be it may not just be the beneficiaries aren't enrolling in hospice because they don't think they're eligible, but the hospices may not want them if indeed the cost of dialysis is substantial compared to the per diem that they're getting. I'm sorry. Was that clear?

MS. NEUMAN: Yes.

DR. CASALINO: Okay. Thanks. Really interesting chapter, by the way.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you for the very clean, crisp presentation here. I'm probably like a lot of people; you know, I struggle with the unrelated non-hospice care and clinical services as well. In my mind, you know, someone in hospice, broadly speaking, are provided clinical services that fall into two categories: there's palliation of symptoms and then there's comfort. And so for someone that may have an expected -- expected to live four to six months, for example, dialysis, depending on the goals of care with the patient and family may, in fact, be appropriate, even if it's unrelated to the primary diagnosis that they're there because it provides some

degree of comfort.

So I was wondering, other than dialysis, just so I can get my mind wrapped around it a little bit, do you have a couple other examples of what is considered an unrelated non-hospice clinical service? Just out of curiosity.

MS. NEUMAN: Sure. So I can talk from some of the interviews that we had, some categories of services that hospice providers said are commonly unrelated, things like: medication for glaucoma, maybe a macular degeneration, some kind of a thyroid issue that's been lifelong. There are a couple of examples.

I can give you the flip side, the things that they said are harder to figure out. There was a difference of opinion on insulin, whether insulin is related or unrelated amongst people we talked to.

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

MS. KELLEY: Greg.

MR. POULSEN: Let me go first to -- because we had the same discussion actually. I checked with a couple of our hospice people, and the ones that came up were hemophilia drugs, which can be extraordinarily expensive,

as you all know; antiseizure medication, antipsychotics were ones that came up all the time as being tricky issues that related to that. And I actually was going to bring that one up, but also, interestingly, related to Robert, there was a study 15 years ago, I think, that looked at the longevity of people on hospice, interestingly, at UCLA and Intermountain. And what they found is that people on hospice tended, with similar going-in diagnosis, to live a little longer than the population that didn't go on hospice, which was counterintuitive, that we weren't -- what it implies is that we were in some ways doing more harm than good when we were treating people aggressively.

But, anyway, my question was related to those outside of the hospice issues, so I think you already answered it. Thanks.

MS. KELLEY: Brian.

DR. MILLER: Thank you for picking up this hot potato topic that probably makes all of us nervous when we talk about it due to the many unpleasant questions that hospice brings, along with us reminded of our own mortality.

I have a simple technical question. On Slide 10,

there was a mention of margin and some numbers. How did we compute that margin?

MS. NEUMAN: So every December we calculate the Medicare margin using data from the cost reports and the claims. And so we estimate Medicare costs and Medicare payments, and then we calculate the aggregate Medicare margin.

DR. MILLER: Gotcha. Thank you.

DR. CHERNEW: And, Kim, real quick. That margin also accounts for the effect of the cap; is that correct?

MS. NEUMAN: We net out the effect of the cap, and then for hospices that exceed the cap, we display their margin before and after the application of the cap.

MS. KELLEY: Cheryl.

DR. DAMBERG: I had another question on the non-hospice spending. I understand you did the interviews, but can you remind me, did you actually look at the claims data to see what types of services were being used?

MS. NEUMAN: So we did some claims analysis in our 2022 report, and what that showed -- it's a little bit old, though; it's 2018 data. But it's consistent with what CMS has recently published for a more recent period. It

shows that Part D is a big chunk, not quite half but almost half. And then on the Part A and B side, a lot of it is physician office, some hospital outpatient. There's inpatient spending, but it's not the majority, not so much home health, not a lot of SNF, more DME. Those are sort of the buckets.

MS. KELLEY: I think that's the end of Round 1 unless I've missed someone.

DR. CHERNEW: Jaewon.

MS. KELLEY: I'm sorry?

DR. CHERNEW: Jaewon had a late-breaking question.

DR. RYU: Yeah, just a real quick one. Also on the non-hospice spending, you gave some examples around the drugs. So insulin, if you'd just play out that example, would ER visits -- services associated with that also be non-hospice spend in the case of -- let's say they're in hospice for some other diagnosis, but you've got whether it's macular degeneration or some other disease, hemophilia, that lands you in the ER. Are the services also non-hospice spend?

MS. NEUMAN: So if the condition is considered

unrelated, then likely the services associated with it would also be unrelated. It depends on how it's coded and so forth, but, by and large, I would say it's likely that they would also -- if the drug is unrelated -- administration of the drug would be unrelated, that kind of thing, or getting an emergency service for that unrelated thing.

DR. CASALINO: A question on this point. Kim, how does it actually work operationally? I should know this, but I really don't. A lot of hospice patients I think can have lots of things wrong with them, and there are many kinds of things that could be considered related or unrelated. But if you're the patient and you're thinking about going to the emergency room or whether to get another round of your glaucoma drops or treatment for macular degeneration, your injections, how do you know in advance whether you're going to have to have at least a co-pay on this or it will be part of your hospice benefit?

MS. NEUMAN: So when a person enters hospice, there will be an intake process where the hospice will go through with the patient, you know, the medicines that they're taking and to the best of their knowledge the other

kinds of treatments that they may be getting. And so in that process, there would typically be a discussion about sort of this is what is under the hospice benefit and potentially these other things fall outside.

Now, there's a lot going on at that time when someone is coming into hospice, and the extent to which these things all get discussed in detail may vary. CMS created a new policy about an addendum where beneficiaries and their families can request a list of what the hospice considers unrelated, and so outside the benefit, potentially with a co-pay if they get it outside. And thus far it seems like beneficiaries and families are not requesting the addendum. So, you know, the extent to which that's clarifying things for beneficiaries is really uncertain.

DR. CASALINO: You mentioned this in the chapter, but moving from the patient to the physician or the hospital, how do you have a clue where to send the bill, whether the bill's Medicare or commercial insurer or hospice, for care that you've just provided?

MS. NEUMAN: So we talk to hospice providers about this a lot as sort of the coordination with other

providers, and hospices told us that they do a number of things to try to proactively inform providers of a beneficiary's status in hospice, and so they may send lists to providers. They've told us they have mixed success with that. Right? Providers get lots of paper, so there's -- you know, that's a challenging situation.

Beneficiaries also -- some providers tell us they give them a little card to present when they go to another practitioner, so they recognize that they're in hospice.

So there are multiple different ways that they try to communicate this sort of fill that gap, but I think that this is one of the issues that makes this challenging, is that the health care system has many diverse providers that beneficiaries have dealt with in the past, and hospices educate their patients about sort of calling the hospice first and so on and so forth. But, you know, things may not always happen as planned.

DR. CASALINO: And how does Medicare decide whether to pay a claim or not?

MS. NEUMAN: So in the billing system, there will be an edit that someone's in hospice, and so then certain claims can get kicked out if there's not a certain modifier

on the claim. So in that way, sometimes that can bring it full circle, and the provider will realize that, oh, this patient was in hospice, if maybe they hadn't realized up front. You know, if these other methods of communication hadn't resulted in them realizing it, it might come around on the back end that way through the claim.

DR. CASALINO: And if hospice wanted to pay them, will they pay the Medicare rate?

MS. NEUMAN: So we asked hospices about what they do in situations where they're responsible for services that are provided by other providers, and we heard -- for those who we asked, most of them said they default to the Medicare rate.

DR. CHERNEW: And now we're going to be really onto Round 2, so I do just want to emphasize, you can obviously say any comments you want about hospice in Round 2. The purpose of the session, which was shorter in part because of the purpose, is really about the work plan as opposed to hospice policy or how hospice works. And so we've outlined a set of issues. So we have about half an hour. Lynn.

MS. BARR: I see this as really a Round 1

question, so I'm kind of messing everything up.

So what percentage of Medicare beneficiaries today have less than two weeks in hospice?

MS. NEUMAN: The median length of stay is 17 days, so more than half.

MS. BARR: More than half.

MS. NEUMAN: A little less than half.

MS. BARR: A little less than half. So I think, you know, one of the things that really strikes me about this data is the initial assumption is this doesn't really change Medicare spending, but nobody actually goes into hospice until it's way too late. And so it can't affect spending. And so this seems to me a bit of a circulate argument, and I'm wondering -- and I had experience with hospice personally with my husband when he had cancer, and he was in there for a week. You know, it did us absolutely no good whatsoever. It was just an expense.

And so I'm wondering, is there anything -- this is on the policy. First of all, when we do the analysis, we should only be looking at people that are in hospice for a reasonable period of time because we can't expect to affect Medicare spending in a week, right? I mean, it's

just -- and so many of them go in there, so I'd love to see an analysis that really takes a look at long term versus short term because it's such a mess in the data. And then from a policy perspective, is there any way to think about, you know, how do we incentivize people to start earlier in hospice? And one of the things I was thinking about with ESRD is all these patients that are getting ESRD in the last month of life for the first time -- right? -- is there -- you know, can you somehow have a requirement that they're offered hospice, you know, as an adjunct? I think these things are all tied together and that they're going to be missed in the data because of sort of the short-term nature. Thank you.

DR. DAMBERG: I'm really glad that Lynn went before me because that was an excellent point about going through time. And also just kind of piling onto that, when thinking about the unrelated spending that we've gotten so many questions on, I think that is super important, but probably for those longer hospice stay groups. So I wonder if it is really focusing on that subset and thinking about their spending in the future stream of work.

And also, if there's any trend in the unrelated

spending among that group. So it sounds like there are some services people are aware of, high-cost drugs and things like that, that might be in that pocket. But it would be interesting to know if we saw changes over time and what's comprising those services.

This is probably just because tomorrow's agenda, when I read this is pay-for and fee-for-service, everybody in MA looks over and has fee-for-service pick up the tab, I don't know whether -- like I could imagine scenarios where that might incentivize a faster move to hospice for people who are enrolled in MA. Maybe slower. I don't know. And I wonder if there's any work at all on differences among people who were previously in MA about the timing of their entry into hospice, like how long do they stay, did they get transitioned over earlier? And especially for people who are using very high-cost services.

So that would just be maybe either a request to put a little bit more content in about why were we doing that, why does MA move everybody into fee-for-service for this, from a history perspective but also some of the timing around enrollment and length of stay would be great by MA, people who were in MA before and then transitioned.

MS. NEUMAN: So if I could comment really briefly. The Commission has a recommendation going back to 2013, 2014, that hospice be included in the MA benefits package, and now the VBID models have a hospice component. So there is some testing going in that area.

We have looked at patterns of MA hospice use compared to fee-for-service hospice use, and there are small differences, but it's not dramatic. And we've never, though, looked at switchers, so we could see if there's something to be learned from the switchers.

DR. CHERNEW: Let me just add, I just want to add one piece of context. I think it's clear from the discussion and the questions beforehand that there's a lot of variation of the impact of hospice based on the disease and the person's status when they got in, and a bunch of other things. I think that's clear and that's important. But I actually think, just to get back, a lot of that will be captured in the work plan, so that's a good thing to say about the work plan -- be aware of that heterogeneity.

But I just want to add there are situations where you could save money on day one if you're discharging someone, say, from the ICU to a hospice or some others. In

other words, there's a sense of when you join hospice, I could think of some conditions in some patients for where the savings, if you will -- and I want to emphasize the goal is really better care for the patients -- but at least there are situations that vary by disease and patient type where you could get savings sooner, but not all of the conditions. It depends on what situation you're in when you get put into hospice, because if you're in an inpatient stay and you get discharged into hospice, depending on the payments and stuff, there are differences.

Anyway, Amol says he does it all the time.

DR. NAVATHE: I wouldn't say all the time, but I would say that there are definitely clinical situations where, because of progression of the disease or what have you, we will transfer somebody out of the hospital or out of the intensive care unit, or instead of going to the intensive care unit they go to hospice, either inpatient or hospice out. And I think that's better for the patients first, but secondly, my suspicion is that it would be savings for the program, to the payer, as well.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you for this interesting work

and comments. I have never understood why Medicare Advantage had a carveout, and maybe that's clear to everybody but that hasn't been clear to me. And so dovetailing on some of the other piece of conversation, I'm really curious what we might learn from understanding that piece.

Following up on comments, I think by Gina and Tamara, about the long stay, high margins, high live discharge, you said that the high live discharges are by organization, not by diagnosis. Is that correct?

MS. NEUMAN: High live discharge varies by diagnosis, but then within diagnosis it varies by organization.

DR. RAMBUR: I mean, one of the things that I'm very interested is, you know, at least my experience is that hospice really started thinking about people with cancer and relieving suffering. And now we have legions of people aging into cognitive disability and other kinds of chronic conditions, and does it need to be totally rethought? Should it be more palliative care, because people can live like 10, maybe even 20 years with a cognitive disorder, that you don't want to be chasing down

a cure when there isn't one.

But I really want to dovetail on what Lynn mentioned. I'm also very concerned on the flip side about short stay in hospice and prolonged suffering because of overtreatment at the end of life. And I'm always sort of heartbroken when I see, in an obituary, that the person died in the hospital after an illness. So I think there are two pieces here and I'm not sure we can get to them easily within the same hospice bag, so maybe there are other avenues.

I will just finally say my own father, when he was actively dying, was offered dialysis, and I knew to ask will that help him die more comfortably, and the correct answer was no, because he was actively dying in that case. So this really gets to be a very stressful thing for families trying to do the right thing.

So thank you. Hopefully that gives a little bit of light on what I'm thinking about.

DR. CHERNEW: My recollection is hazy, Betty, and Kim will correct me. But I believe the concern originally with having hospice in MA is that MA plans would use hospice as a way to deny care and encourage people to get

into hospice and not get care. And so I think the feeling was that you could at least mitigate some of that incentive by not having them do that. When it was founded or not is beside the point. I think that was the original concern. Hospice was quite new and I think there was a lot of concern it was going to be used as a way to deny people care that they really needed, and they didn't trust MA plans to do that.

MS. KELLEY: Brian.

DR. MILLER: I appreciate it. That was one of the things I was going to mention, so I appreciate that context.

Some thoughts. I'm going to put on my practicing hospitalist/doctor hat. When we talk about dialysis, I think it's important that we take a step back and that we recognize that we should let hospice medical directors and patients and their families make those decisions as opposed to us weighing in as to whether hospice should or should not offer dialysis in end-stage renal disease. There is a lot of granularity in end-stage renal disease patients, and different patients have different values, so we should respect those differences.

Multiple people have brought up the integration into MA. I think we've, at least my perception is we've clearly shown that there is no reason why hospice should remain a separate fee-for-service benefit. So one of the things that might be interesting in this work stream is to discuss what integration into MA could look like, because eliminate that switching incentive and build in appropriate consumer protections. Maybe MA does a worse or a better job delivering hospice care. I imagine that integrated delivery systems could do a very good job delivering hospice care in an MA-like setting.

On the interview section, I think we should not just interview as nephrologists and hospices but we should go to the hospice medical directors, visiting nurse practitioners, the bedside nurses, the social workers, the beneficiaries and their families, and I think integrating into this, from a lot of the question that I heard, I think describing the hospice model of care and how people arrive at hospice. In the hospital, for example, if you're sending a patient or exploring hospice even, the first point of contact is usually the social worker, maybe a registered nurse. It's actually not the physician. The

physician is much later. So I think describing how patients get to hospice is important.

I think another thing that we should explore is, I realize it's very easy for me to say and it's hard to actually operationalize, is talking about how different diseases have different criteria. It's not just six months. There are other criteria that are used to determine whether a beneficiary is eligible for hospice. For example, under dementia it's the FAST criteria, which is for functional status. You could actually make the argument that CMS might be too restrictive, depending upon how you look at it.

I think another thing that we should leave in here is sort of autonomy, patient autonomy and preference. You know, I used to be of the mind that patients didn't spend enough time in hospice and that we were catching them too late, and that might be valuable and true for some patients. But there are a lot of patients who don't want hospice, for whatever their preferences are. They don't want it until much later or they don't want it at all. And I think that it's important that our chapter respects that difference of opinion because we don't want anybody to feel

like they're forced to use the service.

DR. CHERNEW: I'm just going to jump in quickly because time is tight. We actually don't, right now, have a chapter. This is going to be a series of chapters evolving over multiple years. So just so you understand where we are in this process. This is a body of work -- and Kim you can talk about the timing -- but it's not like there's going to be a chapter on this comprehensive set of things. This is the things we're thinking about.

DR. MILLER: On more additional thought, then, along that. I think that important stakeholders to talk to as we think about integration to MA plans, like talking with the Center for Medicare Advocacy and other consumer groups like that to understand what they would see as problems with that integration into MA. And then I think we should talk with a variety of medical ethicists and maybe the Council of Bishops about end-of-life care and patient autonomy.

MS. KELLEY: Scott.

DR. SARRAN: Thanks, Kim. Excellent work. Just a small number of very brief comments, largely reinforcing others.

On the related versus unrelated expense issue, yeah, I think that's an area that's very confusing, often conflictual, and it may be best addressed by some qualitative interviews with hospitals who had claims denied, things like that, and providers who get caught in between, or even worse, to Larry's point, a beneficiary sometimes get caught in between and winds up with a claim that's getting denied by both potential parties.

Definitely a deep dive on ESRD. I think one of the good things happening broadly in the ESRD space is people are looking at it much more holistically lately, over the last few years. Of course, it's just a tradition that you have ESRD you go to clinic hemodialysis until you die, and that's the extent of the vantage point. But lots of issues, including that whole issue of is it palliative or curative in nature. So that definitely needs reinforcing.

The VBID, I think there has been concern from some advocacy groups about turning over -- and I'm being a little facetious now when I say this, but this is language I've heard used -- sort of turning over what is intended to be a very humanistic patient beneficiary-centered benefit

to potentially for-profit MA plans who will find a way to deny care. There has been pushback by at least some advocacy groups I'm aware of about integrating hospice more fully rather than as a sort of demonstration approach.

But I think we should call out, though, the potential for better care within integrated -- I'm meaning if it wasn't a VBID but EPBID elective, but it was a way of doing business that MA provided the hospice benefit. But also call out that there needs to be a lot of good thoughts, and just call out both sides to this story.

And lastly, whenever we talk about outcomes, beneficiary-centered outcomes, I strongly believe that in the hospice space it's important to keep track of the small number of really bad outcomes, which essentially, in hospice, is sort of a never-event philosophy. No one should die with unaddressed symptoms. No hospice should fail to respond in a really acute, timely fashion when the need is there. Those are the two big ones. The whole promise of hospice is you won't die with unresolved symptoms, and your family will be supported in how they take care of you during those unpredictable crisis times.

So from a quality and an outcomes measurement,

it's a challenge because we're talking about measuring a small number of never-events rather than measuring -- and I'm not suggesting it's replace other measures, but it's not just measuring broadly how many people are satisfied, or families are satisfied with the hospice experience. That number may be high overall satisfaction, but the small number of people who had experienced a never-event, that needs to be called out.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. So, Kim, as you were answering questions, I had an aha moment, because I think you might have revealed sort of the issues that we're all wrestling with. And you mentioned that this whole billing model came about in 1983, with aggregate caps and unrelated diagnoses and things like that. So if you think about 1983, and what people thought of hospice care, it was very different than today. Even the field of palliative care, to my knowledge, came about formally in 2006.

So I think what we're wrestling with is contemporarily palliative and hospice care compared to an antiquated billing model back in 1983.

So if you think about unrelated, nonhospice care,

I'm not sure it even actually exists. Because what happens is that you have these patient and family conversations that focused on their personalized goals of care, and the whole purpose of that conversation is to alleviate suffering in hospice care. Greg mentioned anti-seizure drugs, anti-psychotic drugs. It may be appropriate for a family because they don't want to withhold those medications if they think it's going to extend suffering while they're in hospice care. So it's hard to really separate these things out.

Same with Jaewon was mentioning about ED visits. If the family wants to have feeding tubes continued and feeding continued through that tube and it falls out, but then the patient has to make a quick visit to the ED to get the feeding tube put back in, that's all part of a customized plan between the patient, the family, and their provider. So that's why I'm wrestling with this a little bit.

The other thing has to do with this whole idea of longer stays, and I do agree with Lynn that we need to do a much better job of getting palliative care involved earlier. But we're certainly much better today than we

were, let's say, a decade ago. So I think we're seeing longer stays because palliative care is involved earlier because physicians are more comfortable consulting them closer to the time of diagnosis as being part of the support team. Therefore, they're becoming eligible for hospice care earlier, staying there longer, and now exceeding their caps. And that's just based on sort of a contemporary model of how we view these things.

And then short stays actually could be problematic because that actually could represent deficiencies in evidence-based care before the patient arrived at the hospice. So lack of advanced care directives, lack of goals of care conversation could represent deficiencies that led to just sort of a quick rollover into hospice care, and the patient has a shorter length of stay.

So I would be very careful about thinking about the work plan in terms of length of stay, and should we be reducing pain meds, et cetera, because people who may, in fact, be providing appropriate care, we may just need to think about what the model needs to be. And I don't know what that is. It could be not having fee-for-service as

Part B separated from everything else because that creates a lot of confusion. But perhaps it just taking what is the average total cost of care for patients that go into hospice care and using that as a model, rather than splitting it between two different payment solutions.

But otherwise I thought this was a great conversation, just at the beginning, so I'm looking forward to continued iterations of this. Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Kim. Very important topic, and thanks for the opportunity to comment on the work plan. I think, like Rob just said, I think there has been a lot of rich discussion here about many of the different aspects. I just wanted to highlight a couple that build upon some of things that Commissioners have said and maybe one that's separate or different.

Regarding the work that we will be doing on the cap, I think that's actually quite potentially high yield. It strikes me that, in general, as a MedPAC principle, we tend to avoid cliff effects and thresholds, for example, and this, largely speaking, feels like it would operate in the same way. So it would be worth exploring a little bit

if there are some distortionary elements that end up not working in the best interest of either the program or the beneficiary, or perhaps even both. So I'm very enthusiastic about that line of work.

The second area I think that's worth highlighting is I think that the end-stage renal disease and hospice, considering the disease/dialysis interaction with hospice is very complicated, clinically speaking, just putting on my clinician's hat for a second, and trying to differentiate what is the life-prolonging aspect of it, what is the part that's really related to symptom control and other things. I think largely it's a bit artefactual from a clinical perspective to truly be able to tease those out or factor them in in any way.

So I'm very enthusiastic about this work for that reason, because I think we probably need to have some more sophisticated thought around how that should work in a way that, as Brian highlights, preserves choice for beneficiaries based on what their values are but still creates the best set of options for them in a way that's transparent and doesn't make clinicians feel like they have to fabricate something or overestimate in some shape or

form.

The other part of that, that I think may have been mentioned but I think is worth noting down explicitly on the slide is making sure that we are factoring in caregivers also into the interviews and into any of the work around, as we think about the effects and also the quality, et cetera, of hospice care, because obviously we can't ask the patient who they felt about it, so we're left to ask the caregivers. And a lot of the beneficial effects actually are accruing to the entire unit of the family or the caregiver that is included with the patient. So I just wanted to make that point briefly.

Thanks for leading us through this really wonderful discussion.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, I really like this line of work, and I like what you guys have done, and I'm glad we're looking at. Hospice is such an important thing.

I think one comment I would make on the four bullet points, the four kind of types of things you are talking about doing in the work plan, I do think, the more I think about it, that hospice's ability to select their

patients, to select diagnoses and to select individual patients is huge in each of those four areas, especially in talking about effects on spending, but really in all four areas. So I would really strongly encourage you to very explicitly consider that in each element of the work plan.

And then the only other thing I have to say is, I wouldn't have said this but when Mike said this is a multiyear project I thought aha. There are a couple of areas that might bear some more thought. One is, you know, median length of stay of 17 days probably is awfully short. That means people aren't getting in until two weeks, basically, before the die. And probably there are a lot of people who could benefit from a longer length of stay. I know there has been a lot of academic work done on this, but at least to think about sometime in the years you're working on this, is there any contribution MedPAC could make to the problem of quite a few patients getting in too late at the hospice, probably.

And the last thing I would say, then, is also another possible thing to think about, if you have years to think about it, you know, dementia patients are, first of all, a real possible source of profits to hospices. And

secondly, the hospice program isn't really necessarily that well suited to care for dementia patients. I remember we had a discussion a few years ago and a Commission at the time, Karen DeSalvo, said, "Hospice is, to a large extent, becoming a dementia care program, and it isn't really well suited for that."

So some more thought along those lines. I mean, the really big think is what would be a good dementia care program? But we're kind of cramming that into hospice care, and probably doesn't serve anyone very well except for the hospices that can profit from it. So maybe some more thought about, just as we're looking at ESRD specifically, maybe looking at dementia and hospice specifically as well, with the big think idea in mind, not that we would necessarily do anything about it, is if hospice is not a good dementia care program, what would be?

DR. CHERNEW: Okay. Thank you all for your comments. I'm not going to do a long summary. I'll try and do a short one. The first point is there has been a lot written about challenges with end-of-life care in the United States, and I think it's widely acknowledged that the system often fails around that complicated time. Our

North Star remains how we make sure that beneficiaries have access to high-quality, appropriate care, and of course this is particularly challenging in an end-of-life setting in a range of ways.

My overall view -- and I know people can reach out to us from home and tell us this -- we have outlined what I consider to be a quite ambitious agenda on a number of issues related to hospice, and we will continue to do them. I think one thing that may have been missed as people went through this is the recognition that the academic community and other outsiders are also devoting more attention to understanding how hospice works and how some of the specific features of the hospice program have been designed.

There was a period of time when hospice was a new benefit, and I think we now have much more experience with it, and we have continued to look at it, and we will, in the range of our normal course of business. I think it was very clear that our update recommendation is going to follow our standard update approach to hospice. But this is very much on our radar and very much dovetails with other things we care about, MA for example, quality

measures for example. And so we will keep plowing along.

But for the time being I just want to give a special thanks to Kim, and a shout-out to Eric for the reading of things. I think if I had a movie, you could be the narrator. But we are all good.

So we're going to take a five-minute break now and we're going to come back and talk about a topic which is, I think, of growing importance, software as a service. So a five-minute break and then we're going to be back at 3:30.

[Recess.]

DR. CHERNEW: -- I think of growing interest and we're trying to get ahead of it. I think it would be fair to say that new technologies are revolutionizing a lot of industries, and health care is no different. And fitting these new technologies into the conventional paradigm of how we pay is quite a challenge.

So I asked the staff to look into this and just provide some information about how it works. We're going to get a summary of that, that will not appear in our reports but will appear as a separate document, so stay tuned. But in the meantime I'm going to turn it over to

Corinna, who is going to talk about software as a service.

MS. CLINE: Good afternoon. In this session, we will discuss a new topic that we have just begun to explore: Medicare coverage of and payment for software as a medical service. The goal of this session is to get Commission feedback on the material presented and to identify any issues to focus on in future analytic cycles.

First, we will discuss the definitions and characteristics of software as a service and prescription digital therapeutics. Next, we will discuss statutory requirements for Medicare coverage, which will be followed by an overview of the current payment status of software as a medical service across Medicare's payment systems. Then, we will discuss principles for coverage and payment in fee-for-service Medicare, and will conclude with a discussion of the material presented.

As technology has advanced, software has become increasingly important to medical devices, to the point where software alone can be considered and regulated as a medical device. During today's session, we will be discussing software as a medical service which includes two types of such software.

The first is referred to by CMS as Software as a Service. SaaS includes algorithm-driven software that assists clinicians in making clinical assessments, clinical risk modeling, and computer aided-detection. An example is an AI-diagnostic system that detects retinal disease. The second type of software is referred to by stakeholders as Prescription Digital Therapeutics. PDTs are software products prescribed by clinicians and typically furnished by patients on a mobile phone, tablet, smartwatch, or other similar technologies. An example is a device that delivers cognitive behavioral therapy to treat chronic insomnia on a patient's mobile device.

Here are the shared characteristics of both software types. Both device types are used or prescribed by clinicians to diagnose or treat an illness or injury. Both software types generally stand-alone from the hardware as it performs its medical purpose, meaning that the software is not necessary for the actual hardware device to achieve its intended purpose. The FDA refers to such software as Software as a Medical Device. The FDA clears most of these types of software as Class II devices, which are devices that pose moderate to high risk.

And lastly, the FDA clears most Software as a Service and PDTs under either the 510(k) pathway or the De Novo device approval pathway. Under the 510(k) pathway, the FDA clears devices that are similar to a device already on the market. Under the De Novo pathway, the FDA clears low- to moderate-risk medical devices for which there is no similar preexisting device on the market.

Now, let's discuss Medicare coverage.

In order for an item or service regulated by the FDA -- that includes drugs, devices, and software as a medical device -- first it must be approved by the FDA; second, it must be in a covered Medicare benefit category, for example inpatient care, outpatient services, durable medical equipment, diagnostic tests; and third, it must meet other statutory requirements including being reasonable and necessary for the treatment of an illness or injury. Based on these parameters, CMS coined the term "Software as a Service," and began to cover and pay for such types of software as of 2018.

However, prescription digital therapeutics are generally not covered by Medicare because, first, the statute lacks a benefit category for this type of

prescription medical software; and second, such a technology is not consistent with Medicare's definition of durable medical equipment, the Medicare benefit category that covers medical equipment and supplies used to treat a beneficiary's illness or injury in his/her residence.

Now, I will turn it over to Dan to discuss Medicare coverage and payment.

DR. ZABINSKI: Okay. The Software as a Medical Service, the SaMS, are covered services in several of Medicare's prospective payment systems. Over the next few slides, we will discuss how SaMS's are covered and paid in each system starting with the hospital outpatient prospective payment system, the OPPS.

SaMS in the form of SaaS is covered under the OPPS. covered services. In general, CMS approves a service for coverage under the OPPS if the service falls in a Medicare benefit category, has a HCPCS code, which is a billing code in the OPPS, and CMS determines the service is safe to provide in a hospital outpatient departments, or HOPDs.

CMS then determines whether a covered service is separately payable or packaged. Separately payable

services are either relatively costly or the focus for an HOPD visit. Under the OPPS, CMS makes payments for these services.

In contrast, packaged services are adjunctive or supportive to a separately payable service. For these services, there is no explicit payment. Instead, the cost of these services in embedded in the payment rate for the related separately payable service.

The OPPS has 10 HCPCS codes for covered SaaS. Most of these SaaS analyze data from imaging scans, such as HeartFlow, which analyzes data from CT scans for patients who have symptoms of coronary artery disease. The covered SaaS devices have some attributes that suggest they should be packaged and other attributes that suggest they should be separately payable. And CMS has generally chosen separately payable status under the OPPS for the SaaS since they were first covered under the OPPS in 2018.

For example, in 2022, only 3 of 10 covered SaaS were packaged, and the other 7 SaaS were separately payable. And now, in 2023, all 10 covered SaaS are separately payable in all circumstances and are never packaged.

In terms of use and spending in the OPPS for SaaS, the most recent data we have are from 2022, when 7 SaaS devices had separately payable status in the OPPS. Of these 7 SaaS devices, only one, HeartFlow, had appreciable volume of 8,665 uses and spending of $8.4 million. Two SaaS devices, LiverMultiScan and Cleery Labs, had volume of less than 100 uses and spending of less than $50,000. The other four separately payable SaaS devices had no volume and spending in the OPPS in 2022.

We fully recognize that the number of SaaS devices covered under the OPPS and the volume and spending on the covered SaaS devices are likely to increase, perhaps rapidly.

Next is the fee schedule for clinician services, the physician fee schedule. The coverage guidelines that CMS uses for physician fee schedule coverage are like those used in the OPPS. Therefore, the 10 SaaS devices that are covered under the OPPS are also covered under the physician fee schedule.

The OPPS and physician fee schedule are both payment systems for ambulatory services, but an important difference between these two systems is that the physician

fee schedule has less packaging and smaller payment bundles than the OPPS. Consequently, all 10 of the SaaS covered under the physician fee schedule have always been separately payable.

A difficulty that CMS has had in setting physician fee schedule payment rates for most SaaS devices is in the practice expense, or PE, portion of the payment rate, where the PE is one of the three components of the payment for a service under the physician fee schedule. Therefore, in 2023, payments for 8 of these SaaS devices are set by Medicare's administrative contractors, generally on a case-by-case basis, rather than having CMS set national payment rates.

Turning to the inpatient prospective payment systems , the IPPS. Under the IPPS, payments are for bundles of services for treating conditions diagnosed and specified in Medicare-severity diagnosis related groups, the MS-DRGs. Under the IPPS, there is typically no separate payment for technology like SaMS because it is usually bundled into the payment rate of the applicable MS-DRG. However, manufacturers of new technology can apply for a new technology add-on payment, an NTAP, which

provides additional payments for two to three years, after which the item is bundled into the payment rate of the applicable MS-DRG.

Usually, a new technology must meet three criteria to gain NTAP status. It must not substantially similar to existing technology, meaning the technology must be new. It also must be high cost in relation to the payment rate of the applicable MS-DRG, and it must represent substantial clinical improvement over existing technology. However, if the FDA designates that technology, the new technology only must meet the cost criterion to gain NTAP status.

So far, six SaMS devices have received NTAP status in the IPP. Two of these SaMSs, ContaCT and Caption Guidance, no longer have NTAP status, and the other four SaMS devices began NTAP status in fiscal year 2024, and all four of these SaMS devices have breakthrough status.

The final sector we'll discuss is the durable medical equipment, DME, fee schedule, which is very different from the other payment systems we've covered. DME are medical equipment prescribed by a clinician, are needed at a patient's home, and meet five criteria, which

are listed in your paper, but we won't cover here. The type of SaMS that are applicable to the DME system are the PDTs that Corinna covered earlier. PDTs are covered under the DME fee schedule if the software is embedded in a device that meets the five DME criteria.

Examples of PDT that are covered under the DME system include software and devices used together to generate speech for those with severe impediments, and PDTs in which the software and medical device are integral to each other. What is not covered is PTDs in which the software is solely usable on personal devices like tablets, phones, and PCs, because personal devices do not primarily and customarily serve a medical purpose, which is one of the five criterion for coverage in the DME system.

Now we turn to Nancy, who will cover potential questions for your discussion.

MS. RAY: Today's presentation ends with potential areas for Commission discussion. To guide your discussion, we summarize the principles of Medicare payment policy set forth in our March and June 2023 reports. For all services, the program aims to obtain good value for the program's expenditures, which means ensuring beneficiaries'

access to high-quality services while encouraging efficient use of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums.

Thus, Medicare seeks to utilize payment approaches that promote provider efficiency and the delivery of high-quality care, spur price competition among manufacturers of similar products, and create incentives for the development of technologist that leads to substantial clinical improvement with an appropriate reward for innovation and affordability for beneficiaries and taxpayers.

The first area for discussion concerns ensuring beneficiary access to high-quality care. How should Medicare ensure that covered services improve beneficiaries' health outcomes? Some devices that pose low-to-moderate risk rely on evidence showing that they are substantially equivalent to existing devices for FDA market authorization. Medicare could require that a manufacturer of new software provide evidence that its product results in a clinically meaningful improvement for Medicare beneficiaries compared with the standard of care.

Alternatively, a coverage with evidence development policy could be used for new software that lacks evidence showing it has a positive effect on care specific to the Medicare population.

The second area for your discussion concerns how Medicare should pay for software as medical service. MedPAC has long supported larger payment bundles because they give providers opportunities to be flexible in the provision of care and incentives to use the most cost-efficient methods. In response to CMS's proposal in the outpatient prospective payment system proposed rule for 2023, to classify all software as a service technologies as separately payable services, the Commission strongly encouraged CMS to seek ways to increase the amount of packaging and the extent to which services can be bundled.

For the prospective payment systems for the inpatient and outpatient hospital and dialysis sectors, the Commission has repeatedly said that paying separately for items and services undermines the integrity of payment bundles; limits the competitive forces that generate price reductions among like services; can lead to overuse, to the extent clinically possible; and shifts financial pressure

from providers to Medicare.

The last area for your discussion concerns paying for software as a medical service in payment sectors where bundles and packaging is generally not used, including the fee schedules for physician services and DME.

Options for setting a payment rate include using the manufacturer's list price; using a market-based price determined by the manufacturer's pricing decisions, which may not be related to the clinical value of the product; accounting for a new product's net clinical benefit compared with the standard of care; And taking into account a new technology's efficiencies when determining Medicare's payment rate.

This concludes our presentation. Commissioners should discuss the payment issues concerning software technologies that your briefing paper lays out and identify any issues that you would like to focus on. Also, of course, we are all happy to take any questions you may have about the material presented today.

DR. CHERNEW: Great. So first of all, I really love that. I know it's a lot to get into something new, and it's kind of like a journey through the complex systems

that we use to pay. For instance, this is what happens in the physician fee schedule. This is what happens if it's in OPPS. This is what happens if it's in the inpatient, if it's in the bundling. This is illustrative of a lot of things that go on in the American health care system.

But that being said, I think we're going to go to Round 1, and is it true that Cheryl is first? Cheryl is first in Round 1.

DR. DAMBERG: All right. You might now know the answer to this, but I was kind of curious, given that there were, on page 24, seven SaaS that were separately payable that were approved, only one of them had substantial use and the others not. And I'm curious, do you have any insights as to why the others are not in use?

DR. ZABINSKI: I have no idea, really.

DR. CHERNEW: I don't either, by the way, but I think it would be interesting to understand the organizations and the values of the organizations that are making these things, because that will tell you something about the anticipated use of the people that develop these things. I suspect the answer is some combination of it's just very new and they have to just get the clinical

community to ramp up. Like HeartFlow just took off, but at the beginning it wasn't. And so once people get used to it, who knows? But I don't really know.

DR. RILEY: I feel compelled to just share that I am on the board of HeartFlow, and I'm recusing myself from this conversation.

DR. CHERNEW: Well, first of all, you don't need to recuse yourself from this conversation. Actually the opposite might, in fact, be true. It's good to know, but you may have much more information that I certainly do about it. I think there are a lot of people here who are involved in some of the things we talk about, so your expertise is probably a plus.

DR. DAMBERG: Yeah, just a follow-on. So maybe it's too new to be tracking this, so now I'm going to bleed into our Round 2. So I think it would be helpful to track these things as they come on the market and how fast the uptick is, and whether some of them are not being taken up, and does that signal that there are sort of equivalent therapies.

MS. KELLEY: I think that's all for Round 1, unless anyone has another question.

DR. CHERNEW: That's all that I had to.

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

DR. CHERNEW: And Round 2 is going to start, I believe, with Brian.

MS. KELLEY: Yes.

DR. MILLER: Okay. I have a lot of thoughts, having worked at the FDA. I organized them in advance.

Just a technical note. We should probably be cautious about language. The FDA usually refers to software as a medical device, not software as a medical service. And then when we use the language "software as a service," that has a very specific meaning in the tech world that we might not always mean, so we might want to pick a different term.

So I think about this from principles, from multiple perspectives. A project manufacturer needs an incentive to innovate, and I mean a product manufacturer that could be a medical device or someone making pure software or software and hardware.

I think collectively we want consumers to benefit from innovation and competition, and in particular, the competition between manual and automated processes. There

are a lot of things we do in health care that are human capital driven that don't work very well. And so using technology, the goal would be to lower costs and improve quality, safety, and access.

Most importantly, from our perspective, we probably want the Medicare program to capture savings from this technological innovation as opposed to just be driving up programmatic cost. So we have to be careful

So I think about the framing of paying for things in different levels. Like there is the bucket of what I call augmentation, which something like HeartFlow would fit into. There is the other bucket of autonomous service delivery, which is something that we want to make possible, or I think we should make possible because it's actually already here.

And then we need to recognize also that what we used to call at the FDA "lumping and splitting" of services, or at the FDA it's like adverse events, is somewhat arbitrary and requires judgment. So what goes into a bundle versus not, there are probably multiple right answer, and that's not to give anyone a free pass but to recognize that is very gray.

And then I would use these principles to sort of think about how we structure payment, because what we don't want to have happen is this sort of precautionary principle where we say, oh, and we're worried about -- and we should be concerned about induced demand, but if we use payment principles, we can address that. With telehealth we waited 30 years to do telehealth, and then there was a global pandemic and then we realized it was okay and it did not bankrupt the health system and it massively increased access and convenience for beneficiaries. So I don't really want us to repeat that mistake with technology here.

I think also that our definitional scope should be much broader. Prescription digital therapeutics is a pretty narrow and small category, as we saw, with not a lot of uptick. We also shouldn't necessarily exclude software in a device. There are lots of hardware devices that could have greater function, either augmentation or even autonomous, if we include software in a device as part of this.

We also need to sort of break that paradigm of human capital as the only deliverer of a service. We should be comfortable with different degrees of human

involvement in service, completely human-driven service, tech-assisted human service, and even tech-driven service.

And so I would look at this broader payment question differently. Rather than saying here are our payment paradigms, let's do some things to figure out technology, I'd say what are the technologies and how do we set them up to compete in the current marketplace and drive down costs and increase quality, safety, and convenience.

Some of the technical questions that may follow from this, for example, would be do we need a new benefit category, do we need a modifier for the physician fee schedule to accommodate differential services, that modifier being zero and one. Obviously, you could say one is human capital-driven service. Maybe point 5 is the autonomous tech-driven service.

The DME, the five criteria are pretty restrictive. Do we need to adjust the DME category to accommodate hardware/software products, meaning if you think about a system like, say, automated anesthesia, you want to be able to bill a clinical service, but then you also want to be able to bill for the hardware, and that could end up being cheaper than having an anesthesiologist,

and arguably safer. And actually this was a product on the market about a decade ago called Sedasys. There are many examples like this. It was automated anesthesia for endoscopy.

And so I think what we should be doing is thinking about how we build a payment system that deploys technology to benefit beneficiaries and lower costs as opposed to worrying about squeezing technology into any one particular payment system.

And then I think then, in the context of this, when people talk about coverage right now we need to recognize that CMS is sort of slow, because they don't have enough staff. There is what I would describe -- and this is longstanding for decades -- a passive-aggressive use of local coverage determination. And beneficiaries, doctors, and manufacturers need transparency, certainly certainty, and timeliness of coverage and the standards that go with that.

And so we should design or think about redesigning our payment system to accommodate technology, recognizing that we're not going to have enough doctors, we're not going to have enough nurse practitioners,

physician assistants, certified nurse assistants, or whatever the human capital is, so we need to make sure that we can use technology to meet beneficiaries' needs.

Thank you.

MS. BARR: Thank you. In my former life I actually took 13 medical devices through the FDA and to market, so I have set a little bit of background in here.

You know, payment policy drives innovation, so it's really important we get this right. And what do we care about? We care about equal or better clinical outcomes that also reduces cost. So we need to focus our payment policy in a way that incentivizes companies to reduce cost, because today they aren't really incentivized to do that. Actually, everything they try to do is to increase costs and get more money into the system. So we need to really focus on that.

Post-market surveillance of medical devices is a disaster. It never worked. So just get CED out of your head because we can't even do post-market safety analysis of all the medical devices that we have out there today. So I don't think that's a wise way to go. And the concern with AI is whatever you test today is not what that product

is tomorrow. So there has to be an ongoing clinical validation.

Now we need to get in our heads what the cost is of doing these studies on devices versus drugs. We're not talking about Stage III clinical trials, randomized clinical trials. So a device that, for example, analyzes images. So you're going to get a bunch of images. You get readings. You get another reading. It takes you about three months. It's not terribly expensive to validate these products on an annual basis. But we need to think about the costs.

And validating software is really, really hard, as anybody who has ever written any software knows, and it's easy to mess it up. And AI has tentacles we can't think about.

So we have to think about the additional costs and build that into our ideas, but there has to be a reevaluation of software that is being modified on a periodic basis. I don't know if that's annually, every other year. But these are devices that should have clinical data, and they should be equal or better to current clinical outcomes.

And then I believe that the payment that would incentives the innovation that we want -- because you've already got that bar of it's no worse than what we've got today, and should be better -- we should pay based on either the reduction in labor, so the reduction of what we would pay the radiologist or whoever is using the device because of the efficiency for the provider, or we should pay it on the reduction in medical costs. So if this device, you know, controls diabetes better, and these diabetics then are less expensive, then there is a benefit there. And I think drug-eluting stents was a good example of how they priced drug-eluting stents based on their ability to prevent restenosis. And that got us from $600 stents to $3,000 stents because they kind of overestimated that.

But this should be in the FDA approval of these devices. It should give us a very clear picture of not only clinical equivalence but what is the benefit to society that we could then compensate them for. And I would base pricing on that. Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks. This was a really

interesting chapter. I appreciate all the work pulling it together.

I think I share Lynn's perspective in terms of wanting to incentivize the development of such tools and definitely broadening sort of what the evaluation criteria are, because I think we want to be promoting the development of things that are cost saving.

And I guess as these things start to emerge in the marketplace, and I think this is going to be sort of an ongoing learning activity, not only do we want to track use on the fee-for-service side, I'm hoping we could track us on the MA side, because that's a place where the incentives are better aligned in terms of application of different technologies.

MS. KELLEY: Greg.

MR. POULSEN: Yeah, I agree completely with what's been said. I think this is great work. The challenges were laid out by the team really well. I think Brian, Lynn, and Cheryl also made really important points about getting to enhanced value and the challenges of retrospective review. I mean, there's just all kinds of potentially major problems.

And I think I may be a little less sanguine than Brian. I think this has the potential to add enormous amounts of expense to CMS that are currently unanticipated, and I worry about that a lot.

I think the principles for coverage and payment are both complicated and difficult to determine. There are lots and lots of difficult areas. Is this a real breakthrough? Is it unique? Is it risky? Does it belong in an existing bundle? Is it in the DME category? Does it replace humans? I mean, every one of those questions is potentially fraught with peril to answer and could be answered potentially by different people in different ways.

There are many, many examples that exist today where we're doing these things with no payments whatsoever because they are part of what is now a bundle, and it's determined that we can do that bundle more effectively with the addition of software and nobody has to make any decisions except whoever is implementing the technology, whether it's safe and effective.

I think the potential becomes the benefit, the value-add to the patient and the provider both in terms of streamlining things. I'm thinking of things that we do

currently in surgery, in imaging, in labs and other places where it's clear that we're adding a value to the process and it ends up with something that's faster or better for the beneficiary but also faster and better for the providers. And we don't have a payment mechanism in there making it more complicated.

We talked a lot about bundles. I think that clearly the broader the bundle, the more effective we are at defining it. What Cheryl just said about, wow, if it's part of a program that exists and it does it better than this is easy. And she mentioned also the MA inclusion, and clearly, I guess -- and this is what Mike has been waiting for me to say -- this whole issue becomes radically easier when the bundle incorporates the entire person.

DR. CHERNEW: I was waiting for him to say that.

MR. POULSEN: Because I always say it, no matter what the topic is. It's going to be better and easier in a prepaid environment than it is in a fee-for-service environment, and that's clearly true in this situation. Then it becomes easy for the people who are actually providing the care to say, "I can do this better with this new technology, this new software, and it makes my life

easier and it makes my patient's life better when I do that." We don't have to figure out who pays for it in the same way.

So I think we're going to have to wrestle with all these, and I'm not arguing that differently. But I do want to put a placeholder in here that every time we look at mechanisms that allow us to broaden the population that is paid for in a prepaid mechanism, this is yet another reason why that's a good thing to do.

MS. KELLEY: Stacie.

DR. DUSETZINA: So I'm again glad to be following Greg this time because that was probably a better way than I'm going to say some of the same things, or plus-one on many of them.

You know, when thinking about this I also was struggling with those same issues of, you know, if this makes the system or the provider or the hospital more efficient, that seems like something they would be investing in to make their work more efficient, or saving when they're getting paid in bundles, and so why is this another thing to add on? Because, you know, studying the drug space a lot and setting up some of the incentives the

way they seem to be so far with the new technology add-on payments, it's kind of like it's incentivizing us going in the wrong direction on costs, and I am worried about that.

One of the things, just trying to answer this first question on the list of how does the technology improve outcomes or how could we study that, it seems like many of the examples that we're going to have to work with first are things that are supposed to try to minimize future care needs. One example on the list that you all provided in the chapter was the lung cancer prediction tool. I thought this was a particularly good example. You know, you have a nodule, you get this prediction tool to determine if you should see a pathologist.

So it seems pretty easy to me, thinking about as this rolls out what percent of people still go on to see the pathologist? You know, does it actually change care or does it just give you more information? And I think that seems like a low-hanging fruit way to determine whether this is probably providing benefits and maybe producing savings.

And some of them might produce savings. You know, there are examples, I think, of tests, like for

example, to try to prevent unnecessary use of chemotherapy for some people. You know, as long as that test isn't priced so high that is erases any savings, it's great to use it, and it's great to use it for beneficiaries not to be exposed to unnecessary harms, which I think we would really love to see as an outcome, regardless of cost.

I struggled with where does this fit in the payment flow. I do agree bundles makes the most sense to me, and also, I agree that if we could figure out how this works in MA and the adoption in MA, I know we have tons of problems with the encounter data, but that seems like it would also signal the selective use, how much value does it have over the existing pathways of care, at least for these new services.

Lots of outstanding questions. Great work to the whole team on this. I think we're going to be wrestling with this one for a while.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. My colleagues said so many of my comments so much better than I did, but I'll go ahead anyway and do it badly and with gusto.

I'm really excited about this area because it

really is a brave new world. And you're right, we're going to see more and more, and I think it's just going to explode. So just a couple of comments.

I agree, you know, the fundamental problem is the unbundling and having additional costs, and I was sort of stunned to look at the text box on page 28, new, that's fine, high cost relative to Medicare, and then substantial clinical improvement. That just seems like a recipe to be gamed. And so, you know, however we think about the model or what we're going to recommend, how do we incentivize things that have low to moderate risk, clinical benefit, and decreased costs? And I know you've all said that, but that just has to be the goal.

I'm excited about the range of human involvement to total to none on this, and I think that that's probably here within my lifetime maybe. And so how do we think about that payment system that can serve us now and in the future. So thank you for the good work, and I'm excited to have a continued discussion about it.

DR. DUSETZINA: I just wanted to clarify, the issue around the new technology add-on payment and the high cost and things like that. You know, one of the things

that was further compelling in the chapter was that because these are receiving break-through status, then they just have to have the high cost component. So it's not even meeting all three. It's just like set your price really high; you can get the add-on payment, which seems like, you know, not a good strategy.

DR. RAMBUR: Thank you. Yeah, exactly.

MS. KELLEY: Robert.

DR. CHERRY: Thanks. This sort of reminds me of, you know, throw a shiny object in the room and watch everybody follow the bounding object, because there's something exciting about this software as a clinical service or a device. But then when you take a step back and you kind of think about the problem we're trying to solve, it becomes really complicated.

I want to reinforce something that Greg said, but in a different way. So let's suppose you have a company that makes defibrillators, and they're approached by another company that says, "Hey, we've got this great software that can integrate with the hospital's physiologic monitors." They say, "Great, we'll do a contract with you, and we'll provide it as a single service." Right? They go

to the hospital. The hospital says, "Yeah, we'll contract with the defibrillator company, and it turns out that you can integrate with the same physiologic monitors that we already have a contract with."

And then you have the EMR company that says, "Oh, this is great, because we can create interfaces with not only your monitors but also with your IV pumps as well, so this way when you go back and you have a cardiac arrest, you can see how all this stuff came together, and you can do your performance improvement activities," right? So you have these contracts between companies that are competitive, hospitals create these contracts based on RFPs, and they have competitive bids, they choose the company with the least price that's presenting either a device or a software company, and the beauty about, you know, the hospitals or providers is that they can assess the efficacy of whatever it is that they have a contract with, and if they don't like it, they just terminate the contract.

So I'm not quite sure why we're getting involved with this, quite frankly, when I think about it, because it sounds like we could be just sort of moving in the same

environment that pharmacy is in right now. You have pharmacy benefit managers. Every time we talk about pharmacy, we get entirely confused with its ecosystem. So I think we should just take a step back and think about, you know, the problem that we're trying to solve. If this was about, you know, AI, yeah, it's probably a little bit of a different issue. But I'm not quite sure we want to get into every kind of software that's out there.

Just my two cents.

DR. CHERNEW: So I rarely -- that was the end, by the way, for those of you keeping score at home. We'll have some more time. But I want to say I rarely go back and look at the transcripts, but I may go back and read that comment again. I think that's really important to keep in mind, that understanding the complicated interfaces between the different entities involved and the number of technologies involved in treatment and the interfaces and the contracting is important.

It does, of course -- Greg is waiting for me to say this -- become easier if there's a bigger bundle when you work around that. But I will say -- actually, Gina wants to say something, so, Gina, before I do my wrap-up,

go ahead. And Jaewon wants to say something after Gina.

MS. UPCHURCH: I just want to say I really agree with Robert's comment. And when I was reading this, all I could think of was patent thicketing that's been going on around medications, and the interface and medications with PBMs and stuff. So whenever we can bundle it, but let the end user be the one who's deciding the value of it in the system, in my mind is the way that we need to go, because if you're thinking about tech -- well, if you think about clinical care just in general when you think about health, what's 20 percent of what influences our health, there's that whole other 80 percent that we know impacts our outcomes, whether it's food or -- you know, the things that some of these Medicare Advantage plans are supporting right now -- access to mental health parity, access to your community pharmacist who knows you. There are a lot of things we could do that add value to the care that we're trying to influence, but they don't have separate payments, and we're not even investing in them, when we know that they can create significant outcomes.

So I just -- I agree with Robert's comments. Thanks.

DR. CHERNEW: Overwhelmed with you on this point, but we're going to let Brian go on this point, then we're going to let Lynn go on this point. And I'm not even sure -- and then we're going to go to Jaewon -- is it on this point?

DR. RYU: I had a comment on Robert's.

DR. CHERNEW: All right. Whatever. We're going to have a free-for-all. We're going to go Brian, Lynn, Jaewon. I'm sorry for not getting that in order because I can't follow the chat, but go ahead, Brian.

DR. MILLER: The reason to go broad is that human capital delivery of service is frequently expensive. We don't have enough human capital. And, frankly, as Larry has often mentioned, the unmeasured quality is what is often our concern, and that the unmeasured quality is frequently terrible.

So when we think about, you know, a payment, it's not that we're saying -- and the comment on capitation, I'm obviously a huge fan of capitation, but I also recognize that there are sunk costs and frictions. And if you run a $10 billion organization or even a $500 million organization, to say that you're going to necessarily adopt

new technology because you're in Medicare Advantage, yes, that's true, but it still takes a lot of time. And if it's not in the fee-for-service system, that's 49 percent of the beneficiaries that may or may not get access to that, depending upon the delivery system's particular payer mix of fee-for-service versus MA.

So I think that the point is to include technology as a competitor to the existing services, not necessarily always as a -- you know, we don't want 10,000 NTAPs for things, that's bad, but having 10,000 new technology add-on payments will drive up costs. But allowing technology to compete on the physician fee schedule, to compete, you know, as a hardware component in DME by adjusting that definition to allow service and product competition at lower cost is a huge win. And I go back to that anesthesia device, not perfect, but if you think about anesthesia for paying a CRNA or an anesthesiologist in an endoscopy suite, if you could automate a large component of that, one, you're allowing anesthesiologists to do other cases that are higher complexity; and, two, you can reduce costs for the delivery system. Our payment chassis can be adapted to do that.

That's what I think we should adapt to do, so that would force technology into a cost reduction and competition framework, and that's why we need to think a lot broader than prescription digital therapeutics, or we'll be stuck with the same delivery system, just like we're stuck with the only sole choice of in-person care and no remote care besides the telephone, which was not reimbursed.

MS. BARR: I agree about bundles. If we can bundle it and, you know, it -- bundle it, right? If it provides value. But there are a lot of things that would be invented that, if they could get approved, if there was a way to pay for efficiency, right? That we don't pay for today.

And so, for example, if there's a device that allows us to pay a radiologist less -- and that's part of their application, and we say, great, we will price this device with a lower radiologist payment -- right? -- so then that makes sense. But there's no incentive for anybody to do that today. So right now the payment, they're separate.

And so what I'm proposing is that we spur innovation to reduce costs by actually paying people to

develop things that can help us lower cost. And I don't think that that's what exists today.

So I agree with everything you're saying, but that does not spur the innovation we need. All the innovation is just to keep the -- is to raise the prices, right? Every new drug comes out with a higher price. Every new device is -- they price it as high as possible. I believe that there's a lot that software could do to make the system more efficient, but we will have to pay people to develop it, and it has to be part of a package that shows a savings, a significant savings to Medicare.

To your point, a lot of efficiencies are just absorbed by the health system, that's great. That wouldn't qualify. But if you can show me a way to reduce the cost to Medicare, I think we should pay for that as a different pathway for approval that we don't currently have today.

DR. RYU: Yeah, I had a similar comment. I agree with what Robert was saying. I definitely agree with Greg's comments as well. I think the only thing I was thinking about as Robert was talking is if there are scenarios where the value occurs outside of the silo, that would otherwise have the incentive to go reach for the

technology. And I think there probably are some of those examples. So as you were talking about the hospital, there may be some technologies where the hospital otherwise wouldn't have the incentive because the value lands outside of its environment. And that is where, you know, Greg's comment, ideally, you'd have everything in a prepaid world where I think then it starts to make sense. Or the other scenario I thought was or the value is so far out in the future because you're preventing something, maybe getting ahead of some chronic disease, patient's going to do better but they'll do better eight to ten years out, and the hospital has no way to, you know, validate or rationalize that kind of investment.

I think those were the only two things. Otherwise, I completely agree. I feel like the incentives are inherently built into some of these actors that would want to seek a more efficient technology or deploy a more seamless solution. But I think there may be some outliers in that mix. That's all.

DR. CHERNEW: I'm looking around. Brian?

DR. MILLER: Just on this point, but it's not necessarily about the hospitals or even the doctors. It's

about the beneficiaries and access to care and cost. So it's good if hospitals or clinics or even doctors have an incentive or don't have an incentive to use these things. But I think that our policies should be focused on driving lower cost and safer and more efficient care for beneficiaries in expanding their access.

DR. CHERNEW: Okay. So, first, I think -- I'm not sure I'm going to get Robert's analogy right here, but this is a shining new thing that just really does mesmerize us in a range of ways, and I think this is happening outside of health care as well in technology. I think ChatGPT was released less than a year ago, and it's just amazing how quickly some of these things can work and how quickly we can develop training algorithms and do things and what's possible is probably beyond at least my comprehension right now. But I will make a few general points about this. The first one is to capture some themes.

The budget effects are important, but in general it's not going to be our core concern. Our core concern is going to be making sure that if there's a technology developed, that individuals have access to it. That

doesn't mean we don't want to overpay and we don't care about the budget. But, again, we are trying to solve a problem about paying to make sure beneficiaries have access.

What I think differentiates this from other things that might improve quality -- and I don't want to say that those things are unimportant -- is there's a development aspect of this that makes it somewhat more analogous to drugs and into new technology things. It is not what you might see in other types of quality-improving initiatives, which, by the way, we also care about and should pay for. But it has a somewhat different set of issues because of the R&D components of it and why it fits into the new technology parts of payment, the add-on payments and stuff, 100 percent.

I am a big believer in bundles, as Greg pointed out. I was going to say -- and Jaewon beat me to the punch -- that we're not going to have everyone bundled. It's just not going to be where we are, and so there's going to be a lot of this outside of the bundles. And the ability of the adopter to appropriate the savings, if the savings are downstream in terms of time or in terms of other

places, there's a disincentive to adopt, which means there's a disincentive to develop, and that becomes a problem, that we at least need to think through --

DR. CASALINO: That's true even in a population-based model, right? For example, a health plan would have to think you're going to be with them for a few years.

DR. CHERNEW: Yes. Yeah, so the temporal thing is true and even in a population-based model, and that leads to another point, which is whether or not something is cost-effective, safe, improved quality, whatever you care about, depends on the system in which you release it. So the technology itself is -- it might actually be quite cost-effective and really quality-enhancing if it leads into a system that is going to manage it and use it in a particular way. And it might be incredibly expensive and used incorrectly if released and paid for in a different system. So I think all of that matters.

The other thing that I want to emphasize here, which does come up and it was a theme in what was said, and I just want to try and say it more explicitly -- and this is true in drugs as well in many cases -- we have this tendency to take the price charged by the producer as the

cost, and so it gets built into the rates. And as people pointed out, the way that you qualify for more is actually to charge more, and that seems perverse. And that's not unique to this, but it is certainly salient in this context. And we don't have a system now where the way that prices get set for new things, drugs included, gets negotiated in a particular way.

I think Robert's characterization is much more accurate, which is there's complicated negotiations, and in fact, in this particular case, these negotiations are complicated because we're paying in a fee-for-service way but the actual providers might be buying in a subscription way or some other mechanism of what they do. And, of course, how those contracts look will depend on the decisions that are made regarding how we pay because people will do the business model around this is how CMS pays, this is what we have to do, this is what we got to get approved.

And so I think at the end of day what seems to be clear in a subset of these things is that there's tremendous potential to make the health care system more efficient with new technologies. It is not clear, for

example, that we have the mechanisms to reduce the work RVU once you've adopted -- you know, there's a lot of different things done in different places that don't automatically respond when different things happen. And that makes how we deal with this very complicated.

So besides saying the obvious -- and I will later kick myself for a long speech where I wanted to say that AI and machine learning is complex, which doesn't seem that insightful -- I will say we are unsure about where we go with how we think through what these issues are. What this session was about was to sort of have a discussion amongst us -- and, of course, the folks at home can comment on it -- about sort of how these new services are being integrated fundamentally into the status quo of things, with a little bit more legalistic interpretation of issues like is it a separate service. There's all of these areas that are really fundamentally legalistic things where we're trying to fit into the existing word to decide what to do.

We're going to have to think about what we can do next. The obvious thing -- and I think, Cheryl, you said this -- is just track to see how big they are. Typologies matter. Are they saving system costs? Are they saving

system costs that are appropriated by the user? Think about are we making the other appropriate adjustments at how we adjust RVUs?

We can think through how we track those things going forward, but we are -- and I'm going to look to Paul in a minute. We are far away from having a set of recommendations about how these things should be dealt with. I think they're both new; they raise a bunch of complicated issues. It's going to require some thinking. I do agree with Brian's point that we don't want to get behind the curve on this because we will, you know, deter development, although I have to say I was at an AI in health care on Tuesday, and I have to tell you, the world is not deterred. I mean, people are moving quickly in a range of ways, with services that I was like, "You can do that?" It is really amazing.

But we will have to see how that plays out because that community will be impacted by the stuff that CMS does. But we are a ways away from getting it.

To those at home that find this discussion or, for that matter, the other discussions this afternoon interesting, please reach out and give us your comments at

Meetingcomments@medpac.gov. You can find us on the website. We really do want to hear what you have to say. And we're going to adjourn now until tomorrow morning when we will have two, I think, really interesting sessions on Medicare Advantage. But to the staff for today, thank you; for the Commissioners, thank you. And everybody have a wonderful night and we will see you in the morning, 9:00 a.m.

[Whereupon, at 4:33 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, November 3, 2023.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, November 3, 2023
9:00 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
JONATHAN B. JAFFERY, MD, MS, MMM, FACP
R. TAMARA KONETZKA, PhD
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD, MPH, MBA
JAEWON RYU, MD, JD
SCOTT SARRAN, MD
GINA UPCHURCH, RPH, MPH

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

AGENDA PAGE

P R O C E E D I N G S

[9:00 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to our Friday session of the November MedPAC meeting. We have two sessions this morning, both of which are on Medicare Advantage.

This first one I want to call out because we have been trying to compare spending for beneficiaries in Medicare Advantage if they've been in TM for a long, long time, and we typically have had sentences that have said things like, "This estimate reflects coding, but it doesn't estimate selection." And we've known for a long time that there has been selection, and we have been doing some work -- we've presented some before -- to try and quantify how much selection there is.

And so I want to make a -- this material in some ways is a little technical, so I want to make a particular shout-out to Luis and all the work he has done. If you look at the body of literature on selection, which is large in some ways, or at least growing, this is, I think, in many ways amongst the most comprehensive work that's done.

That does not mean that it is complete or

definitive. It is difficult analytic work. We're going to continue to kick the tires on it. I will tell you in advance the number we get is both bigger than the number I thought we would get when we started and seemingly robust to a number of things we've done as we've tried to scratch the surface to see what it is. And I would be remiss -- it is true that all the staff do a lot of work on all other chapters, but I do think this in particular requires noting the attention that we've paid to a lot of the details in doing this.

So that was a longer-than-normal but still heartfelt thanks, Luis, for everything you've done, and I'm going to turn it over to you to describe to the Commission and the public.

MR. SERNA: Good morning. Medicare beneficiaries who have both Part A and B can enroll in a Medicare Advantage plan.

In 2023, the majority of eligible beneficiaries are now enrolled in MA. In today's presentation, I'm going to discuss favorable selection in MA and the extent to which it increases payments to MA plans.

I'd like to thank Andy Johnson for his help with

this presentation. This material will be included with our annual MA status report in March 2024, and Commissioners will review a draft of that chapter in January.

As a reminder, the audience can download a PDF version of these slides on the right side of the screen in the control panel.

I'm going to start by discussing how Medicare uses fee-for-service spending to pay MA plans. Then I will explain how this creates a potential bias through favorable selection and coding, which would result in higher MA payments. Next, I will describe MedPAC's analytic framework for how we estimated favorable selection. Then I will present the results of our updated estimates of the effect of favorable selection in MA. Combining our most recent estimates of favorable selection and coding, I will then discuss their implications for MA payments relative to fee-for-service spending. Finally, Commissioners will provide feedback on the estimate of favorable selection and provide guidance on future work.

The MA program allows beneficiaries to receive their Medicare benefits through private plans. Payments to MA plans are directly tied to fee-for-service spending.

Payment benchmarks, the maximum amount Medicare will pay for an MA plan to provide A and B coverage, range from 115 percent to 95 percent of local fee-for-service spending. Even the MA risk adjustment model, which is the basis for risk-adjusting benchmarks, is developed using the experience of fee-for-service beneficiaries.

The risk scores produced by the model increase payment for MA enrollees with higher expected costs associated with demographic factors and submitted diagnoses. Average risk scores can accurately predict costs for MA enrollees when there are similar coding patterns between fee-for-service providers and MA plans. In fee-for-service, on average, risk scores predict costs accurately but will underpredict or overpredict costs for each beneficiary.

Underpredicted costs occur when actual costs are above the predicted costs. Overpredicted costs occur when actual costs are below the predicted costs.

MA payments assume that, on average, the accuracy of the risk adjustment model will be the same for fee-for-service and MA enrollees.

Discrepancies in coding have led to unintended

higher payments for MA plans. Coding generates excess payments because MA plans have a financial incentive to document more diagnoses than providers in fee-for-service Medicare, leading to higher MA risk scores and greater Medicare spending when a beneficiary enrolls in MA.

CMS currently lowers MA risk scores by 5.9 percent because MA coding is more intense. In September, we presented our most recent estimate that coding led to more than 8 percent higher payments to plans in 2021 after accounting for the 5.9 percent adjustment.

Favorable selection would also generate higher payments to plans. The effects of favorable selection are absent any intervention from plans. Favorable selection occurs if risk-standardized MA spending would have been lower than the local fee-for-service average. This means that risk scores would overpredict MA spending and lead to higher payments for MA plans.

Given the availability of data, the effects of selection are difficult to directly measure, but selection could have important implications. MedPAC has been examining the effects of favorable selection. We estimated the effect of selection one year prior to enrollment in

2012, and we expanded on this method in 2023 to estimate the cumulative selection for enrollees in one year.

We continue to make refinements to our estimates of favorable selection and are open to feedback. We emphasize that selection is separate from coding and the two effects are additive. We now further examine some potential reasons behind favorable selection.

MA plans may influence favorable selection through care management restrictions that are unlikely to occur in fee-for-service, such as preferred networks and prior authorization. Katelyn and Ledia will discuss these utilization management tools more in the next presentation.

MA plans have an incentive to require at least some cost sharing for many services to avoid unnecessary care. These plan incentives may influence self-selection of beneficiaries by those who have certain health conditions and seek care from providers that may be out of network, such as cancer centers and psychiatrists. In addition, some beneficiaries may seek to mitigate delays in care that may result from prior authorization.

Further, beneficiaries who expect to use more medical services may prefer to stay in fee-for-service and

purchase comprehensive Medigap coverage. These incentives are not exhaustive, and other factors may also contribute to favorable selection.

In June, MedPAC estimated that favorable selection alone led to 11 percent higher payments in fee-for-service in 2019. Because MA benchmarks rely on risk-standardized fee-for-service Medicare spending, they reflect the higher level of costs associated with the fee-for-service enrolled population rather than a plan's enrollees. This results in MA plans experiencing favorable selection. To the extent selection occurs, it allows plans to bid lower than fee-for-service spending before producing any efficiencies in care delivery. This creates both higher payments for MA plans and introduces bias in the comparison of risk-standardized spending between MA and fee-for-service enrollees.

The estimates we published in June are consistent with a substantial body of research literature that suggests risk scores on average overpredict spending for the MA population. Again, this is before any coding differences occur between fee-for-service and MA or any other plan interventions.

Some studies have found evidence of favorable selection using indirect measures such as mortality and Part D event data. One recent study found that MA enrollment was systemically disproportionately higher in counties where CMS overpredicted risk-standardized spending for fee-for-service.

Other studies have examined selection more directly using the risk scores and spending in the year before beneficiaries switch from fee-for-service to MA. This approach is appealing given that an increasing share of MA enrollees were once in fee-for-service. We note that these studies all find a higher selection effect than we reported in our June report. For example, one recent white paper by Lieberman and colleagues estimated selection equivalent to 14.4 percent of MA revenue in 2023.

Given the availability of data, our estimates of favorable selection also rely on comparisons of risk-standardized fee-for-service spending prior to MA enrollment. Because the majority of MA enrollees were in fee-for-service at some point, looking at their prior fee-for-service spending is a viable method for estimating selection.

Slide 10 provides an example of how we calculated a favorable selection percentage for the 2022 cohort of MA entrants who switched from fee-for-service. We used their 2021 fee-for-service spending and compared it with the 2021 spending of beneficiaries who stayed in fee-for-service in 2022. The MA cohort had a monthly spending average of $665. We matched the MA cohort's geographic distribution and risk profile to the fee-for-service comparator, and then we calculated a monthly spending average of $736 for this group, an amount 10.7 higher than the MA cohort average. Thus, in the year before MA entry, the MA cohort spending would have been 90 percent of fee-for-service spending based on the effect of favorable selection alone.

However, only estimating selection in the year before MA entry is potentially limiting. As the length of time increases for a cohort of enrollees, favorable selection can be affected by two factors: one, attrition of the original cohort; and, two, the potential increase in risk-standardized spending as beneficiaries age, a concept often referred to as "regression to the mean." The figure on Slide 11 conceptually walks through how both of these factors affect the selection estimate in 2021 for the

cohort of 2017 MA entrants. We would initially examine their selection based on their fee-for-service spending in 2016.

However, some enrollees in the cohort will either return to fee-for-service or die between 2017 and 2021. Because beneficiaries who leave MA or die are likely to have high utilization of services, the attrition in MA enrollment likely reinforces favorable selection for MA plans. Thus, the initial favorable selection will need to be recalculated to reflect the remaining cohort.

After recalculating the initial selection effect for the sub-cohort of remaining MA enrollees, we approximate their likely change in selection effect between 2016 and 2021. Put another way, we account for the potential regression to the mean as beneficiaries age. The net effect of attrition and regression to the mean produced the final selection effect in 2021 for enrollees in the 2017 cohort.

Since June 2023, we have made four updates to our analysis of favorable selection.

First, we have expanded our analysis to estimate the cumulative selection effect annually from 2017 to 2021.

Second, we now include employer plan enrollees directly in our estimate and include hospice users that meet our enrollment criteria.

Third, we previously measured regression to the mean using the change in selection effect for proxy cohorts based on their duration in fee-for-service. We continue to use the same proxy cohorts for regression to the mean, but we now first account for their magnitude of their initial selection effect.

Fourth, we now trend forward the selection effect of the most recent MA entrants. More details on these updates can be found in your mailing materials.

Applying our updates since the June 2023 report, we now will walk through the effect of attrition using cohorts of 2021 MA enrollees. The figure on Slide 13 first looks at the favorable selection percentage in the year before MA entry. Consistent with the findings in our June report, we find favorable selection among all initial MA entrants in the year prior to MA enrollment.

We now look at the effect of attrition on each of these cohorts of MA entrants based on who was still enrolled in MA in 2021. Attrition reflects the base year

selection of a cohort after beneficiaries either return to fee-for-service or die between the MA entry year and 2021. Consistent with the findings in our June report, we find that attrition clearly reinforces the effect of favorable selection. Longer duration of MA enrollment generally coincided with larger changes in the selection effect in the year before MA entry.

For example, let's look at the selection effect in 2009 for 2010 MA entrants. The initial 2010 cohort of MA entrants had a base year favorable selection percentage of 95 percent in 2009. After recalculating the 2009 selection percentage to account for attrition, the subset of remaining enrollees had a base year selection percentage of 79 percent. A key takeaway here is that we should not assume the selection effect will regress to the mean based on the original cohort of MA entrants. The selection effect in 2021 must be based on the enrollees that actually remained in the MA cohort through 2021.

After accounting for the effect of attrition, we also accounted for the effect of regression to the mean. This effect measures the change in risk-standardized spending relative to the local fee-for-service average for

each additional year that beneficiaries age. Consistent with our findings in the June report, we found that cohorts regressed toward the mean of the MA population rather than the fee-for-service population. In fact, when we look back at the historical fee-for-service experience of 2018 to 2022 MA entrants, we consistently found that MA entrants regressed toward the MA mean rather than the fee-for-service mean, even after more than a decade of aging.

A key takeaway here is that it may be unreasonable to expect cohorts of the MA population to regress to the mean of the fee-for-service population. This assumption is also informed by persistent differences we found between MA and fee-for-service among decedents, and details on this analysis can be found in your mailing materials.

We estimated the regression to the mean effect using proxy cohorts who entered MA immediately after the measurement year. For example, we used the fee-for-service experience of 2022 MA entrants to estimate the 2021 regression to the mean effect for each of the 14 MA entrant cohorts from 2008 to 2021.

Now we look at the estimated net selection effect

of each cohort in 2021, this time identified by the year they entered MA. After combining the effects of attrition and regression to the mean, we find substantial and consistent MA favorable selection in 2021 across all cohorts of MA entrants. Each cohort had made spending in 2021 that was at least 10 percent below the local area fee-for-service average. Again, this estimate is before any intervention from MA plans, including coding and utilization management.

The preceding figures walk through our next selection effect estimates for each MA cohort in 2021. Now we look at how the net selection effect factors into the estimated cumulative selection effect in 2021. We repeated our analysis of attrition and regression to the mean for each of the 14 MA entry cohorts in 2021. We weighted the results for each of the 14 cohorts by the total 2021 MA enrollment corresponding to each entry year. Thus, we assumed the same selection effect for MA enrollees with less than two years of prior fee-for-service enrollment who were not in our data.

Your mailing materials include additional sensitivity analyses we conducted and literature we

reviewed to inform this assumption. To calculate the cumulative selection effect in 2021, we calculated the weighted average of the net selection effect of the 14 cohorts.

Now we show our estimated cumulative selection effect which aggregates each cohort's net selection effect in each measurement year from 2017 to 2021. The preceding slides walked through how we calculated the cumulative selection effect in 2021. We repeated those steps to measure the annual cumulative effect of selection in years 2017 to 2020. This includes calculating the next selection effect of each MA cohort in each measurement year, which accounts for attrition and regression to the mean for each MA cohort.

As described in the prior slide, we weighted the results by total MA enrollment corresponding to each cohort in the measurement year. Overall, we estimate that the cumulative effect of selection increased annually from 2017 to 2021. In 2017, selection resulted in spending for the fee-for-service comparator being 5.9 percent higher than MA spending, and the effect of selection rose in each subsequent year, reaching a 12.8 percent effect on the fee-

for-service comparator in 2021. These estimates have substantial payment implications.

We combined our estimated effects of selection, represented by the orange bars in the figure, with our most recent coding estimate, represented by the green bars in the figure. We applied these effects to our retrospective analysis of MA to fee-for-service spending from 2017 to 2021, represented by the purple bars.

Prior to the effect of selection and coding, the purple bars show that MA payments were generally slightly above but relatively close to fee-for-service spending in the pre-pandemic years with some divergence in 2020 and 2021 due to prospective payments being less accurate during the pandemic.

When we include the estimated effects of selection and coding, MA payments were far above fee-for-service spending levels. We estimate that MA payments were 10 percent above fee-for-service spending levels in 2017 -- increasing to 18 percent above fee-for-service spending levels in 2021. Thus, these levels of additional spending are far above what the Commission previously estimated in March.

We also combined our estimates of selection and coding to calculate the resulting payments above fee-for-service in dollar terms. We estimate that selection and coding resulted in MA payments that were $50.8 billion above fee-for-service spending 2021 and $192.5 billion over the five-year period from 2017 to 2021. As a result, we estimate that these payments are far above what would have occurred in fee-for-service.

The combined effects from selection and coding underscore concerns about basing MA payments on the Medicare fee-for-service population. We found that MA enrollees were consistently favorable relative to the local fee-for-service average prior to MA entry. After accounting for the estimated effects of MA attrition and regression to the mean, the annual cumulative effects of selection increased during the 2017 to 2021 period -- reaching payments that were 12.8 percent above fee-for-service spending in 2021.

Our estimates are backed by several checks of robustness. They are also reasonably consistent with the estimate we published in June and the findings of several other researchers. When combining the effects of selection

and coding, we estimate that MA payments were 18 percent above fee-for-service spending in 2021, or an estimated $50.8 billion in higher payments to MA plans.

We plan to continue monitoring the effects of favorable selection into MA and include favorable selection in our annual March MA status report.

For your discussion, we are happy to answer any questions you have and welcome any feedback on our methodology to estimate the effect of favorable selection into MA.

We also welcome any guidance you have for future work. As a reminder, we plan to include this material in our March 2024 MA status report, and you will have an opportunity to review and discuss that draft in January. With that, Mike will now lead our discussion.

[Audio interruption.]

DR. CHERNEW: All right. After that brief technical hiatus we are now back, and for those of you following along at home we are now at point two. Actually, Amol, you should start at point one again, because I don't think that was heard. So Amol is going to now kick off the Round 1 queue on questions about the selection material

that was just presented.

DR. NAVATHE: Okay. So hopefully everybody can hear me now. First off, Luis, I just wanted to thank you for this very thoughtful and comprehensive work on a very challenging topic. I'm glad that we're doing some work on this at the Commission.

I have five questions which are not in any particular order. The first question I had is related to Slide 13, if you can go to that slide, which I believe is the same as Figure 2 in our mailing materials. I just wanted to confirm here that this is the one-year effect such that when we're looking at, as you later go on to consider longitudinal factors like regression to the mean or selective attrition, the estimates that we see here on Slide 13, however, are not subject to those, quote/unquote, types of confounding. Is my understanding of that correct?

MR. SERNA: That's correct.

DR. NAVATHE: Great. The second question I had, really a clarification question, is as we're looking at all the spending dollars that you're using here, there are all spending in fee-for-service. In other words, to the extent that MA plans are creating efficiencies in spending, or

trending lower, none of that per se is actually measured or captured here. This is all based on the fee-for-service spending and the fee-for-service risk scores also.

MR. SERNA: Correct.

DR. NAVATHE: Okay. The third question here is, so as we've done this analysis we are focusing on switchers. So we're focusing on individuals or beneficiaries who are first in fee-for-service for some time period and then move to MA, and then we're using that later on as we do some of the estimates and we get to the 18 percent number and the $50 billion number. Those numbers, however, are applied to the entire MA population. We are not cordoning that off to just the switchers. Is that correct?

MR. SERNA: Correct.

DR. NAVATHE: Okay, great. Next question is, so selection notably is always challenging to measure because oftentimes it's hard to concretely and tangibly put our empirical fingers on it. And so what I wanted to just confirm here is that when we mean selection, to some extent we're including a number of different factors that could be in this selection effect, meaning that certainly it could

reflect health of the beneficiaries, but there are other things that could be also at play. It could be related to their preferences for utilization, other factors about them, maybe the types of health insurance they've had before and how that might influence their spending patterns. All of that is essentially wrapped into this selection that we're measuring.

MR. SERNA: That's correct.

DR. NAVATHE: Okay, great. And then the last question is, and the slides very nicely called out some other literature that's looked that's from an indirect and direct perspective, and I thought it was really helpful. I am somewhat aware of that literature. But I thought it would just be helpful to get your thoughts on relative to the magnitude of our effects from the selection percentage how do those compare generally with the literature, particularly on the ones that are measuring the direct effect as opposed to the indirect?

MR. SERNA: Generally our estimates are a little bit below what's estimated in the literature when you align the years that were looked at. So our selection percentage obviously depends on the year. We have a selection

percentage of roughly 11 percent. The literature is typically a little bit higher. It can be 13, 14, 15. It depends on the study.

DR. NAVATHE: Okay, great. Thank you so much, Luis.

DEPUTY DIRECTOR KELLEY: Robert.

DR. CHERRY: Yes. Thank you. I just have two clarifying questions and I will take them one at a time. The first has to do with the 6.5 percent rebate, which is the difference between the bid and the benchmark rates. Is there any, I don't know, guardrails around that, or is that 6.5 percent under certain circumstances, either clawed back or reconciled on the back end based on certain efficiencies or benchmarks or is it just automatically given?

MR. SERNA: It's automatically given, and it has to be used to provide extra benefits to enrollees in some way. So that's essentially the only restriction that there is. There is no clawback in payment apart from the medical loss ratio when it's under 85 percent, and there are some clawbacks that may occur when there are audits for risk adjustment. But other than that those are the only clawbacks.

DR. CASALINO: Just a clarifying question on this. Luis, the rebate can be also for administration and profits, correct, not just for extra benefits?

MR. SERNA: Right. So administration and profits are built into what the plans project is needed to provide those extra benefits. So there is an administrative and profit loading onto those extra benefits, and that's used with the rebate dollars.

DR. CHERRY: Thank you. That's helpful to know. And the second question, I know the answer to this but I just want to go on the record and answer it anyway. So basically favorable selection is not implying in any way that the MA plans are cherry-picking their membership. It's just based on the fact that the methodology is exclusively based on the fee-for-service population, which is a bit distorted because they have high risk scores. Is that correct?

MR. SERNA: So it's more that the plans have certain incentives, and when a beneficiary has a choice between fee-for-service and MA some beneficiaries will more naturally choose fee-for-service if they have certain preferences. Other beneficiaries will more naturally

choose MA. And that kind of causes this divergence between the two populations.

It's not necessarily based on the level of risk score. The analysis essentially says that if you apply the same risk score to both populations that there are still spending differences, and the spending differences are higher for the fee-for-service population.

DR. CHERNEW: An example would be if someone who never likes to go to the doctor is more likely to join MA you would see this type of pattern. If someone who is unobservably healthier is more likely to join MA you would see this pattern. If someone had less generous coverage when they were in fee-for-service than subsequently joined MA you might see this pattern.

There are incentives, clearly, for plans to do things to encourage selection, but we are not now parsing any of this selection into behavior of the plans versus natural selection activities by individuals. I think we're just making a quantitative point, and I think Amol was clear, if you look at that one slide, which is 13, if you look at the gap between predicted and actual spending for individuals the year before they join, the people that

joined had much lower spending, which could be for a range of reasons. And then if you look at 14, the attrition, we can discuss the methodology but is reinforcing that.

DR. CHERRY: So it's actual versus actual.

DR. CHERNEW: No. I think the selection is the predicted spending that they had in their fee-for-service service relative to what they actual spent in the pre-service year. Am I --

MR. SERNA: Essentially mathematically it's sort of standardized, so it's the actual spending divided by their risk score. So it is a prediction on the actual spending.

DR. CHERNEW: That's right. But the selection is basically a bunch who spend less than they were predicted to spend.

MR. SERNA: That's correct.

DR. CHERNEW: And they actually spent less than they were predicted to spend.

MR. SERNA: That's correct.

DR. CHERNEW: It's the difference between their actual spending versus essentially what their predicted spending would have been.

MR. SERNA: That's correct.

DR. CHERNEW: Risk or adjusted.

MR. SERNA: That's correct.

DR. CHERRY: So I think what could be helpful in terms of subsequent iterations of this is just to define favorable selection more clearly. So if this is based on sort of patient choice and patient behaviors and therefore by natural selection, the patients with the higher risk scores are naturally choosing, disproportionately, fee-for-service, and then we're using that pool of patients exclusively. That's what is creating the distortions.

I think you have to do some digging into the material to figure that out, so the higher you put that up in the materials I think it makes it cleaner and easier to read and this way everybody is on the same page. Thank you.

EXECUTIVE DIRECTOR MASI: Can I jump in real quick for clarification on Larry's question from a moment ago, and Luis, you should watch this carefully to make sure I don't get something wrong.

I think the administrative load -- so the rebates and supplemental benefits -- I think it varies based on

what the supplemental benefit is. Is that correct?

MR. SERNA: That's correct. So if you have a Part B buydown that's the case where the money is going to go straight to Social Security. So it's not going to have any administrative or profit load built into it.

DR. CHERNEW: But it's also the case that when they look at the costs of the benefit, that cost of the benefit isn't an actual audited sort of cost.

MR. SERNA: That's right.

DR. CHERNEW: It is the cost that is sort of actuarially estimated for offering that benefit. So while there's a profit built into the system, there is also a profit that potential -- I'm not saying anything about this -- but there is potentially a profit built in under the system because we're not measuring the utilization of transportation. We're not measuring a whole bunch of other things. And we have, for a long time, noted both the generosity of Medicare Advantage benefits, which we basically like, and our inability to understand the value of that added generosity, which we would like to do better.

MR. SERNA: That's correct. We don't know.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you so much for this work. I'll leave the how we analyze it exactly to some people who are more familiar with that. But I have some very basic questions. I'll have several comments, but questions.

Are we looking at A and B spending only for fee-for-service or are we looking at secondary coverage, which I imagine we're not? So that's the first question.

MR. SERNA: It's A and B only.

MS. UPCHURCH: So is it A and B also only on the Medicare Advantage plan side, or are you including the extras that come in -- and I'm calling them extras, not supplemental -- extras or additional benefits. Are those costs included also or just A and B?

MR. SERNA: It's just A and B. So everything is estimated using the fee-for-service experience of MA enrollees.

MS. UPCHURCH: Okay. So it's not including that, and it's not including D, the drug plans.

MR. SERNA: That's correct.

MS. UPCHURCH: Okay. I just wanted to make sure of that. Thank you so much.

Oh, I'm sorry. There's one more. And it doesn't

include what we talked about yesterday, where you talked about the critical access hospitals, the rural emergency hospitals, all the extra fee-for-service payments that go to prop up some of those systems. That's not assumed here at all?

MR. SERNA: So any payments apart from what would be excluded in benchmarks, which is GME and IME, it is included, and that's because we want to show the effect on benchmarks. So if it's included in benchmarks then that spending is included in the analysis.

MS. UPCHURCH: Okay. Great.

DR. CHERNEW: I want to say one other thing, and it might be helpful if you go to the slides, and I'm not sure which slide. The estimate of selection, which is basically taking us through Slide 19 is really just about one portion of this. When you get to Slides 20 and 21, that's where those things are talking about, Gina, are included in the overall payment stuff, because that starts with in the bar that was orange or whatever -- my colors aren't that good anyway -- that one bar of like other than selection and coding, that is an estimate of a lot of other factors -- the quartiles, the stars, just a bunch of things

that are all in there. But for the actual selection analysis bulk of this, All of the treatment of that is sort of outside that.

MR. SERNA: That's correct.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Two quick questions and an extremely quick Round 1 type suggestion. The questions are, in the slides towards the end, Luis, where you estimated an 18 percent selection effect, is that after the 5.9 percent coding adjustment?

MR. SERNA: Yes.

DR. CASALINO: Okay. So if it weren't for a coding adjustment it would be closer to 24 percent. Is that correct?

MR. SERNA: That's correct.

DR. CASALINO: Okay. The second question is, you showed that it appears that the selection effect increased in recent years, year after year. Any idea why that would be happening?

MR. SERNA: We haven't dug into why that trend occurred.

DR. CASALINO: Okay.

DR. CHERNEW: Can I say something about that, which might be an answer, although again we haven't dug into it. If you look at the consistency of the selection into MA, on Slide 13, it's very stable, and we're seeing very little regression to the mean. So my guess as to what's going on is selective attrition, which if you look at Slide 14 is actually changing quite a lot. We need to look into that more -- I agree with you completely -- but my guess as to what's going on is it's some combination of the combination of selective attrition growing in a range of ways and how the cohorts are done.

But I think, Luis, it's fair to say we can look more into that issue?

MR. SERNA: That's correct.

DR. CHERNEW: But I'm hoping that my inference from the materials seems reasonable based on what I've seen. Sorry. I wondered the same thing.

DR. CASALINO: Okay. And briefly, my one suggestion is I think that a lot of readers may have a question about how easy is it to move in and out of Medicare Advantage, and in particular how easy is it to move from Medicare Advantage to fee-for-service Medicare.

And my understanding is that is not great but I think it varies according to what state you live in.

So it might be helpful just to have a little contextual discussion somewhere just saying yes, you can leave and it may or may not have friction to leave, and I think that's kind of a natural thing to think about when you're thinking about selection. So that would be easy to do. You could do it in a paragraph or two probably.

That's it. Thanks.

MS. KELLEY: Lynn.

MS. BARR: Luis, I just can't say enough about this analysis. This is like the greatest thing I've ever read, so I'm super excited about it.

So on the Round 1 side, COVID effects. I'm looking at '22, and I'm going oh my gosh, you know, but that's COVID. In '21, it's COVID. So what are you thinking about what is 2023 going to be looking like? Do you have any sense of, you know, are we coming off a big bubble or is it going to continue to trend upwards?

MR. SERNA: We have internally talked about that. I think we'd have to dig in more and kind of talk internally about what we think. But we did see an increase

in the trend from '18 to '19. So it's not all COVID but it's hard to say.

MS. BARR: Right. But we should probably be thinking about the numbers in '19 still because of COVID effects. It's a little hard to understand -- which are plenty huge, you know. So I don't have any problem with that.

I would be very curious to see this analysis broken down a little bit, if it's at all possible. One of the things that is really hard about risk adjustment is some providers do it and some providers don't. Some plans spend a lot of money it, and some plans don't spend a lot of money on it.

So when we're looking at averages, I imagine that the swing between the lowest coding plan and the highest coding plan is going to be pretty big. Would you be able to give us some insight on -- can you break this down by plan for us?

MR. SERNA: I don't think we can do it by plan, but we may be able to do something by geography. We can look into that.

MS. BARR: Or possibly even just types of plans,

like provider-based plans, in particular. Because my experience is the provider-based organizations are more focused on patient care and less willing to do extensive coding. So I just want to understand. I don't want to throw the baby out with the bathwater. I want to see if we can identify is there something here.

The other stratification I'd love to see of the data is by disease. I'm going to steal a little of Stacie's thunder here on oncology, but we were talking about this quite a bit last night. And getting cancer treatment at a cancer center or an academic medical center is more expensive because they have access to a lot more things, which are lifesaving and important, and access to that is important to the beneficiary.

So I'm wondering if part of this, you know, people that are leaving the plans, is there a diagnosis association? Is it oncology? Is it cardiology? Would that be possible to do?

MR. SERNA: That's something we can think about for future work.

MS. BARR: Awesome. That's it. Thank you.

DR. JOHNSON: Just to add one point to your first

question. So to the extent that the plans differ by coding, we wouldn't see that show up in changes to the selection estimate part of that because that is all based on fee-for-service spending. But we would see changes in our coding estimate separately.

MS. BARR: Yeah. So for example, when we were in our ACOs we'd by data from Milliman that would tell us which counties were most favorable, and we would concentrate our activities -- we wouldn't concentrate our activities in those counties but we would be aware of them and we would striate our programs that way.

And I'm just curious. You mentioned something about the patients that were under-coded, those counties. So there is some evidence that the plan is doing some specific possibly marketing activities that are related to data they have, and I was just curious if you can kind of -- so that's why when I look at it from a plan, because if we can see that behavior in the coding, we might be able to see the behavior somewhere else. Thank you.

DR. CHERNEW: I just want to say one other thing that's gone back and forth about geography. There is this question you raised, which is think is valuable -- does

selection vary by geography, which is the question you asked, and I completely agree. But I do think in the predicted spending regressions we actually have controls for geography.

MR. SERNA: That's correct.

DR. CHERNEW: We just haven't done a separate estimation of a differential selection effect by geography.

MR. SERNA: That's correct.

DR. CHERNEW: But this is not driven by variation in geography.

MR. SERNA: That's correct.

MS. BARR: And when we talk about geography, what are we talking about? County?

MR. SERNA: Yes.

MS. BARR: Okay, great.

DR. CHERNEW: And I do think there are important sub-county geographies, by the way, but the point is that's the answer to your question.

MS. BARR: County is good enough for me.

MS. KELLEY: Tamara.

DR. KONETZKA: I also really enjoyed this chapter. I found it a very, very clear and thorough

analysis of a very difficult question, so thank you for that.

For obvious and justifiable reasons all the analysis is based on switchers, basically, people who switched into MA, people who switched out, because then you can use their prior fee-for-service spending. But the group then that's left out are the people who just enter MA right away and never have prior fee-for-service spending, or I guess there were some that had not enough prior. But anyway, this group that just entered MA right away is the group that's left out. Clearly, as we were just talking about, people who switch in or out might be different from people who never switch, in important ways.

In the chapter I think you had mentioned that in 2021, 26 percent of the population had no prior fee-for-service enrollment. And then we take these analyses of switchers and sort of apply it to that whole population as well.

So I guess the two questions that come up about that is, is that as people get more and more used to managed care and are used to having that their whole lives, is that percentage increasing over time? And do we know --

I mean, obviously you don't have the same claims for them, but do we know anything about the population that enters MA right away and who are not contributing to our estimates, in terms of are they really different in measurable ways from the population we're using to derive the estimates?

MR. SERNA: So I think on the first question we haven't seen an increase in the enrollees in a given year who are newly eligible for Medicare. It seems to be the opposite, and of course, this may change over time, but an increasing share of MA enrollees have some kind of fee-for-service experience.

On the second question, I think what we could do, and what we did do, and it's in the paper, is we looked at beneficiaries who switched after one year, and because they were consistently favorable over the five-year period, we assumed that beneficiaries who made the same choice 12 months earlier would've had similar selection patterns.

There have been studies using indirect measures on mortality for newly eligible enrollees which showed differences. There was a recent white paper that did look at a small population of enrollees at age 65 and whether they had selection in the year before, and that paper did

find selection.

So those are the things that we used to kind of assume that the selection patterns would be at least similar, if not possibly more.

MS. KELLEY: Scott.

DR. SARRAN: Yeah, incredibly impressive work and some of it went way over my head but I think I got the gist of it and it's all directional. Three brief Round 1 questions/comments that build off some of those.

First, building off Lynn's question about can we segment. I think that would be very helpful. And I'd suggest, if we could, looking at whether we can segment by for-profit plans being one category, not-for-profit but not provider-owned being a second, and provider-owned being the third. I think that would be very useful in terms of the dynamics and behaviors of those plans.

I would also like to see if we could segment by SNPs versus non-SNP. I think that would be very informative.

I would reinforce Mike's earlier comment about if we can tease out selective enrollment versus disenrollment, I think that would be very helpful in the data.

And to Tamara's point just a moment ago, I would think we could get at some of this issue about is there something different about the people, the newly eligible beneficiary who chooses MA versus selecting traditional Medicare by looking at the subsequent, in their first year, after becoming eligible, some key diagnoses and procedures. So for example, if there is a cancer diagnosis in that first year of eligible or if there is a major elective surgery, those likely reflect health status or illnesses that pre-existed their choice decision, and I think that would be very informative as well.

MR. SERNA: We could certainly think about that aspect. I think the aspect of segmenting by plan type becomes difficult because you do have smaller N's at the geographic level, and I think that's what we want to try to avoid. But we can look into what kind of segmenting we can do. I mean, as it is, we don't really have to worry about standard error because we're using everybody, but we could think about that.

MS. KELLEY: That's all I have for Round 1 unless I've missed anyone.

DR. CHERNEW: No, I think that's good because of

our technical glitch. We're going to go to Round 2. We're a little tighter on time, and I think the material coming next in the next presentation is very important. But I don't want you to not make your comments. I just want to be aware of that.

What we're going to do is we're going to skip the break, the five-minute break between the sessions and just kind of go right through to try and make up on some of that time. But we should jump through Round 2.

MS. KELLEY: Okay. I have Stacie first.

DR. DUSETZINA: Thank you so much. This was super interesting. One of the things I kept struggling with is a lot of the way we approach this is because of a lack of data in the encounter data. And this might not be a surprising question given how I always think about the drug data. The drug data, the Part D data, are quite good for both. So any thoughts on maybe looking at a version of this that includes the Part D enrollees, whether they pick MA first or fee-for-service first, and see if that helps to address both the selection and the coding-related issues if you just focus on the drug-related spend?

DR. JOHNSON: This isn't exactly on point but

there is one paper that did calibrate a risk adjustment model using the Part D data, and did find some selection of roughly a similar magnitude. I think there are some reasons why we think that wouldn't be exactly the same as the method that Luis has implemented, but it is supportive I think.

MS. KELLEY: Let's go to Gina.

MS. UPCHURCH: Thanks so much. Just three points. Again, I want to know the impact of brokers and agents on selection. I know that people that are agents or brokers that sign people up for Medicare Advantage plans can make a lot more money than they can signing up somebody for supplement and Part D. So how much of an influence do we think that has on what people are selecting, and can we get to that? I mean, it's a question but it's also something I hope we can talk about a little.

The second one, on page 14 in the chapter you talk about Medicare Advantage plans meeting the preferences and needs of individuals. I just struggle with that because there are so many variables, they may, given a few choices, choose the one that feels best for them.

Of course, none of us have a crystal ball about

what our future holds in terms of health care, but the extra benefits, yes, I need more dental, yes, I need more vision, yes, I like the rollover of the funds from quarter to quarter, I don't use mail order so I like that I can go to my local pharmacy to get my OTCs. Yes, it meets their preferences to some degree but there are so many options and so many variables, I struggle with that, even that statement that it meets their preferences and needs, because there are too many options. So Just want to point that out.

And then lastly, it's really just building off the point that Larry made. I'm in a state that does not have guarantee issue rights to supplement outside a very restricted periods. So we see a lot of people that really cannot make the selection to go back. They're in a Medicare Advantage plan for a few years. They want to go back. They don't have guarantee issue rights without underwriting to a supplement. So they can be denied total coverage or really high rates.

Now I know there are certain states like Massachusetts that have continuous guarantee issue rights. Their premiums tend to be higher, they have community-rated

premiums, but you have the right to go both directions.

So I really just think if we can somehow look at states, or at least acknowledge that the preferences to go back and forth really depend on what state you live in. These plans are by county, but then they're within the restrictions of state policy. So if we could just point that out would be great. Thanks.

Oh, one other thing, sorry, about trial rights. For those of you who don't know, when you first select a Medicare Advantage plan, usually after you start Part B you have six months to have guaranteed issue rights to get a supplement without underwriting, but you have 12 months to try a Medicare Advantage plan and go back, and you could still get a supplement. Or if you're in a supplement and you cancel the supplement and you choose to go try -- say you're 80 years old and you see these extras. You have 12 months to try a Medicare Advantage plan. That's another trial right. But within that 12 months, you can't wait for the full 12 months, you've got to get back to be able to get that supplement back.

So there are two trial rights that Medicare Advantage plans are given so that some of that churn

happens because of these trial rights. Thanks.

DR. NAVATHE: On Gina's point?

MS. KELLEY: Amol, go ahead.

DR. NAVATHE: So to the extent that there is inertia created or frictions to switching out or state-based variation in the supplemental coverage rules and guaranteed issue, in some sense that is resulting in our number. But if there wasn't that friction -- in other words, if there were higher spending MA beneficiaries who would otherwise switch out -- that would actually make our selection percentage even higher, right? So to some extent those are resulting in a selection percentage -- it's what we estimate, but I'm just saying theoretically speaking, if we remove those frictions, from what you understand, it means that the percentage would only be higher. Correct?

MR. SERNA: Theoretically, yes, that’s correct.

DR. NAVATHE: Thanks.

MS. KELLEY: Brian.

DR. MILLER: Thank you for a variety of questions. EGWP plans are distinct from the general MA marketplace. Employers and unions use this as a distinct model to offer retiree benefits. They can have a national

bidding model, and there is 2006 CMS guidance that sort of dictates the rules of the road for CMS, and EGWP plans are not available to the general public.

And my question is, do we think it is accurate to include these in measuring selection bias in the overall MA program?

MR. SERNA: The June 2023 analysis did not include them in the analysis and just included them in the overall estimate and just assumed that they had no selection. But upon actually looking to see whether they had favorable spending before entering MA, we did see that. Of course, it was not as much of a selection effect as the general population. So it clearly seemed more accurate to include them rather than to assume that there was no selection effect whatsoever, and that is consistent with the period that we looked at.

DR. MILLER: I wasn't saying that there wasn't selection bias. I was saying that if we're looking at the general MA program and beneficiaries entering into MA, I think that the EGWP market would be more accurate to have it be treated distinctly rather than include it as general MA.

MR. SERNA: Right. But this analysis was from benchmarks, and because the payment for EGWPs is basically assumed based on the general MA population. So it's a reflection of it when we're looking at the estimate for benchmarks.

DR. MILLER: I understand what you're saying about the payment. I'm talking about the beneficiary choice of electing into an EGWP. It's not available to the general population.

MR. SERNA: Correct.

DR. MILLER: So I stand by the fact that this should be treated separately.

DR. CHERNEW: I want to ask a clarifying question. Originally the EGWP assumption was there was no selection.

MR. SERNA: Correct.

DR. CHERNEW: And you have now added it in.

MR. SERNA: Correct.

DR. CHERNEW: But when you add it in, did you add it in, per Brian's point, which I think is a good point? I know you're not reporting a separate selection --

MR. SERNA: Right.

DR. CHERNEW: -- which I think is part of Brian's point, and I think that's reasonable. But it is, in some sense, being captured separately. In other words, if we pushed you to go give a separate number, you're just not reporting it, but the difference is being reflected in the average.

MR. SERNA: The difference is reflected in the average. Correct.

DR. CHERNEW: Right. And I think your point, Brian, is spot on, that there is a different selection, and we worried a lot about that different selection, because the beneficiary selection issues, as you said, and I think you're right, are different when the employers are doing it versus when the individuals are doing it. I think that was your point, and I got confused.

DR. MILLER: And I think that same argument probably applies to D- and I-SNPs. The general beneficiaries cannot access that so those should be analyzed separately.

I guess the other thing I wonder about. I was an FDA product reviewer, and when you're an FDA product reviewer you review the entire dataset from a

pharmaceutical product development program. As an example, the study protocols can be about 2,000 pages long. So as you can imagine, it's sort of taxing and tiring, and there is a lot of data.

And one of the things that you always do when you analyze that much data, and you get an interesting result that doesn't necessarily fit, is say, does this make sense? And if it doesn't make sense, you go back and take a look at your model and reassess your model.

So my question is, if we're saying that favorable selection has increased from 5.9 percent to 12.8 percent when market penetration has grown from 33 to 53 percent, intuitively it seems like selection would decrease as market penetration increases. How would you explain this differential result?

MR. SERNA: So there is a paragraph of that in the paper, and it's not so straightforward. Because you can envision the MA population having higher standardized spending as they accrue more beneficiaries from fee-for-service. The offset of that is that the fee-for-service population can also increase as the distribution of spending in fee-for-service, as they become more

concentrated among the higher spenders.

And so it's that kind of push and pull. So it's not going to be linear. But if you have an MA population that had monthly average spend of $900, and you had fee-for-service $1,000, and had the MA population enrolled some of the fee-for-service population which had an average spend of $950, that does increase the risk standardized spending of the MA population, but in turn it also increases the risk standardized spending of the fee-for-service population, because those who remain are now higher for standardized spending.

DR. MILLER: I was going to say --

MR. MASI: Sorry. Can I jump in just for one minute. And I appreciate your questions, Brian. At a high level I took it as how do we think about this fitting into the big picture in terms of other checks and things like that.

DR. MILLER: I would say that the question is when you get a result that doesn't follow intuitively or what logically makes sense then you need to take a look at the model very carefully and say is my model correct and are my assumptions correct.

MR. MASI: Yeah, and I appreciate that question, and I think if there are kind of specific ideas that any Commissioners or any other folks have for things to check or to look at, we are very open to doing that work.

And I just wanted to say one other thing. One other kind of bigger picture check that we went through was, as Luis talked through, looking at what other researchers have said about this. Okay, go for it.

DR. MILLER: I was going to say, I have some other questions that I would like to get to and be respectful of time. And I would say that if we do follow this it would suggest that the MA plans, if we follow the logic of this model, it would suggest that MA plans are doing a great job of harvesting healthier beneficiaries as their market penetration increases, which would suggest that the fee-for-service earlier was actually healthier and that MA was sicker. So that, intellectually, I don't follow this.

And then in the context of demography, we have pretty good evidence that MA plans have poorer beneficiaries and also more minority beneficiaries. Both of those are well-established across a wide range of

literature from a variety of stakeholders to correlate with poorer health status. So if this is the case, again, how do we reconcile that with this model?

And then I think an important question, right, we talked about selective entrance and selective attrition, if hospice is not part of the MA benefit that obviously drives some selective attrition.

I think also we have to put this in the real world. So if we just think that their selection into MA -- and I definitely think that there is favorable selection into MA -- the question is in the setting of aggressive advertising regulation, enrollment oversight, and other regulatory restrictions on MA plan operations, and we no longer have the third-story sales seminars for MA that we had in the '90s, what is the operational business mechanism by which MA plans enact favorable selection, because that is not entirely clear to me.

And then I think another thing that we should explore is we should look at other managed care markets because plans have multiples lines of business. So what does the literature tell us, if they are doing this in Medicare Advantage are they doing this in the Medicare MCO

space, because we would expect them to go into both and do this sort of corporate behavior across all plan marketplaces.

I also did appreciate your robust citation of the literature. One thing that I would note is we know that there is selection and publication bias in the literature, and so I agree that the literature is all direction on this issue and in agreement, and just differs in order of magnitude. But I think we can all agree that it would be very hard for someone to do an analysis and show that MA and fee-for-service don't have favorable selection, and get that published in peer-reviewed literature, given the publication bias.

So I guess my other question, in the aims of being more broad-minded about this, could we also analyze and respond to the industry arguments on this. And I say this as someone who reads peer-reviewed literature, white paper, and industry literature, and as an example during the last MedPAC session I actually cited an American Hospital Association letter. So I think it's important that we look at the industry arguments and dissect them in order to make our argument stronger. Thank you.

Oh, one more thought, actually. One additional thought is if we do think that this is really a concern along with coding intensity and we think that this is a $15 billion a year problem, our recommendation shouldn't be necessarily additional mathematical models, but it would be more pragmatic for our recommendation to Congress to be that they invest $100 million to do the chart audit, go back through the claims, do the coding, go through the claims, do the two charts, construct risk scores, assess for coding intensity, assess for upcoding, and assess for favorable selection. We have the data, and we should answer all of these concerns about the MA program definitively, considering that we think that they're expensive.

Thanks.

MS. KELLEY: Scott.

DR. SARRAN: Building off Brian's comments, although we're not making recommendations in this chapter, I think we completely understand how industry will respond, and so I use the phrase, let's bulletproof our analysis and let's anticipate very reasonable, understandable ways industry will push back, and maybe even do a Q&A, text

boxes kinds of things around key points such as, you know, why did we decide to include AGWIP [phonetic] or not, what would possible explanations be for such a significant increase in the delta over time, you know, put that right out there. What about thoughts that in general low-income status, minority status tends to be a driver or predictor or correlate, rather, of high-cost? How do we think about that? Because, otherwise, we'll be reacting, I would bet, to a lot of industry letters that come in, so better to anticipate them and get that discussion up front.

DR. CHERNEW: Let me respond to a few things. I agree 100 percent with both of your points, both in terms of -- two things are important. One is it is important for us to understand the top-line number and how that just plays out in general, and it's important to us to continue to push the tires on a number of analytic issues, which I think the whole point of this session is to surface what those are and go through them. So in that sense, I just want to say to folks at home -- and I think this was said in the beginning. I think Luis was very clear. This is a work in progress. We're presenting a bunch of things. I thought the number we presented -- it was too high. We

kicked a lot of tires. It actually turns out now it's a little bit high. I do think there's still a lot more to do in this space.

I do want to say one mathematical thing about Brian's point, and I'll just say it very quickly, which is what matters in terms of selection when the market share grows is actually the skewness of spending about how it's played out. So that the distribution of spending is how that's going to work mathematically. But Brian's broader thing is right on. We could be crisper in how that -- there's a paragraph in there now, and we can be crisper about how that plays out.

The other thing, though, that I think is going on even more so than that is a lot of this is driven by the attrition estimates, and we can spend a lot more time thinking about how the attrition estimates are working and how that plays out, and I think that's also quite important as an exercise to do. So all of that is quite well taken.

MR. SERNA: And just quickly, the literature actually says, when you look at risk standardization, you see scores of ethnic minorities, Blacks and Latinos, that actually do have lower spending than the average. So the

literature actually says the opposite when you actually look at risk-standardized spending. And then the other point being that there's less selection opportunities in a Medicaid type market because it's more of an all-in market rather than what we have here.

DR. CHERNEW: And, again, I said this before, and I'll reiterate it again in response to Brian's comment and yours. We're not blaming selection on the industry per se, although obviously there's some reasons why that may contribute. And we are not attributing selection fully to health, although obviously health can be a part of it.

In a world -- I think in response to one of the very first questions, in a world in which MA is attracting low-income beneficiaries, as Brian said, and if you believe that individuals have different residuals, if you will, in a spending equation based on income, which is a reasonable thing to believe, you would observe selection, and you might not have a problem with the selection. You might say that's exactly what -- you can think about payment, but you could make a case that, well, we want to avoid the algorithmic bias associated with that payment. That's a perfectly reasonable thing to say. Or not.

We actually aren't there in this discussion, but this is not inherently a measure of health status differential, although it is partly a measure of health status differential. We can do a lot more work on understanding how that breaks out. What I don't want to get lost in this is if you're climbing a mountain that's really tall and you get partway up the mountain, I want to avoid the perception of people being concerned that we haven't gotten to the top of the mountain. And I appreciate -- what a lot of this conversation is, and I appreciate Brian's comment and others, is we are going to continue to try to move along that path --

DR. MILLER: I have an on-this-point response, if it's all right.

DR. CHERNEW: Yes.

DR. MILLER: I think what I'm trying to say is we should be thoughtful about how we construct this mountain, and if this is the right mountain that we should be climbing.

DR. CHERNEW: Okay. I'm just going to leave that, and we'll have to talk separately. But I think to the extent that the mountain is understanding how much

selection is in the system, I think that's a mountain that at least I would say is important to get --

DR. MILLER: I agree, but I'm saying we should go broader with the data. And, again, if we think that this is a very expensive problem, with coding intensity, favorable selection, et cetera, instead of modeling we should definitively answer the question.

DR. CHERNEW: Yes, that's right. And when we get to that stage, I think that the point about doing a deeper dive into the health status differentials is a reasonable point to do. It's a reasonable point to say if we think there's this much selection, let's really try and understand the health status better, that's it. That's a reasonable thing to do given the amount of money on the table. In fact, there's a bunch of other things that one might want to do to deal with the differences, and so I think that point is well taken. Okay.

MS. KELLEY: Jaewon.

DR. RYU: Thanks. Luis, I thought you did a great job with a very complicated set of dynamics and probably many, many variables. Just a few comments.

I really like Scott's comment about some

additional cuts that would be informative. I think that's right. And I think the broker channel, Gina's comment, I would also totally agree with because I think that does shape beneficiary individual choice and probably drives some component of what we're seeing.

On the geography point, I think that would be helpful. I think Gina's example is the great one around just the guarantee issue. But even within counties in the same state, I think there are probably some differences in the degree of selection that may be at play. I think some of this -- and this gets to some of Brian's comments around penetration, I think is one of the variables we need to look at, because as you're at a different place in the penetration curve, I think you have different dynamics going on. And if you extrapolate to the logical end where everybody's in MA, clearly no selection would be possible.

I think there's a difference between being at 30 percent penetration of MA versus now being over 50 percent. I don't know how it cuts. I could actually argue it both ways. But I think it would be helpful to see that.

And then the other variable that kind of goes along with that is it's not just that penetration has

changed. I think the richness and the benefit design has changed across the industry between even seven years ago and now. And as a result of that, I think the program is attracting a fundamentally different consumer set, if you will.

And so some of the dynamics of selection that may have been in place seven years ago, I don't know that those are the same that are in place today. And I forget which graph it was, there was sort of this difference -- it wasn't totally consistent, and I think we may be hitting different parts of that curve, which I think you made the comment, Luis, is not linear. I would totally -- if I had to guess, I would guess it's not linear. But I don't know what the curve looks like, and I think some additional inquiry into that would be helpful.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. I'll be brief, knowing the time is limited.

First of all, really heavy topic, heavy lift, and I really appreciate the analysis that has been done.

Similar to my comments earlier about, you know, clarifying what favorable selection means, I think also

probably putting into any report exactly how these rebates are used, because they do seem to have a multi-purpose component to it. You know, some of it may be used for additional benefits. Some may have an administrative component. It may be used for profit, that type of thing. And the reason why I mention that is there's probably no broad, sweeping solution here, and it's probably multiple small levers that have to be pulled. And I see the rebate as being potentially one of those levers, because if you look at, you know, both coding intensity and favorable selection taken together, for the MA population it's 104 percent of the fee-for-service. So if you had that 6.5 percent delta there with the rebates, if you say, you know -- I know we're not proposing solutions, but I'm just putting it out there. But if you say, you know, 2.5 percent has to be used towards additional benefits and the other 4 percent of the rebate is at risk, and you have that at-risk component, you know, tied towards other efficiencies, so, for example, it could be tied towards, you know, delays in pre-authorizations. So if you're not performing around a metric like that, you don't get your four percent. And then both populations are at least at

100 percent. If you are meeting certain types of efficiencies, provided they're designed correctly, you may get the same net effect.

So it may be sort of small, incremental changes like that, but it may be good to sort of unpack the rebate question just so that everyone has an idea that may be a potential solution or part of a total package of solutions.

Thank you. Great work.

MS. KELLEY: Amol.

DR. NAVATHE: Luis, once again I just want to commend you. You know, it's easy for us as Commissioners to take a look at this work, read it, you know, it's 60-odd pages, and say, "Hey, that was easy," you know?

[Laughter.]

DR. NAVATHE: But there's obviously a ton of work in here, and not only that, I would say relative to the other reading materials, this was a denser read. I'm sure it started out at like 150 pages, and you found a way to cut it down. So I just wanted to recognize the volume of work that you've done here. I think it's totally not trivial, and I know the other Commissioners appreciate it, but I think on behalf of everybody, I just wanted to thank

you for that.

I have a few thoughts here. In general, I think it is notable to me that there is -- and you've highlighted this -- that there's a big interest in the academic literature. Some of these are also going to be our working papers and other types of papers that don't go through a publication process, which is helpful to us just to recognize.

There is variability in these estimates, and I think it's a reflection of the fact that this is a really hard problem, right? It's a really important problem, so I think it's worthy that MedPAC is dedicating its resources and talents, like you and Andy have, to it. But I think to some extent it would be helpful to include in our public sessions even some calibration to what's happening in the literature on the estimates, just because I think it gives another scaffolding for people to interpret. Certainly somebody like me would benefit from that.

The second point I wanted to make is I really like Slide 13 and Figure Q, the one that I pointed out, because I think it is also helpful as a scaffolding. Right? It does have this longitudinality. I think Jaewon

very rightly points out that these programs are evolving over time, right? And this is the one slide that, you know, doesn't -- it's not vulnerable to some of the longitudinal confounding that makes switcher, quote-unquote, switcher analyses even more challenging. And so not to discount any of the further work that you did, but I think this is just really -- to me it's really informative. It's very telling. I think it gives us some answers around what Jaewon was saying to some extent, and I think, again, it gives us another scaffolding from which to work -- not to say that these are the perfect estimates, because obviously they don't represent the totality of the MA enrollment and other issues that you've highlighted and why we're doing the additional analysis.

But, nonetheless, when I read this, I think it gave me a really good sense of what I think we should be expecting, and I think that's really helpful. So thank you for including that and using that as a base from which you then went on to do other work.

I do think -- so I'll try to make two other bigger points. I wanted to just echo Stacie's point that I think the Part D data here could be important in a couple

of ways. One, it's another data source, and that's really helpful, but also because Part D varies across fee-for-service venues and MA, and MA obviously a lot of times subsidizes the Part D premiums in the MA-PD world. And so I think if we could incorporate that, I think that is an area that might be important for us to reflect, because it's to some extent a missing part of our broader picture. And I'm not at all saying that we have to do it because I know it's a lot of work, but I think it would be great if we could, depending on our time and resources.

Then the last kind of meta point I have is I think a number of Commissioners have made the points that it would be helpful to have some discussion and probably further analysis to try to unpack what the differences in the beneficiaries are. I think we've had comments that reflect that. You know, we do notice that there are sicker beneficiaries going into MA, you know, some -- I think some even further clarification around the points that you explained nicely, I think, in the public session, I think some of those should hopefully make it into the paper to the extent that we can do that. And some further analysis also that reflects anything that we can learn about --

around both the benefits and those pre-MA enrollment patterns would be helpful.

So what do I mean by that? So, you know, one big benefit design difference, of course, is supplemental coverage, and Gina had some questions about that. You know, if we could look in the fee-for-service experience prior to MA versus the fee-for-service enrollees who move on in fee-for-service, it would be helpful to know how many of them had MedSup, for example, some type of MedSup. I think that would give us some sense of how to interpret the pre-MA enrollment or pre-continuing into fee-for-service spending numbers, right? Because those could obviously influence, especially if more low-income folks are going into MA, you might imagine that they couldn't afford the MA Sup -- sorry, the MedSup, and so that might influence what we see before they switch. So that I think would be helpful. I think some greater analysis around the utilization patterns, you know, where the utilization is differing. Obviously, the risk-adjusted spending is differing, so the utilization has to differ somewhere. So I think it would be good to get a little bit of a sense of that.

I think there is, as you point out, in direct literature, there's some commentary around some aspects, and so I think that does give us a reference point to be able to do some contextualization.

And then I think it would be helpful to work -- I could certainly benefit, I guess, from a little bit more analysis/explanation around some of the attrition work. So, for example, in Figure 4 in the reading materials, there's a comparison of the MA selection effect or selection percentage over time for MA enrollees who stay longer and longer. And inherent in that is kind of a survivor bias, right, because the people have to survive to make it that long. So I think it would be helpful to us to see that exact chart for the fee-for-service reference group that we're comparing to, those folks that are fee-for-service who also make it along their way, because I think that would also be helpful, again, just all in this notion of having a little bit more context and I think unpacking a little bit more about what's going on.

But, overall, I just want to congratulate you. This is a volume of work. It's very clear from the analysis how much thought and effort you've put in, and

hopefully we can keep driving it forward. Thank you so much.

MS. KELLEY: Cheryl.

DR. DAMBERG: I just want to say hats off to the team for undertaking what is a very complicated analysis. And I'm appreciative of the work that's been done and the refinements that you've made in this latest iteration. So many thanks.

I also recognize that this work is ongoing and that further refinements are in play, and I think those refinements will strengthen our understanding of selection. And as many of the Commissioners have said, and Amol just more recently, trying to unpack some of the factors that influence selection would be super helpful.

I'm very supportive of this work and the continued exploration, and I think the results that we've seen thus far, you know, underscore the importance of the Commission's ongoing discussions about how benchmarks are constructed.

And similar to some of the other comments that have been made, I think it would be helpful to further understand the approach that has been taken for accounting

for regression to the mean, the assumptions that are made, what some of the alternative approaches might have been, and potentially what some of the ramifications of applying different approaches.

I think in any analysis, you know, there are choices of different approaches and rationale for those types of approaches, and I think perhaps providing a little more clarity for the reader on that would be helpful.

MS. KELLEY: Unless I've missed anyone, that's all I have for Round 2, Mike.

DR. CHERNEW: So I feel like that was a fire hose of comments, with actually stunning consensus. So I will say them quickly for time.

There seems widespread both support for this type of work and appreciation of the people who do it. There is widespread interest in how the findings will ultimately influence policy and recommendations, although we aren't actually here yet.

For those of you at home, this is one of several chapters related to Medicare Advantage that we are undertaking, and as the program becomes -- as Medicare Advantage becomes a bigger and bigger part of the program,

more and more of our work will focus on different aspects of the Medicare Advantage program. And one of the biggest challenges is to figure out how to sequence and segment those particular type things, and that leads us to this topic today, which is admittedly a really important, very technical, but just one part of this much broader policy issue, which we will continue to focus on.

I will say before we move on to the next chapter, I think there's both an acknowledgment that Medicare Advantage offers a lot of benefits to beneficiaries that are funded in a range of ways, and I think there's been a longstanding MedPAC belief that if your goal was to have payment parity -- and that's -- if that's your goal, we are in a certain direction, we are paying above that, and this is one attempt to quantify a portion of that, which will continue to happen.

So I will just say we are going to continue this. This work, as Luis said in the beginning, is going to be woven into the status chapter that we will see again, and I think it's probably going to be in January. It might be in December when we see the status chapter -- yeah, so in January we'll see the status chapter. We will have another

bite at the broader apple when we see that. We are not in that chapter going to be making more recommendations about what to do, although I think there have been a number of suggestions about things that we might recommend. For those who follow the work that MedPAC does, we are slow -- we are deliberative. I don't know what I was thinking. I was having -- I was having a small stroke.

We are deliberative in the process by which we get to recommendations in any analysis that we do, but the suggestions in that vein are certainly appreciated. But I want to make sure that people understand how this fits into that broader context.

So, again, thank you. And as I said, we're going to skip the break because of our technical difficulties, so we're going to do a quick turnover, if you guys want to switch the slides while I'm in the process of thanking you. And this is another aspect of the work we're doing on Medicare Advantage, all of which will get pulled in to where we go.

So if anyone needs to step out for a break for a second, please do. But I am going to jump right through to the presentation, if that's okay.

UNIDENTIFIED SPEAKER: Live TV.

DR. CHERNEW: Live TV. I do want to make sure that we get time for comments on this work. So, Katelyn, is it you or Ledia? Okay. Katelyn.

DR. SMALLEY: Good morning. This presentation will outline some of the ways that Medicare Advantage plans can influence access to care for Medicare beneficiaries. Today, we will focus on the management of provider networks, and the use of prior authorization in MA. Before we begin, I'd like to remind the audience that they can download these slides in the handout section of the control panel on the right-hand side of the screen.

MA plans have tools not generally available in fee for service to reduce low-value care and improve outcomes. For instance, they can facilitate the coordination of care between providers, more actively manage the care that enrollees receive, or provide incentives to enrollees and providers to encourage the use of higher-value items and services, and discourage the use of lower-value care. In short, MA plans can manage access to providers and services, in order to impact outcomes such as quality and cost.

These activities have the potential to improve value, but stakeholders have raised concerns about the misapplication of these tools. Administrative burdens for providers and enrollees, and barriers to access that delay necessary care, might outweigh potential benefits.

As Luis mentioned in the previous presentation, these techniques may also serve as a mechanism for favorable selection in MA. When plans take measures to discourage certain types of utilization, they may dissuade certain beneficiaries from enrolling in their plan.

In today's presentation, we focus on two of these tools in particular: network management and prior authorization. We consider the current regulatory landscape, and present some analysis of the data that plans report to CMS on their use of these tools. We also raise, for Commissioner discussion, some opportunities for future analysis of these topics.

First, we will discuss the use of provider networks in MA. In this presentation, we focus on the adequacy of MA plans' provider networks, as defined by CMS's criteria. In your mailing materials, you will find more information about these standards, as well as other

issues of relevance for provider networks. We plan to return to the issue of provider networks over time, and will provide information about other aspects of MA networks over the next few cycles.

Medicare beneficiaries consistently state that the ability to see their chosen provider, especially in primary care, is a key factor when weighing up coverage options. However, many beneficiaries are willing to trade some degree of choice for the extra benefits that MA plans offer, including reduced cost sharing, limits on out-of-pocket spending, or additional benefits such as dental, vision, or hearing coverage. Plans can be selective about the providers they contract with. They can, for instance, decline to contract with providers with poor quality outcomes or excessive costs. This could potentially improve value to the program.

Most MA plans are either health maintenance organizations, HMOs, or preferred provider organizations, PPOs. These are the types of plans we focus on today. In MA, HMOs and PPOs from the same parent organization often share the same provider network. However, the rules for how beneficiaries can access that network differ. For

instance, enrollees in PPOs are able to access providers outside the network, but generally have to pay higher cost sharing when they do. By contrast, HMOs generally provide no coverage when enrollees seek care outside the provider network. Except in rare cases where an appropriate in-network provider cannot be identified, HMO enrollees are fully liable for the cost of out of network care.

To ensure that enrollees in MA plans can access needed health care services, CMS has developed standards for network adequacy. Today we will walk through CMS's standards and the way they audit compliance with these requirements. We will use the fictional County X, as shown on the screen, as an illustrative example.

Network adequacy is assessed at the county level, and thresholds vary by population, from large metro areas with the highest populations, to counties with extreme access considerations, or CEACs, with the lowest. Our County X is a micro county, meaning it has between 50,000 and 200,000 residents, and population density between 10 and 100 people per square mile.

CMS assesses network adequacy for 27 provider types and 13 facility types. Each specialty and facility

type has a minimum provider ratio, which is established nationally, and each county has a number of beneficiaries required to cover, which is an estimate of potential enrollment for a plan in that county. The minimum number of providers of each type is the product of these two figures.

Here we can see that a plan in County X has contracted with 3 gastroenterologists, fulfilling the minimum number standard.

However, the minimum number standard is not sufficient on its own. CMS also has minimum time and distance standards, so that providers are accessible to enrollees within a reasonable range.

In micro counties like County X, providers must be accessible within 60 minutes or 45 miles, for at least 85 percent of potential enrollees. We can see that, even though our 3 gastroenterologists are accessible to much of the population in County X, the northwest corner of the county is not well served. In order to meet the time and distance standards, a plan would have to contract with a fourth provider that is closer to those beneficiaries.

CMS has made some recent changes to network

adequacy standards. First, they have relaxed some of the requirements to encourage the entry of MA plans into rural areas. For instance, the requirement that 85 percent of beneficiaries can reach providers within time and distance standards is a recent change. Previously providers would have needed to be accessible to 90 percent of beneficiaries within time and distance standards. Metro and large metro counties are still required to meet the 90 percent threshold.

Plans can also now receive 'credits' to further reduce that percentage for certain specialties. For instance, if plans contract with telehealth providers in 12 specialties, they can reduce the percentage threshold by an additional 10 points. In County X, a plan that offered telehealth for, for example, dermatology, would need to demonstrate only that 75 percent of beneficiaries could access an in-person dermatologist within 60 minutes or 45 miles.

On the other hand, CMS has also expanded its definition of network adequacy in two ways: they have codified guidance on maximum wait times for appointments, and beginning in 2024, will assess network adequacy for an

additional two provider specialties: clinical psychology and clinical social work.

MA provider networks are audited on a three-year cycle, at the contract level. Audits can also be triggered in certain circumstances, such as upon application for a new contract or service area expansion, if CMS receives an enrollee access complaint, or if an MA organization identifies a gap in their network.

About one-quarter of MA contracts were audited in 2021. Because contracts can span multiple, sometimes noncontiguous, states, network adequacy is assessed at the county level. These contracts covered about 75 percent of all U.S. counties in 2021, spanning 49 states, Puerto Rico, and D.C. Plans must demonstrate network adequacy for each specialty and facility type, in each county in which they operate.

When contracted networks do not meet network adequacy standards, MA organizations can either negotiate contracts with additional providers, as in the previous example, and resubmit their documentation, or request an exception to the adequacy requirements for that provider or facility type.

In 2021, a total of 448 exceptions were requested. This represented only about 6 percent of the total number of specialty-county-networks configurations for which MA organizations needed to demonstrate adequacy. However, about 58 percent of these requests were denied, most commonly because CMS was able to identify suitable providers for plans to contract with to fulfil the criteria. Plans are not penalized for failing to meet the criteria, but rather are given guidance on how to bring themselves into compliance.

Beyond ensuring that their networks are sufficiently robust, MA plans must communicate network information to enrollees through provider directories. Enrollees rely on these directories when making decisions about where to seek care. MA plans are required to provide information on contracted clinicians, including their specialty and expertise, office location(s), and whether they are accepting new patients. However, there are logistical challenges for both plans and providers in keeping these directories up to date. You can read more about this in your mailing materials.

Directory accuracy is important, however, because

it can give a false sense of the adequacy of a network. For instance, a recent GAO report found that inaccurate directory entries for some plans led enrollees to be functionally unable to access behavioral healthcare. Some beneficiaries in our focus groups this year reported encountering inaccurate provider directories. Last year, CMS raised the idea of creating a national provider directory to facilitate the maintenance of these documents.

We would like Commissioner input as we build an analytic plan around MA networks. In the coming cycles, we plan to return with further analysis of MA networks and the implications of these networks for enrollee access, quality, and cost. For instance, we plan to conduct a literature review of how provider networks are used in MA compared to other health insurance markets.

We also plan to conduct analysis of MA networks using data from CMS and other sources. We could, for instance, characterize MA networks by their size and breadth, and look at how networks differ by plan type, specialty type, geography, or other dimensions. We could look at the use of narrow networks in MA, or the extent to which plans in a local area contract with the same

providers. We could also link network data to service use data and analyze, for example, the use of out-of-network services.

We would like Commissioners' feedback on these potential lines of analysis, and we look forward to you discussing them today.

Now, I'll turn it over to Ledia who will discuss the use of prior authorization in MA.

MS. TABOR: Thanks. Switching to another topic of access to care in MA, prior authorization is a utilization management tool designed to help health plans determine the medical necessity of services and minimize the furnishing of low-value services, thereby helping to contain costs and protect patients from receiving unnecessary care. We'll focus discussion today on prior authorization for services and products. Discussion of prior authorization for Part D prescription drugs can be found in other Commission work, for example in the March 2018 report to the Congress.

MA plans are permitted to require enrollees to obtain prior authorization to access certain services, a practice that is not widely used in fee-for-service

Medicare. In 2023, nearly all MA enrollees are in plans that require prior authorization for some categories of services.

Although MA plans must follow Medicare coverage rules when deciding whether to authorize a service, they are also permitted to use additional clinical criteria to determine medical necessity, as long as such criteria are "no more restrictive than original Medicare's national and local coverage policies."

CMS requires that MA plans establish procedures for making decisions about whether to approve or deny PA requests. CMS also requires that prior authorization requests are reviewed by MA plan clinical staff to determine whether items and services are medically necessary and reasonable for the beneficiary, and whether they meet Medicare and MA plan coverage rules. MA enrollees, and providers on their behalf, have the right to appeal a plan's determination to not allow for a service that they think should be covered or provided.

Let's walk through some of the levels of the MA prior authorization and appeals process.

Starting at the top, the process typically begins

when a provider submits to an MA plan a request for prior authorization for an enrollee to receive a health care service. Next, the MA plan makes a determination to cover or not cover the service as expeditiously as the enrollee's health condition requires.

If the MA plan fully approves the PA request, the green box on the left, then the enrollee can receive the service or item. If the MA plan partially or fully denies the request, the enrollee might elect not to receive the service, pay for it out of pocket, or the provider may request a reconsideration from the plan, the peach boxes on the right.

The MA plan can fully overturn their initial denial and then the enrollee can receive the service. If the MA plan upholds their denial, then the independent review entity must review the request. The IRE can overturn the MA plans denial and the enrollee can then have that service covered.

If the IRE upholds the plan's decision, then enrollees have additional levels of denial appeals available to them including review by administrative law judges and further to the Medicare Appeals Council within

the Department of Health and Human Services.

MA contracts must report to CMS the aggregate number of determinations and reconsiderations for services requested by enrollees or providers, as well as the outcomes of the reviews. We analyzed these plan-reported data and found that the majority of MA determinations and reconsiderations were fully approved in 2021.

Looking first at the chart on the left, MA plans made about 38 million prior authorization determinations in 2021. Ninety-five percent of those determinations were fully favorable, meaning the MA plan fully approved the service for coverage and payment. Turning to the chart on the right, MA plans were asked to reconsider about 229,000 of those initial denials. MA plans deemed 80 percent of these reconsider requests favorably, or in other words overturned the denial.

Before moving on, I want to point out that there are limitations for our analysis. For example, MA organizations do not report by determinations by service type or specialty so the program does not know how prior authorization requests, denials, and approvals vary across services and across MA contracts. Although we cannot do

service level analysis of determinations plan by plan, there are other data sources that point to certain beneficiaries and providers or physician specialties that are more likely to be affected by PA.

Most MA plan enrollees are required to receive prior authorization for the highest-cost services such as certain Part B drugs, skilled nursing facility stays, acute inpatient hospital stays for certain surgeries.

Researchers led by Dr. Aaron Schwartz applied one MA organization's prior authorization rules fee-for-service Part B claims with an aim to further understand the scope of prior authorization. They found that 41 percent of fee-for-service beneficiaries received at least one service that would have been subject to prior authorization in that MA plan. They also found that the largest share of prior authorizations were for Part B drugs/injectables, radiology, and musculoskeletal services.

Finally, they found that physician specialties varied in rates of services that required prior authorization, with highest rates among radiation oncologists at 97 percent to pathologists at 2 percent of services.

As described in previous slide about the PA appeals process, if the MA plan upholds the denial after a reconsideration review, the case file must be forwarded to the independent review entity for review. The IRE upheld the plan's denials, and 96 percent of the roughly 50,000 prior authorization cases it reviewed in 2021.

MA contracts must report to CMS the aggregate number of determinations and reconsiderations for services requested by enrollees or providers, as well as the outcomes of the reviews. We analyzed these plan-reported data and found that the majority of MA determinations and reconsiderations were fully approved in 2021.

Looking at information reported by the IRE, we see that beneficiaries with certain conditions and certain providers or specialties are more affected by IRE determinations. CMS publishes short summaries of the IRE's decision on all Part C appeals, which we reviewed and categorized for a snapshot of time to get an idea of the types of services that go further in the appeals process. About half were requests to pre-approve acute inpatient rehabilitation facility admissions/service, 20 percent for durable medical equipment, and about 10 percent for acute

inpatient surgeries.

Over the years, there have been concerns about MA prior authorization requirements and processes. First, the OIG examined a subset of denied prior authorization requests and found examples of MA plans inappropriately denying PA requests. The reviewers found that 13 percent of denied prior authorization requests met Medicare coverage rules.

Second, some providers report that prior authorization is an increasing burden. For example, in our focus groups this summer, prior authorizations came up unprompted, and clinicians expressed frustration with the number of prior authorization requirements from insurance companies, with several noting that their practices have hired dedicated staff members to manage these requirements.

The third major concern is that stakeholders have voiced concerns that prior authorizations may cause enrollees to delay care, abandon care, or pay out of pocket. During our focus groups, we also heard some accounts of negative effects on beneficiaries due to prior authorizations.

In recognition of some of these concerns, CMS

recently finalized regulations governing the use of MA prior authorizations. CMS clarified coverage criteria guidelines to ensure MA enrollees receive access to the same medically necessary care as fee-for-service. CMS further clarified that when coverage criteria are not fully established in Medicare, an MA plan may create internal coverage criteria based on widely used treatment guidelines or literature and that those criteria must be publicly available. The new regulations also added that denials of coverage based on medical necessity must be reviewed by health care professional with relevant expertise. Also, prior approval given by an MA plan is required to be valid for as long as necessary to avoid disruptions in care.

In December 2022, CMS proposed a number of requirements for MA plans with the aim to make MA processes more efficient and transparent, but those rules have not been finalized. CMS proposed a requirement for MA organizations to build an open-source interface to automate the process for providers to determine whether a prior authorization is required and identify prior authorization documentation requirements, also known as real-time benefit tools. They also proposed that MA plans must include a

specific reason why the MA plan denies a prior authorization request.

And third, an MA plan must send prior authorization decisions in 7 calendar days for standard requests, as opposed to current 14-day requirement.

We would like the Commissioners' feedback on the potential directions for analysis of prior authorization that could inform options to improve prior authorization policies. One possibility for future work is to consider whether CMS has the plan information necessary to adequately monitor and provide oversight of MA plans. For example, under current reporting requirements, the volume of prior authorizations is not reported by service type.

A second potential direction for analysis is to analyze the interaction of prior authorization and claims denials. If a provider does not seek prior authorization before providing a service, then an MA plan may deny payment for the service which negatively affects providers. We could review existing data sources to understand MA plan denials of claims and explore impacts of claims denials on providers and enrollees.

This brings us to your discussion. We would like

to discuss your questions about the potential directions for analysis related to network management and prior authorization. With that we will turn it back to Mike.

DR. CHERNEW: So again, this has been such a good set of presentations this morning. I think we'll just jump in to Round 1, but I am really grateful that we are sort of digging into this kind of under-the-hood look. And I think, if I'm right, Larry is number one in the queue. Is that -- I never get the thumbs up, by the way. So good.

DR. CASALINO: Yeah. I think clinicians throughout the country will be glad that MedPAC is paying some attention to this.

In Round 1 I have one brief Round 1-type comment and one question. The comment is actually the same comment I made last session, that just a paragraph or two discussing what it takes to switch from MA to fee-for-service would be important because people need to understand if someone is in MA and for whatever reason doesn't like the prior authorization or the networks, you know, the network they can sort of see, to some extent, before they enroll, but prior authorization you really don't know what's going to happen to you. So switching

back would be important to just provide a little context here. That's the suggestion.

The question is this. When I was in practice as a primary care physician almost everything required a prior authorization. By that I mean if I wanted to refer a patient to a dermatologist, or almost any specialist, we needed to get prior authorization. Certainly to order an MRI it needed to get prior authorization. None of these things were prior authorization for things that we were going to do ourselves or get paid for. They were so that our patients could get other services.

But what I don't know now -- I'm not close enough anymore to what's happening -- is to what extent, if anybody can answer this question; if not, it would be a good thing to look into -- to what extent do especially primary care physicians we're talking about here, but it could be other physicians as well, is prior authorization required before referring a patient to another specialist or a specialist? Do you guys, off the top of your head, have a sense of that? Because it was really prevalent when I was in practice for 20 years. I think it may be less prevalent now, but I don't know how much less prevalent.

MS. TABOR: This is something we can dive into deeper. I will say, in the information that plans currently report to CMS, it would be hard to tell this because the provide IDs are not associated with the data that's reported. But we can think about this for focus groups and other data sources.

DR. CASALINO: That's it.

MS. KELLEY: Cheryl.

DR. DAMBERG: Great work. I really appreciated reading this chapter. I had two quick questions. For those folks who get a final denial, it's not overturned, do we have any sense of whether these patients go elsewhere for treatment?

MS. TABOR: So from the first round of review, like the plan does an initial review and then unfavorably -- they still have kind of the six levels of appeals, and there are people who make it down to that. I will say that once you get to the level of the administrative law judges and the Medicare Appeals Council it's publicly hard to kind of parse apart the cases for us to analyze.

DR. DAMBERG: Yeah. I think I'm trying to understand whether these people forego treatment entirely

or whether they ultimately get care but they're paying out of pocket.

MS. TABOR: Yeah, so that's a lack of data that we can't tell because plans report the determinations at this aggregate level. It's not tied to beneficiaries or providers.

DR. DAMBERG: Okay. Thanks.

DR. CHERNEW: Can I just say one other point? One thing that I think is important to understand is ultimately not getting care isn't necessarily a bad thing. It could certainly be, but there is a lot of care that people shouldn't get. So I think in having this conversation it's important to understand that if they got care somewhere else, that's not like, yay, they got around the system. It might be yay, they got around the system that was too restrictive, but it could be they found a way to get care that they probably shouldn't have gotten anyway. So I just think that balance is hard and comes up.

DR. DAMBERG: Yeah, no, point taken.

And then my second question is, you noted that prior authorization us not used very often in fee-for-service but it is commonly used in the commercial market

and PPO plans, and I'm just curious why, and maybe that could be elaborated on a bit more in the report.

MS. TABOR: Yeah, that's a good point. We didn't include any information on commercial, but that is my understanding as well, that commercial insurers are using prior authorization quite a bit, and we can add that to the paper.

MS. KELLEY: Gina.

MS. UPCHURCH: I want to reiterate Mike's point there that managing care is not necessarily bad. One of the things a physician told me one time, that ran all these specialty clinics, was teaching med students what not to order because it wasn't going to change the care plan. It's just more data but not changing the care plan. So we're not opposed to managed care. It's just how you manage the care.

My quick questions are, I'm confused by HMO-POS, and we counsel people all the time. I thought point-of-service HMO plans paid in-network if they agreed to see you. But you all are saying it could be more than that, depending on the contract, but you wouldn't have a contract if you're out of the network. Is this like PPO groups? I

mean, I guess I just don't understand it. There's not a contract rate if they're out of the network if you're an HMO, and how is the consumer to know this when they're making a decision -- HMO, HMO-POS, PPO? There's such fuzziness around the POS.

DR. SMALLEY: Yeah, thanks for the question, Gina. We can certainly be clear about this in the next iteration of the paper. I think that our understanding of the POS, or kind of what we presented in the paper, was not so much -- you're correct, there is no contract between a non-contracted provider and a plan, but there might be stipulations on the plan side in terms of the beneficiary cost sharing. So the beneficiary cost sharing is similar to a PPO. The understanding is if you go to an out-of-network provider you can still see them, but you'll pay a higher rate of cost-sharing. Our understanding is that's similar in an HMO-POS.

MS. UPCHURCH: That sounds like PPO.

DR. SMALLEY: For those certain providers that HMO-POS's allow their enrollees to go out of network for. But we can definitely be clearer about that.

MS. UPCHURCH: That would be good. And I guess

the concern I have is that people can't know ahead of time like who those providers are. You either contract or you don't contract. You are either in-network or out-of-network. We can't look at a provider directory to see this POS possibility for you. Correct?

DR. SMALLEY: That is true. My understanding is that the POS designation is for certain provider types, not specific individual clinicians.

MS. UPCHURCH: Yeah, it would be great if we knew a little bit more.

DR. SMALLEY: We can do more to clarify that.

MS. UPCHURCH: Great. Thank you so much. Then the next one is, you know, say if it's medically necessary care but there's no one in-network in your Medicare Advantage plan, you're able to go out of network but pay in-network rates. Who monitors that, and do we see that a lot?

DR. SMALLEY: That's a great question. That's something that we're planning on looking into more as they use that out-of-network care. It's also not clear the extent to which enrollees are aware of that as an option.

MS. UPCHURCH: Right, and you never know to ask

for it. And my last question is, my understanding is if you go to the emergency room and it's emergent, then that is considered always in-network, no matter if you're a PPO or HMO. I wanted to make sure that was still the case. And what about urgent care? Sometimes urgent care is included. Sometimes it's not. Do we know?

DR. SMALLEY: We have not looked at that yet.

MS. UPCHURCH: Okay. I think some plans do include urgent care in that work and some don't, but it would be good to know that.

DR. SMALLEY: Sure.

MS. UPCHURCH: Thank you for doing this, and I love the graphics, by the way.

MS. KELLEY: Wayne.

DR. RILEY: Great work, Katelyn and Ledia. A question. I seem to recall that the HHS inspector general looked at this whole issue last spring. Did any of that work get migrated into both of your analyses? Because my recollection is that the inspector general had similar concerns about constricted access because of this prior authorization phenomenon. But I'm just curious, did you look at that as well?

MS. TABOR: Yeah. So we did report out on the OIG. There have been a couple of reports but the most recent one that you are referencing was the OIG had some medical reviewers look at a sample of charts from MA plans of prior authorization denials, and they did find that about 13 percent of those denials did meet Medicare coverage rules. So that really flags for us that this is an issue.

DR. RILEY: Right. Thank you.

MS. KELLEY: Greg.

MR. POULSEN: I'm just wondering, have we thought about subdividing, really on both of these analyses but primarily on the prior auth one, different types of plans. For instance, in commercial it's been clearly demonstrated, and I think it has in MA to a degree too, that provider-sponsored plans have significantly lower rates of PA requirements and even lower rates of PA denials. And I wonder if that's worth bringing in, because we're talking about something that could be a problem, would it be good to talk about something that would either mitigate that problem or be a solution to it?

MS. TABOR: Yeah, so on the prior authorization

side, we did look at the top six insured plan sponsors and there was variation even across those. We can think about doing the provider-sponsored plans analysis. Like Luis mentioned before, I wonder if there would be some N issues, but we can think about it.

MS. KELLEY: That's all I have for Round 1, unless I've missed someone. Shall we go to Round 2? All right then.

DR. CHERNEW: And I think Larry is number one.

MS. KELLEY: Larry is number one.

DR. CHERNEW: That's what's on his Father's Day card.

DR. CASALINO: I didn't hear you, Mike.

DR. CHERNEW: I said that's what's on your Father's Day card. It's been a long morning.

DR. CASALINO: I want to start off by saying that I certainly recognize that prior authorization can be beneficial in both theory and in practice. It can reduce spending and can improve quality.

My wife had three elderly aunts in their 80s and 90s who lived in Queens but had a physician, an internist, in New Jersey. And every three months they would hire a

car and go over to his office, and he'd do an EKG and blood tests in his office, and pulmonary function tests, and I don't know what else. And they just thought he was the greatest physician in the world. I was unable to convince them otherwise.

So that's kind of small potatoes, but I do recognize that there is a function for prior authorization. But in practice it's really been a huge problem since the '80s. Actually, it's been a huge problem before I think a lot of the staff were born. Just to give you an idea of how long this has been going on, we're talking about going on toward a half a century. This was, without question, the biggest problem for me when I was in practice for 20 years, primary care practice, and I think a lot of physicians would agree with that. Huge cost in time and effort for physicians and also for patients, really.

So there have been a lot of proposals to fix prior authorization over the years, often quite big proposals, many promises by health plans to fix it. I think things have improved, and there are new technologies now. But in spite of that this is still a significant problem, and it's a good thing that we're studying it.

My comments will not be very lengthy, considering. No, they won't. They will be aimed at the importance of the problem and also a few ideas for additional things to study. I will just say, in summary fashion, the ideas, the things you do propose for both network access and prior authorization to study, I totally agree with. I think they're good.

I mean, there are some pretty egregious facts. So 80 percent of the health plan denials, the health plan approves on appeal. Why was it denying those 80 percent and then approving them on appeal? Why was the wrong decision made so often? Why is there such large variation? You didn't really give figures on this in the presentation, but in the paper, there is pretty large variation in denials across health plans, large variation. And I guess it would be interesting to understand why.

And the other thing is that we had been referred to this CMS audits of health plans, what the OIG has found, OIG finding about half of audited MA contracts in 2015 were inappropriately denying prior authorization, sending insufficient denial letters, and so on.

So I just want to give two examples, very

briefly, for how things work on the ground. On page 30 you mentioned that physician offices sometimes hire additional staff to deal with prior authorization. In our primary care office we had nine physicians. We had two of our highly paid staff, that was their job, to get prior authorizations. Not for anything we were doing and not for anything we were going to get paid for, but just so our patients could see specialists, get MRIs, and so on. It actually cut about 10 percent out of each of our incomes, for what it was worth. But even with them spending all their time on it, still the physicians had to get involved, yeah.

The other thing, which will strike some of you as quite ludicrous, this was pre-EMTALA for part of the time I was in practice, and emergency room visits had to be prior authorized. So every about six nights, when I was on call, the phone would ring, sometimes many times during the night, and I'd get a call from the emergency room, you know, "Your patient, Wayne Riley, is here. Do we have permission to treat?" And I'd say yes, and then I'd be so angry I couldn't get back to sleep, nor could my wife. After a while I learned to just say, "Permission to treat,"

and put down the phone. You're really going to say, "No, send my patient home. Don't treat them in the emergency room"? So that's the kind of thing that a lot of physicians have experienced.

A couple of other things you might study with relation to prior authorization, and I'm almost done, actually, believe it or not. I think it would really, as I mentioned earlier, actually, to the extent to which primary care physicians and specialists are obtaining prior authorization, not just for things that the specialists want to do themselves but for things that their patients need -- referral to other specialists, MRIs, and so on -- and then looking into it a little bit more what is the cause of the denials rates and in the reconsideration of denials across plans, which I think ranges from 2 to 21 percent, it says on page 20. That 2 to 21 percent, that's a pretty big deal in denials of care.

In terms of networks, I think for the individual physician this is less of a hassle. I like your idea of doing a literature review. One thing you might do, in terms of the adequacy of networks, you know, it's been well established and this is not entirely the plan's fault, that

the directories are not all that accurate. But beyond that, even if a physician is in the directory, it doesn't mean that they are actually the patients from their particular health plan, or they may erect barriers to that, as I've experienced personally, actually, in commercial.

So it might be interesting to look at claims to determine to what extent the listed providers in the directory are actually seeing patients for a plan.

And then just two last things. More on narrow network plans would be helpful, I think. That could be a very good thing, narrow network plans, or a bad thing, and probably some are good and some are bad. But how many are they? How many beneficiaries do they service? What types of beneficiaries do they serve? Are they offered more by large or by small insurers? Where are they? How narrow are they really? Anything you can get about quality and utilization. So that would be worth looking into, and I think not that hard to look into.

And then the last thing, I just want to mention behavioral health. I don't know if this is still true. I suspect it is. But again, when I was in practice the health plans would hire behavioral health management

companies, and if you wanted behavioral health care for your patient, it wasn't so much you had to get prior authorization, you had to refer the patient to that company. What this meant, in practice, was -- and patients often don't really want to go see a psychiatrist. You know, they're not chomping at the bit to do it.

So I would be saying, "Wayne, I know you don't feel really very comfortable with this, but I've known the psychiatrist, Cheryl, for years. She's really good. I think you'll be very comfortable with her. Here's the number, and I'll call her and we'll talk about you, and it'll work out well." That was a way to get patients to actually see someone, and see someone good that you knew, and they would be happy with.

Instead, in the last years I was in practice, I had to say, "Here is an 800 number." So I had no idea who they were going to see. I often got no feedback whatsoever on what the behavioral health provider actually did with the patient. I mean, when you actually have a patient in front of you who needs psychiatric care and you're giving them an 800 number, it would be hard to exaggerate the discontent of a physician who has to do that. So this

would be a thing, I think, worth looking into, to what extent is that going on today.

That's it.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you so much for this work. I actually think this probably one of the most important things we could be doing as a Commission, given the growth in MA and the problems that narrow networks can cause for people.

I had a couple of specific suggestions for the paper and will reiterate a comment that was previous made and then a few ideas for additional analyses. The first is when you describe the MA plan types, the HMO, PPO, POS, it would be really great to know how many people have elected into those different plan types, just for context. Even a little bit more information on things like out-of-pocket maximums in a network, kind of on average across those would be good, I think, for context.

Larry made this point, and the point was brought up in the prior session as well, but I think a text box probably around, when you were talking about special enrollment periods on page 16 of the chapter, putting a

text box in there that talks about the restrictions on access to supplemental coverage, what that looks like if you want to get out of that decision, and maybe a little bit more context for the reader that most states, I think, look a little bit more restrictive in that. So that, I think, is really key for why we should care so much about the narrow network issue.

As far as some general comments, I think that the issues raised in the chapter around network adequacy, rates of denials, and then use of out-of-network care, that should be reflected in something like star ratings or something beneficiaries can see when they are shopping for a plan. That might also make plans have more incentives to try to not deny so much access to care. But it needs to be a lot clearer to people, because the variability that you guys showed in the chapter is pretty stunning, the idea that you could be in a plan that's denying so much care. That should be really clear when you're picking plans.

Also I will just say for the record, having out-of-date directories is completely unacceptable when we think about the fact that people will pick plans based on the coverage of their providers. And I get that that's

really hard to do, but, you know, we figure out how to pay people so it feels like we should be able to tie these things together in a way that makes it really clear who is available, who is accepting patients.

For the analysis, I think the use of the Ideon data is a really great place to start, and I will maybe pitch that I personally think that looking into a specialty care area would be one sub-analysis I would love to see. As an example, in the cancer space, there is kind of this real variety of markers of like the more specialized centers. So for example, comprehensive cancer centers, accredited cancer centers, and then none of the above. And prior research has suggested that there are some problems with network coverage of any of those levels of kind of more specialized care. That really matters for thinking about whether or not a person who has been diagnosed might try to get then out of their network. So any kind of subgroup analysis focused on a clinical area like that I think could be really high yield.

And in that same vein, one of the things I would be really curious about is can you detect, if you are able to identify those narrow specialty networks, what percent

of those people are switching out into fee-for-service, like get a real estimate of that selection effect. They might end up having to switch back if they can't buy a supplement and then they're being charged 20 percent of cancer care, which is unaffordable. But that would be on my wish list.

Okay. Almost done.

For prior authorization, I think if possible, to dig into some of the services, the one that seemed really obvious to me is the Part B drugs. Obviously, that's big part of the spending. And it struck me that there could be some synergies between the prior work we did around the drugs that have low-cost substitutes that could be blended together. So I'd consider that a good use of prior authorization, like, you know, stopping the use of a higher-cost drug when there's a good substitute, versus is it really more of a blanket prior authorization on everything that's expensive, in which case I would consider that a poor quality prior authorization, where it's adding a lot of administrative burden when there aren't lower-cost choices. So that would just be my suggestion for if you're going to dig into services, where to go.

But absolutely fantastic work, and thank you so much for pursuing this line of research.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. Great work. Certainly a critically important topic. I know we're not ready to jump into recommended solutions, but, you know, I always tend to, in my head, and perhaps we could call out that there are at least a variety of potential solutions to what is clearly, I think, in everyone's mind, a set of significant problems. So I'll just tee some up for consideration and we could perhaps put some in a text box about there are solutions available should CMS decide to pursue them.

First, taking off a little bit on Stacie's point, for both network and the UM, plans do chase stars, so anything that can be done to maximally weight a question phrased in the right way around access to needed specialty care. I think plans will chase that. So that, in and of itself, could be a game changer. And maybe it takes much more weighting than is currently being used on a single member, but that uses a vehicle that already exists, which is the stars program, that is a huge lever.

All right. Just a few things on network. On the

idea of a national provider directory that was mentioned, it would be wonderful if a prospective member can search by provider rather than have to search by plan, which is how they have to do that. I think that's a game-changer on the front end. You go in and say, "I want to know which plans have University of Chicago in network," rather than go to every single plan and look to see, and what is oftentimes a cumbersome process.

Secondly, consideration requiring plans to highlight exclusions from their network might be an interesting approach. And you could require listed exclusions on Planfinder of cancer centers, of teaching hospitals, of major hospital systems with large market shares. Again, we want an informed consumer. Industry cannot reasonably, and would not reasonably argue against an informed consumer making good, informed decisions, so how do we enable that?

Another thought on networks, I think there is a lot that could be done in the real world to increase the availability, the access, and the user-friendliness of remedies to a truly reasonable buyer's remorse, the whole ability to have a special election period or to go back

into fee-for-service, traditional Medicare. And the ideal solution -- and I know there are issues with who has got jurisdiction over that -- would be if a member attests to a reasonable buyer remorse they have guaranteed issue to go back to traditional Medicare. I mean, I think that's ideal from a public policy. There are all sorts of reasons why that would be challenging, but --

MS. UPCHURCH: Just a point on that. They can go back to original Medicare. They just can't get a Medigap necessarily.

DR. SARRAN: Thank you.

MS. UPCHURCH: Right, to a supplement.

DR. CHERNEW: And that's a state regulation, and that varies.

DR. SARRAN: I know. I get that. But I think we should just call a dialogue. Maybe we could call that out as an unsolvable issue right now because of things, but get the discussion out there, because again, having a really accessible remedy to reasonable buyer's remorse around really critical decisions is certainly idea.

In the UM space, and I've done a lot of work over the years in this space, on both provider and plan side,

the reporting, we definitely need more detailed reporting by service type and by plan. It should be clear to a prospective member making a buying decision how Plan X compares to Plan Y and their percent of denials, percent of overturns, maybe any corrective actions that have been taking against the plan, enforcement actions by CMS. You should have an informed buyer on the front end.

Second under UM, there is probably a lot that can be done to increase the user-friendliness of appeals process for both the members and providers. There's lots of room to make that. The more we make that an easy remedy, the more plans will back away from unnecessary denials on the front end.

The third point Larry made about BH, yeah we should absolutely look at BH, behavioral health, as a distinct category in light of mental health parity and the struggles about are we getting the true impact from that law. All sorts of reasons why that needs to be looked at as its own category.

And last, in the Part B cancer drugs, I really think that that cries out for an innovative, distinct approach. You know, my personal belief is no plan should

be able to require anything more restrictive than first-choice access by a provider to any treatment that is on label or NCCN compendium incorporated. There should be no requirement for a step to get to anything that's in that category.

I know we're not ready to make recommendations, but maybe there's a way again to sort of call out. Because the Plan B cancer drugs, they are a protected class so they should be covered. But I think what's happening is plans are requiring steps and putting things in their prior auth, and I just think that's a unique space and could be dealt with uniquely. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much. I really appreciated this chapter and your work, and I'm very supportive of the specific comments that have been made by the Commissioners.

For example, Scott's suggestion of posting the exclusions I think would create some market pressure to think about what those exclusions are. And because you've done such a great job on the details, I'll be very maybe broad in my statement here.

I'm very concerned about value transparency, for lack of a better word, value transparency as people have talked about, and we see that provider choice is really important. But people are willing to give it up, we've said in this chapter, for these other benefits, but it's impossible for them to really trace what they're giving up because it shifts over time, it's too opaque. And the example of the incorrect directories is one. Gina's example of the challenges with accessing supplemental is another.

So the word "value transparency" isn't the right word, maybe, because value has a particular meaning. But anything we do that helps people understand what they're giving up and what they're getting I think is an absolutely central principle.

I can't help but briefly comment on prior authorization. It's a pain in the neck for providers. It's a worry for patients. But, of course, we have that because of overzealous ordering, right? We know that 20 to 50 percent of what we do doesn't matter. We have some skin in this, too. So I would just suggest maybe all-inclusive total cost of care models might be a different solution,

not for this paper.

But thank you very much, and I look forward to seeing what comes next. As I think Stacie said, this is one of the most important things we're doing.

MS. KELLEY: Brian.

DR. MILLER: So I have a few schizophrenic comments, so I apologize in advance for that. My first thought is this is my competing with the software as a service for my most favorite chapter of probably the entire cycle. I really appreciated the level of detail and the granularity that was included in talking about prior auth and also networks, and I thought the examples for networks were particularly helpful.

One or two on-point comments before my thoughts. Back to Scott's comments about prior authorization and Part B oncology drugs, I agree it's a problem. I also think that we should be cautious about making specific recommendations in specific therapeutic areas about specific types of treatment or groups of treatment. I think that we potentially could run out of scope and it would be better to defer to the organizations like ASCO for guidance on that area.

As for Stacie's comments about NCI cancer centers, I think one of the challenges with service delivery is that not all designations are necessarily -- mean clinically what we think they are, so we should be cautious about relying on designations to measure network adequacy. And then I agree that we should do prior auth just because something is expensive, but that prior auth if something is expensive should be that there are cheaper equivalent alternatives so prior auth should be thoughtful.

So my thoughts, I'll talk about prior auth and then I'll talk about networks.

So for prior auth, I think at the beginning of this chapter, I echo Betty's comments that context is important so that Medicare beneficiaries know what their tradeoffs are. Those tradeoffs are often not clear. I think if we put a table in noting what fee-for-service has and what MA has in terms of the benefits package, that would make it clear to then say this is what they're receiving in exchange for accepting a network, accepting utilization review. I think it would probably be helpful if we use the phrase "any willing provider" for the Medicare fee-for-service network from a network design

perspective, because that's what fee-for-service is.

I think we should also note that Medicare fee-for-service is unique in terms of being in any willing provider network. It's not a very common network design. Most of the commercial market, the ACA market, the FEHBP market, the Medicaid managed care market -- when I say "commercial," I mean if I am ACA, have a network, so Medicare fee-for-service is very unique.

There is a nice CMS staff paper that I pulled up as I was reading this chapter to educate, to sort of remind myself of the history. It's the history of health spending in the U.S. from 1960 to 2013, and it was published in 2015. It's great. We should probably reference that. And it notes that at the peak of managed care in 1993 to 1999, utilization review was the one thing that has actually bent the cost curve in American health care spending history.

For example, personal price growth of expenditures was 2.5 percent per year instead of 5.7 per year. So while, you know, prior auth is uncomfortable for us, I think adding the context that it controls spending is one of the few if not only thing that we know that controls spending is important. And, for example, at that time I

think it drove Medicaid's spending growth from 13 percent per year down to 7.8 percent. And 64 million Americans were on an HMO during that time.

So a few other thoughts about prior auth. In that context, we should say what are the other alternatives for cost control? There aren't a lot, and I think that that is important to emphasize. I think that the operational issue for us here is that prior authorization has high friction and it's not targeted particularly well.

CMS is actually working very hard on this, and the Biden administration and the Center for Medicare under Meena Seshamani have issued several rules about -- to improve the prior authorization process, I know that those rules are long and probably painful to read in the Federal Register. You know, I read the Federal Register every weekend, but I suspect many other people do not. It has been suggested that I need new hobbies, and I agreed to this. But we should probably highlight those rules and note that the specific changes in the timeline that they're doing in improving the prior authorization process.

I think another thing in the sort of aims of solutions for this is that there has been this longstanding

suggestion -- and it's a bipartisan suggestion -- for a gold card for prior authorization, the idea being that if you are a neurosurgeon and you are doing surgery and your prior authorizations have been upheld, as we show -- your appeals have been upheld, as we showed in the data, that those providers, be they physicians, nurse practitioners, hospitalists, whatever it is, get that sort of free pass from prior authorization. I think that is a great solution, and it's a bipartisan solution that has been proposed in Congress every year for the past three years. I think it was Gonzalez and Burgess who have supported that.

So moving to network access, I agree with everyone, provider directories are a problem. It's sort of ridiculous to enroll in a plan and have the provider directory be out of date. It's unbelievable that we are having this discussion in 2023. I think we all are on the same page there.

I agree with Stacie. If plans are getting paid, they should have an incentive to do provider networks and have those provider networks be up to date in the directory. I think Scott's point that we could tie that

into star ratings is a good one. I'd also note that we could do that -- tie that to improving the Plan Finder, which is something that my colleague Lisa Grabert has written about extensively.

I think in terms of a centralized provider directory, we need to be cautious. Centralization of technology historically has not gone well on an operational perspective. The ACA Exchange rollout was problematic for a variety of reasons, largely because of the huge technical scale. So I think that encouraging plans and providing them a financial incentive to improve their provider directory which then feeds into the Plan Finders, the beneficiary could search, say, for UCLA or Dr. Damberg or Dr. Konetzka and see that their physicians, their hospitals, et cetera, are in network is a really important thing. And I think the other thing we should note -- and I really appreciated seeing this in there -- is that CMS is actually working to improve network audits. The 25 percent number in 2021 and doing it every three years is a huge improvement from historically where CMS was in the early 2000s, and so I think that the administration has done a good job on working to improve network audits.

I realize that my comments are largely very gray, but, you know, in summary, I think networks are implement, making those tradeoffs clear to beneficiaries is important, and making sure that they have early access to that appearance of what that tradeoff is, and then making prior authorization more targeted and decreasing friction for beneficiaries I think is really important.

So, in summary, I love this chapter. I think it's going to be absolutely important for health policy, and I'm glad that we're doing this. Thank you.

Oh, and automation and AI is something that we should also talk about in prior authorization to decrease friction and increase access.

MS. KELLEY: Cheryl.

DR. DAMBERG: I have comments both on the MA networks and the prior auth, but I'll start with the MA networks.

So one thought that occurred to me, because this is something I see going on in the marketplace, is that providers are kind of churning, and so I think it would be interesting, as you do network analyses, to look at the stability of these networks over time and try to see how

consistent they are, because this creates a lot of challenges for beneficiaries in terms of getting a primary care physician and having an established relationship and care coordination. And it may be a factor in people's switching behaviors.

The other thing that I've struggled with vis-a-vis network adequacy measures is this distance type measure. I don't have a great solution for it, but the part I'm struggling with is a lot of beneficiaries, especially individuals who are poor and rely on things like public transportation, you know, there often are not providers in their sort of immediate surrounding areas that they can easily access. I don't know whether we could be trying to think more creatively or think harder about some improvements to network adequacy measures, but that's something I would like to put out on the table.

Then transitioning to prior authorization. So to Mike's point, I recognize there's a lot of low-value care out in the wild, and that UM is an important mechanism to try to tamp down on that. But I think just sort of looking at Figures 2 and 3, it raised questions for me given the high percentage of denials that are overturned. And, you

know, I sat there scratching my head about, you know, is the juice worth the squeeze here, and kind of plus-one on what Larry said, which is, you know, it's adding a lot of costs to the system to create these friction points. And, you know, if I did the simple math, out of that total there were 45,800 services denied. And I'm just wondering, for all the costs in the system, did we actually get savings? I don't know.

But, anyway, I think it's all to say that, you know, as we think about UM of the future and our ability to better -- to get a better hit rate, because right now the hit rate is very modest. You know, is there an opportunity here for AI or better predictions tools that could get us to the space we want to try to tamp down on low-value care.

DR. CHERNEW: So I was going to say quickly I think the cost-saving effects may well be in claims not submitted that then don't get denied. So you could save a lot of money and deny nothing ever because people don't submit things. In fact, you would save a ton of money eventually if people knew -- you know. So I think it's very challenging to understand. I'm probably where Brian is, which is we're saving a lot of money, but it's not

reflected in the denial rates.

DR. DAMBERG: Thanks.

MS. KELLEY: Gina.

MS. UPCHURCH: Great. Just to add on, I believe the directories -- I mean, if you go to healthcare.gov, for younger people, you can look up the provider and see what networks they're in, so Medicare.gov is behind the times. And to explain what we do, senior pharmacists just in one county alone, we call providers' offices. We speak to the contracting person, not the person who answers the phone, and then we go through, no, we're just talking about Medicare Advantage, we're not talking about Humana or the commercial. Just to get a straight answer that they're confident in is really tough. We have this huge spread sheet that we have to create every year.

So one question I have about this is do we know when those contracts get locked in between the providers for the upcoming year? Because we start these calls -- we know about the plans and the plan names and everything, so we can ask the questions, not until the 1st of October or the last day of September. So we have to quickly start making calls.

So the question is: When do providers and insurance companies know or the plans know that? That would be good to know.

Number 2, just six steps in helping people with insurance counseling. Do you want original Medicare or do you want a Medicare Advantage plan?

The second step is if you don't want a Medicare Advantage plan, HMO, PPO, POS, you know, private fee-for-service, depending on which Medicare savings account, whatever you have. It can't be fuzzy if your providers are in and out of network there, because there are whole other steps. You go from are you going to be in Medicare Advantage? What flavor of Medicare Advantage? Then we put your drugs in. Then we put your pharmacy in or several pharmacies in. Then we look at you're A&B cost sharing, and then we look at all the extras. So there's a lot. So to be real fuzzy about whether your provider is in or out of network, early on in the process, just blows everything up. Okay.

The last point I would make is I have real concerns about prior authorization, especially around skilled nursing facilities. And I know certainly in the

rehab facilities, they won't see a lot of people in Medicare Advantage plans, as we talked about last month. But Susan Jaffee wrote an article about artificial intelligence being used obviously to create these prior authorizations and put them in place, so just understanding that a little bit better. Obviously, AI can help, but it also can be used to deny coverage when coverage is needed.

Thanks so much for this work.

MS. KELLEY: Greg.

MR. POULSEN: I agree and reinforce the statement. I think this is a great chapter. If we weren't short on time, I'd have a whole bunch of comments. Let me be really brief, though.

I'd reinforce the difference in plan types that I mentioned in Round 1. Prior authorization is used very, very differently by different plans and by different plan types. Some feel really intrusive and some seem to act to inhibit appropriate care while others don't at all.

The 2 percent to 21 percent I think is striking, but I think we actually see that -- even in relatively micro communities we see that kind of huge variation. And it's really very much aligned with the type of plan and the

type of providers, and it's not just a vilification, and it shouldn't be viewed as a vilification of the plans that use it. It can also be an indictment of the provider approach, whether providers are aligned in a high-value mechanism or whether they are trying to get away with doing things. And so it can be a response to that. So I'm grateful for the description that we had there and wanted to call that out.

I also wanted to just expand a little on Brian's history lesson. I think that, you know, as you all will recall -- some of you don't because you weren't around, but in the 1980s and particularly the 1990s, there was a huge backlash against many of these approaches, and I remember in, I think it was, 1999 -- I just tried to look it up, and couldn't find the exact timing. But it was 1990-ish when Bill McGuire, the CEO at United Healthcare, stated that prior authorization was no longer necessary and that it had served its purpose and that the denials were now so low and were so often overturned that it was no longer relevant to have it around, and they discontinued it in the year 2000.

Well, it was back with a vengeance by 2003 because what they found is that the impact was not -- I think, Mike, you mentioned this. The impact is not just

whether or not something is denied. It's whether it provides an appropriate hesitation in terms of something is ever requested. And what they found is that in its absence we saw it increase really dramatically, and it's not just about cost. It can also really truly be about quality. We all are aware of unnecessary -- things that are unnecessary add risk and not just cost. They put people in harm's way. And so having those in there can be helpful if we don't have other mechanisms to align practice patterns around things that are of high quality and high value.

Thanks very much.

MS. KELLEY: Robert.

DR. CHERRY: Thank you for a great report that really touched on a couple of really hot-button issues here, and I really appreciate it.

I guess to take each of these topics separately, in terms of, you know, network adequacy, you recommended several options for future analysis. I think all of those are great suggestions.

One of the ones that kind of popped out to me is developing relationships, you know, statistical relationships between network design and health care

utilization, quality metrics, and local market analysis. How you define network design I think will be critical here based on previous discussions that we've had around the dizzying array of MA choices that members have and also even based on today's discussion, how those different types of, you know, plans could potentially influence selection. So I don't think it will be necessarily an easy analysis, but it is rather appealing.

Then as far as the provider directory, you know, it's -- that's a very difficult problem to solve. The states have the active licensure of individuals. Of course, you know, the states have firewalls between them. It's not like databases communicate with each other. The health plans have their own credentialing databases, so it should be useful to pull from those. But it will be good to cross-reference both the state licensing databases as well as the credentialing databases to make sure that the information is as up to date as possible. But that may not be sufficient because there may be providers that, yes, are actively seeing patients, but they're closed to new patients. And so unless you have some sort of data point around that, you wouldn't be able to tell, and all because

you see, you know, a cardiologist that has an affiliation with the hospital that is local to your community doesn't mean that it's the right cardiologist for you if they are exclusively an interventional cardiologist and you need to have your atrial fibrillation managed.

So, you know, it's challenging. I only mention it because I don't have a solution for that, but it is difficult.

The other par as far as pre-authorization goes, I remember as a resident other attending physicians complaining about the pre-authorization process, so it dates back a very long time. Nevertheless, it may be a good idea to kind of focus on a few selected areas that feel high risk to us. One area is intra-facility transfers from a patient that may be in network at one hospital, needs to go to an out-of-network hospital for an urgent or emergent condition, and many facilities have difficulty contacting the health plan in real time, particularly after hours and on weekends. And there's an element of risk when those facilities accept those patients and then they get denied on the back end. So that is an issue, and I know it's causing probably issues in a number of states in terms

of delivering timely quality of care as a result.

The other areas around pre-authorizations, you know, we touched on at least one of those, which is oncology and access to oncology, not necessarily hospital care but outpatient care and pharmaceuticals as well. I'd also throw in complex neurologic disorders, too, into that, both in terms of care and treatment as well as pharmaceuticals.

Otherwise, great report, looking forward to future analysis on all of this.

DR. CHERNEW: And, again, 11:55. It is like magic, no matter how stressed I am, what a good job you all do.

So that was a terrific discussion, and, again, thanks to Katelyn and Ledia for leading it. I think there's a ton of interest and a lot going on here.

I will say one substantive point that I didn't hear and I'm sorry if I missed it, but I think it's important, and I'm surprised I didn't hear it from Brian and Larry, given how much I hear from Brian and Larry on this point. The interaction between network adequacy and competition and consolidation is actually really important,

because it's hard to figure out how this influences the market power when you force plans to contract. And so, on one hand, I think our guiding -- our North Star principle is beneficiaries need to have access. That doesn't mean we don't worry about situations. I think the dialysis work we've done shows that in a very consolidated market, the MA plans end up paying way more than you would in fee-for-service, which I think is a consolidation problem. And network adequacy can feed into that in a bunch of ways.

So I think it is not simply an exercise in access, although that is, I think, probably the most important part, or consumer choice, although that is certainly an important part. It is also an exercise in the market dynamics of what MA plans can do and how the pricing mechanism works in a plan. I think consolidation with influence that in the Medicare market in ways that aren't really appreciated.

But that substantive point was a little bit of an afterthought, and so I'm going to go back to both thank you all, thank you to all the Commissioners. And for those of you that are home, please send us messages -- some of you have already have -- on your thoughts on both selection,

prior auth, and network adequacy requirements. We really do appreciate them, and you can find us at meetingcomments@medpac.gov, or you can go onto our website and otherwise send comments. As I think I said in response to the last session, we have a lot of work in MA. MA is increasingly prominent in the Medicare program. It's important fiscally. It's important for quality. There's a lot of issues there, and this is another, I think, really exemplary chapter on an area that's important. And as before, we will continue to push on it.

Again, thank you. We will be back again in December, and I very much appreciate all of your comments. So, again, be safe.

[Whereupon, at 11:58 a.m., the meeting was adjourned.]