MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 11, 2024
10:33 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
LAWRENCE P. CASALINO, MD, PhD
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
JONATHAN B. JAFFERY, MD, MS, MMM, FACP
KENNY KAN, CPA, CFA, MAAA
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 the April MedPAC meeting. It is our last public meeting of this cycle, and I think we have a really good agenda for what we're going to talk about. I'm not going to go into much detail. I think we're going to jump into a topic of continued interest, which is telehealth, and who's starting. And Ledia is starting.

MS. TABOR: Good morning.

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

In our June 2023 report, the Commission responded to a congressional mandate to study the expansions of telehealth services during the COVID-19 public health emergency. Some of these expansions have been made permanent or temporarily expanded through 2024. Today, for your discussion, we provide updated analysis that could help inform the Congress's decision on the extension of telehealth flexibilities beyond 2024. These materials will not be part of the June report to the Congress.

Before moving on, we would like to thank Corinna Cline for her contributions to this work.

First, I will present an overview of Medicare's telehealth policies and then discuss trends in telehealth use. Then Brian will review some analysis on two topics of interest to policymakers. Then Commissioners will discuss the materials and provide guidance on future work.

Before the PHE, Medicare's coverage of telehealth was discretionary in MA, two-sided ACOs, and some fee-for-service payment systems. Under the physician fee schedule, Medicare paid for a limited set of telehealth services provided to beneficiaries in rural areas in certain settings, such as physicians' offices and hospitals, with some exceptions. As a result, use of telehealth was very low.

During the PHE, Medicare temporarily expanded coverage of telehealth under the fee schedule to allow beneficiaries to maintain access to care and help limit community spread of COVID-19.

The PHE ended in May 2023, but because of telehealth's potential to improve access to care, Congress has extended many of the flexibilities until the end of

2024. Congress also made permanent the coverage of telebehavioral health services beneficiaries receive at home.

I won't go through this table in detail, but it provides some more information on coverage before, during, and after the PHE. I'm happy to discuss on question. The main takeaway is that many of the policies were temporarily expanded after the PHE ended and are set to expire at the end of 2024.

I'll now briefly review Medicare payment rates for telehealth services. The chart on the left-hand side presents physician fee scheduled telehealth rates. Beginning during the PHE, the physician fee schedule generally pays for telehealth service at the same rate as if the services were furnished in person.

The chart on the right-hand side presents telehealth rates at federally qualified health centers and rural health clinics. As background, the Congress established special payment rates for FQHCs and RHCs to improve access to primary care services in rural and underserved areas. These rates are generally higher than the fee schedule. Currently, Medicare pays these standard

FQHC and RHC rates for telebehavioral health services, which have been permanently expanded. For all other telehealth services, FQHCs and RHCs receive physician fee schedule equivalent rates throughout the expansion period.

I'll now present some trends in telehealth use during 2022, which is the most recent year of available data. While the volume of telehealth services varied across these Medicare payment systems, utilization declined across all of them in 2022.

On the left-hand side of the screen, we see that the number of telehealth services billed under the physician fee schedule has continued to decline since peaking in the second quarter of 2020. The number of total telehealth claims was steady at about 5.6 million claims in the last two quarters of 2022.

On the right-hand side of the screen, we see that the number of telehealth claims also declined in FQHCs and RHCs from 2021 to 2022. The number of total telehealth claims for FQHCs, the orange line, was about 250,000 for the last half of 2022. For RHCs, the green line, there was about 90,000 telehealth service claims per quarter for the last half of 2022.

The share of claims with the telehealth service also continued to decline across these payment systems. FQHCs had a greater share of claims with the telehealth service at 17 percent in 2022 compared to the physician fee schedule in RHCs in which 4 percent of claims were with the telehealth service.

An interesting finding is that the share of physician fee schedule services delivered via telehealth varied by service type. About 6 percent of common E&M office visits were delivered via telehealth, while 50 percent of common psychotherapy services were delivered via telehealth.

From 2020 to 2022, behavioral health services accounted for an increasing share of telehealth services. In this period, the share of all telehealth services related to behavioral health and billed under the physician fee schedule increased from 26 to 40 percent.

Although behavioral health accounted for an increasing share of telehealth services, the volume of telebehavioral health services decreased from 2020 to 2022, even after considering the declining number of fee-for-service beneficiaries. This decline occurred even though

the Congress permanently expanded Medicare coverage for telebehavioral health services in the Consolidated Appropriations Act 2021.

It is important to also consider beneficiaries and clinicians' experiences with telehealth when thinking about future policy. Beneficiaries and clinicians had mixed reactions when asked about telehealth in our focus groups. We heard some beneficiaries express hesitation about receiving telehealth care because of limitations in what exams can take place virtually. Other beneficiaries in the focus groups appreciated having telehealth as a convenient option in certain situations.

In our annual beneficiary survey, about 35 percent of respondents were interested in continuing to have the option of telehealth. About 90 percent of beneficiaries who had a telehealth visit were satisfied with that visit.

In focus groups with clinicians, we heard that while acknowledging the value of telehealth to facilitate access, some clinicians raised concerns about what might be missed during telehealth visits, where examinations are limited.

I'll now turn it to Brian.

MR. O'DONNELL: So I'll now review some analysis of clinicians who provide only telehealth services. Under the telehealth flexibilities that began during the pandemic, beneficiaries can receive telehealth services in their home instead of being required to receive that service at a health care facility.

Some have expressed concerns that this policy may lead to a proliferation of telehealth-only providers who do not provide any in-person services. The concern is that such providers may not incur the costs of maintaining an office or other items, such as supplies, that are only needed for in-person visits.

If payment rates are not set appropriately, more clinicians could move to providing only telehealth services, which could jeopardize access to in-person care.

To monitor this potential issue, we group clinicians who build the fee schedule into three categories: those who billed only in-person services, those who billed some telehealth services, and those who billed only telehealth services.

The columns on the left-hand side of the chart

show that the shares of non-behavioral health clinicians that fall into these three categories in 2020, 2021, and 2022. In 2022, we see that the share of non-behavioral health clinicians who provided only telehealth services was 1 percent. The share providing some telehealth was 10 percent, and the share providing in-person only was 90 percent, meaning that almost all of these clinicians were providing some or all services in person.

However, looking at the columns on the right-hand side of the slide, which are the shares of behavioral health clinicians broken out by these categories, we see different trends. The share of behavioral health clinicians who used only telehealth in 2022 was much higher at 21 percent, as was the share of clinicians providing some telehealth at 45 percent.

These results suggest that the vast majority of clinicians are providing some or all care in person. Our analysis is based on a short period of time, and the market may change going forward, especially if Medicare makes certain telehealth flexibilities permanent. But to date, it's unlikely that telehealth flexibilities are substantially impeding access to in-person care across all

clinicians.

Our results did indicate that a sizable share of behavioral health clinicians are telehealth-only providers. Behavioral health clinicians who furnish care exclusively from their homes likely incur lower costs than those who maintain an office. But these reductions in cost are likely modest because behavioral health services already have a low share of payments attributed to practice expenses, and allowing telehealth-only services could improve access to behavioral health care services, especially in areas with ongoing access issues.

Because behavioral health services make up a large share of all telehealth services, reducing payments could have an outsized effect on beneficiaries' access to behavioral health care, which is a potentially concerning implication, given that access to such care can already be problematic.

I'll now switch topics to in-person visit requirements for telehealth visits.

The Congress permanently expanded Medicare coverage for telebehavioral health services. This expanded coverage requires an in-person visit with the clinician in

the six months preceding the first telehealth visit and subsequent in-person visits as determined necessary by the Secretary. CMS will require annual in-person visits beginning January 1, 2025.

In rulemaking, CMS established flexibilities for these requirements to recognize beneficiary preferences and access to in-person behavioral health care. For example, either the initial or subsequent in-person requirements may be met by another practitioner of the same specialty and subspecialty in the same group as the practitioner who furnishes the telehealth service. Also, the subsequent in-person visit policy does not apply if the practitioner and patient agree that the benefits of an in-person service are outweighed by the risks and burdens associated with an in-person service. And certain established patients may not be required to have the initial in-person visit.

To examine the potential impact of these in-person visit requirements, we calculated the share of beneficiaries with telehealth visit in the first quarter of 2022 who also had an in-person visit with the same provider group in the preceding 12 months. We stratified this analysis by services billed under the fee schedule, FQHCs,

and RHCs, as well as behavioral health and non-behavioral health services.

In reviewing these results, it's important to consider a couple limitations.

First, using the most recent available data, our 12-month look-back period extended back through 2021, which had higher telehealth and lower in-person visit utilization. So the percentages may be different with more current data.

Second, it's difficult to know how many beneficiaries and clinicians are aware of, or will avail themselves of, the flexibilities built into the in-person visit requirements that will apply in 2025.

Looking first at telebehavioral health services on the left-hand side of the chart, we see that only 21 percent of beneficiaries with a fee schedule telebehavioral health visit had an in-person visit with a clinician in the same group in the preceding 12 months.

This finding suggests that imposing an in-person visit requirement for behavioral health services could be disruptive. More specifically, it could require visits that might not be needed, and some beneficiaries might have

difficulty accessing in-person behavioral health care. In that vein, our analysis of telehealth-only clinicians suggests that the pool of clinicians who offer in-person behavioral health services is more limited than it was before the pandemic.

Requiring an in-person visit in other circumstances may be less disruptive than for fee schedule telebehavioral health services. For example, looking at the far right-hand bar on the slide, we found that 68 percent of beneficiaries who had a non-behavioral health telehealth visit at an RHC in the first quarter of 2022 had an in-person visit at that RHC in the preceding 12 months.

Beyond the in-person visit requirement, policymakers could consider alternative safeguards to protect the Medicare program and beneficiaries from unnecessary spending and potential abuses of telehealth services.

For example, the Commission has suggested applying additional scrutiny to outlier clinicians who bill for many more telehealth services per beneficiary than other clinicians.

Also, the program could prohibit incident-to

billing for telehealth services provided by any clinician who can bill Medicare directly. This would not limit access to telehealth services but would instead focus on increasing transparency.

So to summarize today's presentation, telehealth volume continued to decline across payment systems in 2022 since peaking the second quarter of 2020.

Beneficiaries and clinicians had mixed reactions when asked about telehealth.

Behavioral health services accounted for an increasing share of telehealth services, but telebehavioral health volume declined despite permanent coverage of services in a beneficiary's home, which began in 2022.

About 1 percent of non-behavioral health and 21 percent of behavioral health clinicians provide telehealth services exclusively.

Requiring in-person visits before telebehavioral health visits under the fee schedule could disrupt established care patterns, but policymakers could consider alternative guardrails.

For Commissioner discussion, we welcome your questions and feedback about the analysis as well as ideas

for future work on telehealth. As a reminder, this will not be a chapter in our June report.

And with that, I'll turn it back to Mike.

DR. CHERNEW: Brian and Ledia, thank you.

I think we're going to jump right into questions, and if I have this correctly, Tamara is first.

DR. KONETZKA: Thanks for this great work. Really interesting chapter.

The act that established or made permanent telehealth for behavioral health, what was the underlying motivation for requiring those in-person visits? I'm trying to get -- you know, so specifically, was there any sort of clinical motivation at all, or was it just about sort of maintaining access to in-person visits? Or was it just sort of a kind of indirect blunt tool for trying to prevent abuse?

MS. TABOR: I can ask Paul to weigh in here too, but I believe that one of the drivers was the cost. It was a way to keep the cost down for this new policy, but there could also be implications, like you mentioned, for access and quality. But I believe cost was probably the biggest factor.

MR. O'DONNELL: Yeah. I also want to mention that it was passed in December 2020. So all the benefit that we have of the two years of hindsight, the Congress didn't have at the time. So it was a slightly different environment, but I'll let Paul weigh in here.

MR. MASI: No, I agree with that. I think we are a little limited also in the extent to which we can interpret congressional intent around this. I don't think we have a lot to go on, but I would agree with the reflections that Ledia and Brian shared.

DR. CHERNEW: MedPAC -- when we were discussing, some previous MedPAC Commissioners would -- you know, this is a potential for abuse on steroids. I think there was a lot of program integrity concerns that we -- I won't speak for the people who enacted the rules. But I think we in the Commission had a long concern about the potential for abuse in a whole range of ways. There was a lot of in our earlier discussions about that, of that potential abuse, and that was one, albeit crude --

DR. KONETZKA: Okay.

DR. CHERNEW: -- the thing that reflected it.

DR. KONETZKA: Okay. I guess I can save myself

an R2 comment here and just say I just wanted to make sure there wasn't really like a clinical reason, given that that's not my area, to require an in-person visit. And given the sort of, I think, success of televisits for mental health or for behavioral health and given ongoing concerns about access and barriers to accessing that care, I think, you know, there's really no reason to require those in-person visits.

MR. O'DONNELL: I will raise one last comment on that. The tug and pull that we have seen at the Commission, too, has been if there's payment parity, some people are concerned that it's important in certain clinical circumstances to access behavioral health in person. So that is the one clinical consideration that we've heard, and that if you pay them the same, the virtual only might out-compete the in-person folks. So that's the clinical concern we've heard. I wouldn't necessarily attribute that to Congress, but I've heard other people say that.

MS. KELLEY: Greg?

MR. POULSEN: Let me pile on and say I really like this work. It was nicely done, and it was timely.

I do have a slightly different experience with a number of provider-sponsored MA plans where they haven't seen anything like the decrease that we're attributing here.

I was just wondering; do you have a broader look at MA utilization? I know that's a topic we're going to talk about later in the discussion in terms of getting data, but do we have either something that would confirm that we're seeing a similar trend in MA, or we're not seeing it, or we just don't have enough data to know?

MR. O'DONNELL: So we didn't do the analysis, but other folks have looked at kind of trends in the employer market. So we can try to reflect that going forward, kind of what other folks have done.

MS. TABOR: And we'll say that there are likely also to be issues with the encounter data as well, which will be talked about later.

MR. POULSEN: Yep, yep, got that. And obviously, that plays in as we're discussing motivations because those are in organizations where the rampant overuse is not as much of a concern. So, anyway, something to think about.

Thanks very much.

MS. KELLEY: Wayne.

DR. RILEY: Ledia, Brian, thank you. Good work.

What can you share about the demographics? At the height of the public health emergency when HHS issued the directive that we could begin connecting with our Medicare patients, I had great concern about Black and brown patients, in particular, as to whether they would be able to avail themselves of the telehealth approach.

When we looked at our own data, it turned out that most of our telehealth visits, quote/unquote, were "telephonic" as opposed to video or by Zoom or other platforms.

Is there anything you can share about the demographics? Because I do think for Black and brown Medicare beneficiaries, that's a key component we can't not be aware of. Thank you.

MS. TABOR: That's a great question, Wayne.

So nationally, we have found that in the Medicare population, Black and Hispanic beneficiaries actually use telehealth more. But some recent research that has been published that controlled for geography actually found that Black and Hispanics used telehealth less. So there are

some disparities there.

You know, it's something that we've talked internally that we're interested in diving into more, but yes, they do exist. Yeah.

MS. KELLEY: Lynn.

MS. BARR: Thank you very much for this wonderful work.

Could you go to slide 7, please?

So, you know, it's funny because we talk about RHCs, which we know are rural, and we talk about FQHCs, which are, last time I looked at the data, were 90 percent urban, right? And I was wondering if you could break the data into rural and urban FQHCs to see, because I think we're averaging two different things, and I think you might see a completely different pattern in the data.

MR. O'DONNELL: Can I respond to that just really quick?

MS. BARR: Yeah.

MR. O'DONNELL: So we actually did do that behind the scenes.

MS. BARR: Uh-huh.

MR. O'DONNELL: So we stratified FQHC and RHC

into their location, and the urban, metropolitan, rural adjacent, rural non-adjacent. And we did see that, regardless of FQHC/RHC, that use of telehealth declined as rurality increased.

However --

DR. CASALINO: As what increased?

MR. O'DONNELL: As rurality increased, it actually became more rural, telehealth use was less. However, even in --

DR. CASALINO: [Speaking off microphone.]

[Laughter.]

MR. O'DONNELL: I wasn't going there.

MR. MASI: Don't answer that, Brian.

MR. O'DONNELL: Yeah, I know.

But even controlling for that, FQHCs still build a higher share. So, like, in the same rural/urban kind of categories, FQHCs build more telehealth.

And I think the thing there is that the mix of services at FQHCs tends to be more behavioral health. So when you think about the bucket of services that FQHCs furnish, it's about triple the volume of -- on a kind of shared basis, of behavioral health that's in the RHC. So

about 6 percent of all care in RHC is behavioral health, and then you look at something like 18 percent in FQHCs. And that's in-person and telehealth.

MS. BARR: That's great.

Would you mind sharing -- adding that data? Because I think it's really, really important.

I was also pointing out how few rural health clinics actually provide behavioral health services. This is where the majority of services are. There's just certain parts of this policy that feel -- I'll save that for Round 2.

And can you go to slide 18?

Okay. For slide 18, what my concern is -- do you think that that the RHC data is affected -- wait a second. Let me go to my own slide 18 here -- is affected -- oh, you mentioned the 68 percent in RHCs indicate that perhaps these visits are not as big a problem as they should be, right? But I think there might be some confounding variables in there that wouldn't get me to draw that same conclusion. So I was wondering if you thought it could be affected by the fact that they only have one provider in the community, and so that provider is likely to be the one

that's providing that telehealth service, where if you live somewhere else, you're going to urgent care. You're going all over the place.

So I think I wouldn't draw that conclusion. That's Round 2. I'm sorry. But I just want you to think about that a little bit and just whether that could be -- that access issue could be artificially inflating those numbers.

MR. O'DONNELL: Yeah. And I think you're kind of dead on, that I think that was our first instinct when we saw that folks who had a telehealth visit and RHC also had an in-person visit. It is just that they access care through their local RHC, but that does mean that if you were to require an in-person visit for RHCs, it would be less disruptive because those folks just go to the RHC to get care in general, more so than fee schedule folks. So that's the two-step of the interpretation.

MS. BARR: I see.

But you're also dealing with super low adoption. So, you know, that means there's very few providers doing it, and those are ones obviously that are really connected to their patients. So I just think it's -- I wouldn't make

any conclusions or use that 68 percent to sort of say I think this could be okay because it worked. Look at the rural numbers.

Thank you. And that's Round 2. I apologize.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks for this information. Very helpful.

Just three quick questions here. On slide 7, you have something about -- it looks like the first quarter of every year, telehealth goes up. Is that because of bad weather somewhere? I mean, do we have any idea what that's about?

MS. TABOR: That's the flu also, flu season.

MS. UPCHURCH: Okay, okay. So it's short term.

MS. TABOR: Yeah.

MS. UPCHURCH: So that's sort of related to the second one. Do we know if Medicare beneficiaries sort of -- is it the same cost sharing for them also based on their insurance? I know the provider gets the same amount as the cost sharing for the individual. Okay.

MS. TABOR: It is still.

MS. UPCHURCH: So I think what happens if you're

getting that in January and you see that, you know, you're on the phone for three minutes with the provider and you get your EOB from CMS and you see how expensive it was, you might think, wow, okay, I don't know if it's that valuable. I mean, I don't know if that's the take you got when interviewing people, not for behavioral health issues but just for other reasons.

Maybe when you go to the physician's office or practice, you're there. You see the front desk. You have labs. It feels more valuable somehow than just a quick phone call. I don't know.

MS. TABOR: That did not come up in our focus groups.

MS. UPCHURCH: Okay.

MS. TABOR: I will say that the telehealth visits that are kind of your Level 3 E&M code --

MS. UPCHURCH: Right.

MS. TABOR: -- for example, the amount of time that you should spend on the patient in a telehealth visit should be the same as it is in person.

MS. UPCHURCH: Okay.

MS. TABOR: So something like a three-minute

visit would, I think, technically be more like a virtual check-in, which does have a co-pay tied to it but is less than a traditional E&M visit.

MS. UPCHURCH: Okay. So it can be more efficient in that way?

MS. TABOR: We did ask about efficiency in our focus groups, and we heard from both sides that sometimes they think they're faster, but sometimes they could take longer because of technological issues.

MS. UPCHURCH: Okay. All right. Thank you.

MS. TABOR: But I would say that the parity is the same on the beneficiary and provider side.

MS. UPCHURCH: Okay. And my last question is really about quality, and I just want to plus-one with Wayne's comment about digital equity. I do have concerns about -- is this telehealth a phone call? Is it video? I mean, we know communication is way more than obviously just speaking to someone and seeing body language and that kind of thing. So I really think it is important to look not only at demographics, but also the way people are receiving the telehealth would be important for us to track.

MS. TABOR: Yeah, that's a really important

point, Gina.

So we are also very interested in deciphering between audio-only visits and video visits. Right now, CMS has required a modifier on audio-only claims that became mandatory this year in -- well, in 2023. So we will be able to look at the data about audio-only versus audio-video in the future.

MS. UPCHURCH: And I know we struggled to look at -- think about quality anyway, the quality of care, but do we have anything about how we -- telehealth is different than in-person quality, especially around behavioral health intervention?

MS. TABOR: The audio -- the comparison of in-person versus telehealth research has been done on that, but we haven't really looked into it much. Yeah.

MS. UPCHURCH: So we can pay for stuff, but we do want to know if it's valuable.

MS. TABOR: I think there is some research, but I would still say that there are opportunities for improvement in literature.

MS. UPCHURCH: Thanks.

DR. CHERNEW: And just as an aside, it's not

clear if the right comparison is going in-person or not going at all.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. I should know this, but I realize I don't. And by the way, the depth of your knowledge and the alacrity with which you're able to respond to questions is very impressive, both of you guys.

The work you did on percentage of claims done via telehealth versus in-person, is that just Medicare fee-for-service data, or does that include MA?

MR. O'DONNELL: Just fee-for-service.

DR. CASALINO: Okay. And with MA, do we have a sense of -- and Greg may be helpful on this as well. Do we have a sense of how MA plans, when they do provide telehealth, how they do it? I can imagine doing it just like any other doctor visit on a kind of fee-for-service basis, or I can imagine an MA plan contracting with a telehealth-only provider to say we'll give you X amount per month, and you just provide whatever number of visits you have to provide via telehealth to our enrollees. Did you have much knowledge of what's going on in that field?

MS. TABOR: I'd say we haven't dived into this

topic. I think through our interviews and through focus groups, we've heard about both of the scenarios that you just laid out. It's something that we can think about looking into in the future.

DR. CASALINO: All right. I won't do -- we've had a couple of Round 1 violations today. I'll keep my comments for Round 2.

[Laughter.]

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I really enjoyed and appreciate this work.

I have a question about something that I just can't quite unpack. On slide 13, we see the dramatic increase in telehealth only with behavioral health clinicians, and then the drop-off in 2020. And I just wasn't clear if we think that's related to in-person visit needs, or are people not entering, you know, entering the service? Are providers exiting? Do we know much about what's behind that? Because it sounded like in MA, from what Greg said, they're not seeing that. So I was curious what that's about, if we know.

MR. O'DONNELL: I just want to touch base about

the -- and so you're talking about the behavioral health clinicians on the right-hand side.

DR. RAMBUR: Yes, I'm talking just about that.

MR. O'DONNELL: Right. And so to start off in 2020, there were a few months pre-pandemic, right? So that's why the share of telehealth-only is likely so low.

DR. RAMBUR: Right.

MR. O'DONNELL: And so 2021, it increased to 26 percent.

DR. RAMBUR: Right.

MR. O'DONNELL: And then it decreased a little bit to 21 percent. So I wouldn't say -- so the share of telehealth-only has receded a little bit from 2021, but it's still quite substantial. So I'm not sure I would --

DR. RAMBUR: Okay. So you wouldn't see that as being a significant change?

MR. O'DONNELL: It decreased, yes.

DR. RAMBUR: Okay. All right. Thank you.

MS. KELLEY: Kenny?

MR. KAN: My question has been answered by Lynn.

MS. KELLEY: Okay. That's the end of Round 1, unless I've missed anyone.

And so, Mike, are you ready to go to Round 2?

DR. CHERNEW: I think it's Brian.

MS. KELLEY: It is Brian with Round 2.

DR. MILLER: Thank you, and thank you for this chapter. I appreciated the compactness and brevity. It was very impressive. I probably could not have written it this well myself. It's hard to do that.

So a couple thoughts, and pardon me for relying on my crutch of notes. On page 7, we talked about the telehealth-only physician. I think we might want to modify our position on that because it sounded like we were describing it as a bad thing. I don't think it is a bad thing because it's the consequence of competition and segmentation in the market.

Some practitioners are going to prefer in-person, and some of them are going to prefer telehealth, and some will prefer a mixture. We should support that. Why should we support that outside of thinking that competition is good? Well, it allows more people to participate in the workforce who might not otherwise be able to. So a lot of the behavioral health physicians, psychiatrists, for example, who are doing telehealth are working mothers, and

their opportunity to work as psychiatrists might be more limited if they weren't telehealth only. So I think we should note that nuance there.

On page 8, we talked about the patient and clinician and the requirements for in-person visits. I think one thing that we should think about -- and maybe some of our more libertarian colleagues have good ideas on this -- is that the patient and clinician, be it a doctor, nurse practitioner, physician assistant, counselor, whomever, should decide together if the in-person visit is needed, because that's something the clinician and the patient should decide, not necessarily the health plan, be it a private or public health plan, because I don't think we can say that CMS or United's judgment is going to be better than that of the patients or their clinicians.

I agree with Wayne on audio-only service, which if you're poor, you don't have a lot of technology, don't have access to technology, maybe don't have broadband internet. Maybe you live in the middle of the underserved section of the city, or you live in rural America. Having that audio-only service is actually really important because your other alternative could be taking three buses

or driving two hours in a blizzard.

I think we talked about a variety of requirements that CMS has. I think that all of us should go back and take a look at the American Hospital Association's letter to Energy and Commerce Committee. Yesterday I was up very late last night reading through things. I read through that. It pointed out a lot of the barriers that we have to telehealth that we should think about removing and removing permanently.

Program integrity, I know, is a concern. I'd point out that the Center for Program Integrity is only 15 years old, which is not that old in the context of CMS but is a reasonably developed organization that we can expect to address fraud, waste, and abuse.

And then I think we also really need to look to the future because we have a shortage of, round numbers, 100,000 doctors, 90,000 nurses, shortage of nurse practitioners, physician assistants, shortage of bedside nurses. We have a shortage of certified nursing assistants. We have a shortage of pharmacists. We have a shortage of pharmacist techs. I think we have a shortage of probably just about every type of clinical worker.

As my colleague Larry has mentioned many times, a lot of physicians are very burned out and disillusioned, which is going to make this worse. And so we should do all the things that we should do to support the workforce.

In addition to that, we should be thinking towards the future about paying for automation. So we didn't pay for telehealth for 20 years. We stuck our heads in the sand collectively and were worried about fraud, waste, and abuse and had an unnecessarily restrictive policy. And as a consequence, looking at the data presented here, we would have prevented -- if we hadn't changed our policy, we would have prevented 5 million telehealth visits in quarter four of 2022 and would have either required those beneficiaries to go without care or somehow get to their clinician's office. That's not really good policy, and that was the policy due to concerns about fraud, waste, and abuse.

I know that those concerns will often be present about sort of AI-driven or tech-augmented service, and so I think we should think about telehealth as sort of a spectrum, right? There's in-person service. There's remote service, where you're on a video and maybe you have

an exam with a doctor through like a Bluetooth stethoscope. There's the doctor and nurse practitioner. Maybe they pick up the phone and call you. There's the chart messaging, and then I should say that there should be a component of automated service in there. So if Google can provide and titrate your blood pressure meds, we should support that, whatever the tech company is or whatever the service is, if it meets the beneficiaries' needs in an efficient, safe, and cost-effective fashion.

So I think that this chapter should be broader in that we should talk about the scope of services and giving beneficiaries choice in how they access services in a way that is most convenient and least burdensome to the beneficiary and then, of course, paying appropriately for that intensity of service, be it in person, remote, or automated.

Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you for this excellent work and chapter.

So I just had a couple of broad comments here. I think, like some of the other Commissioners have said, I

worry a lot about the in-person visit requirement and reducing access to behavioral health services because we know of so many shortage issues there, and I also found myself kind of wondering about the motivation. I appreciate that we can't, like, read the tea leaves and understand exactly what the motivation was, but it does seem that that piece was missing. That was something I was hoping to have included in the chapter or even, you know, possibly why this was being required and whether or not it should be rethought, given, you know, that we are seeing this overall decline in service use, which I think is -- like, for non-behavioral health services, which I think is kind of a good sign. People are figuring out where telehealth fits in and not abusing it. But I am really concerned about the in-person visit requirement.

I also wondered if there was a way to dig into the companies that are offering a lot of these in-person, -- oh, sorry -- telehealth-only services and also wondered a little bit about are those companies that focus primarily on counseling versus medication prescribing and just if there's any way to get details.

As far as, like, monitoring to make sure that the

use is kind of more appropriate and there's not fraud or waste, I do like the idea of just looking at billing outliers, one of the things you all had suggested as an alternative way to kind of keep a check on it.

And then I think, in general, you know, the telehealth-only group, there was a comment about, like, the lower cost of providing those services and things like that. I'm not worried about overpaying for behavioral health care at this point, especially knowing how much shortage we have. So I think that's less of a concern. I think you all did a nice job of kind of, like, allaying some of those concerns and not flagging this as a major issue. But I think given the shortages in this space, encouraging more access to care would be a really important thing.

But I'm excited to see this work, and I do think this is a really important area to monitor, especially the behavioral health component moving forward.

MS. KELLEY: Lynn.

MS. BARR: Thank you.

I echo the other Commissioners' concerns about requiring that inpatient service -- there are other ways to

monitor for fraud and abuse, and I think it really harms the ability for people to have access. So it would be important to really reconsider that policy, although I do understand why it was put into place.

The other unique rural issue is I've heard from many rural providers that they did not offer telehealth services, because it was paid at a lower rate than what they would get in person. So everybody else, except for FQHCs and RHCs, got paid the same, right?

And then when it comes to FQHCs, like you said, a lot of them were behavioral health services. FQHCs typically have just incredible capacity issues. I could see why they were willing -- and they get paid lower rates than RHCs. They get, you know, the grant on top of it, and so they were less affected financially because their rates were actually closer to the fee-for-service rates.

But for rural health clinics, it created a host of issues, and I know we don't want to be paying, you know, 3-, 4-, $500 for a telehealth visit, but if that's the appropriate visit -- and it's cost-based reimbursement. So if you start taking these things off of cost-based reimbursement, the accountants can't figure it out. The

data is very clear that we are not giving the same services.

Now, if your data, when you split the behavioral health versus fee-for-service and non-behavioral health services shows that they were actually giving equal amounts of non-behavioral health services, then I think that's a different story. But based on the data I see here, this is another -- I think this really supports that we should pay providers what they get paid for doing the services they do, because it will all come out in the cost report for these cost-based reimbursement facilities.

Thank you.

MS. KELLEY: Scott?

DR. SARRAN: Yeah. And, Ledia and Brian, thanks for the really excellent report. In a very brief chapter, you teed up, I think, all the relevant issues.

So I have just one framing comment and then one more specific comment. So the framing comment is I think it's sometimes helpful to think about or to prioritize what problem or problems we're trying to solve, and I'd suggest that in this space, the highest-priority problem we're trying to address is access. And the secondary problems

are around quality and program integrity.

And I suggest that because access is front and center. We know that's an issue, whether it's rural, whether it's challenged populations. I mean, we know access is right in front of us as a major issue. Whereas the quality and the program integrity, we just have some speculation but not data to support it yet.

So the specific comment then looked at through, first, the lens of access, I completely agree that in the behavioral health space, we should do nothing to impede market innovation. And I agree with Brian's comments about, gosh, this is a space, thankfully, maybe more than most in actual care delivery, where there is true market innovation occurring.

So given the huge challenges with access to behavioral health, let's not impede that by turning too quickly to regulation and putting brakes on things.

In the non-behavioral health, initially, my thinking when I was reading and pondering this was, well, I thought back as a provider and probably overvalued what I accomplished with a physical exam, think back to how I like being in an office as a patient with a doctor rather than

just being distant over phone audio. But when I broaden my thinking to think about people who don't have my history or perspective or access to time, money, and transportation, again, I kind of land back where I did with behavioral health, which is let's prioritize access. Let's not jump to overregulate too quickly. Let's encourage market innovation.

I think Gina's points about there's a feedback loop with beneficiaries who, if they don't think they're getting value from the service, they will weigh in in terms of their co-pays and so forth.

Overall, I'd say let's kind of keep moving towards prioritizing access, keep our eye on the quality and the program integrity piece, but applaud innovation.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you. Really helpful information in this chapter and appreciate the update work.

I had some thoughts about -- maybe this is future work because I suspect you don't have enough time to bake this in this round. So I find myself wanting to unpack a few things.

So we've seen this pretty significant decline in

the use of telehealth. So the question is, what do we know about people who do and don't use telehealth for any given visit? Are the non-telehealth visits for people with, somehow or other, higher complexity of issues or more challenging patient populations? And so I think trying to unpack some of the differences and kind of where is telehealth being used and how much of that sort of patient preferences versus like physicians are strategically making choices based on a medical complexity.

And then in terms of slide 8 around the federally qualified health centers, again, I was interested in sort of seeing some of the data unpacked about whether telehealth uses primarily around primary care services versus specialty care services. And I know patients who go to federally qualified health centers often have difficulty around specialty care, and so maybe this is providing a mechanism for greater access.

And I think, lastly, I do want to support the monitoring of outliers and trying to think of strategic ways to identify potential overuse of services. I think we face challenges in determining the appropriateness of services, particularly in the data we have access to, as

well as being able to measure the quality of care. But I think we shouldn't ignore those issues, and I think we just need to think harder about how we might be able to monitor in that space.

MS. KELLEY: Larry.

DR. CASALINO: Very brief comments about audio-only and then pretty brief comments about telehealth-only providers.

At a very high level, I think, I'm glad you're going to continue the work on audio-only because I think it is important potentially with regard to disparities. But also, I don't think it should be denigrated. I think there's a lot of visits that can be done pretty much as well by audio-only as by video, because even now, we do some video visits as patients, my wife and I. There's still uncertainty and tension for each call on both sides, the doctor side and our side. Is the technology going to work? So, anyway, keep up the audio-only work.

The telehealth-only issue, provider issue, is really important, I think, and I would separate it into behavioral health and non-behavioral health. I think that for -- you know, it looks like it's not important because

you're getting like 1 percent of claims coming from telehealth-only providers or whatever. But I don't think that that's going to be necessarily a stable statistic. Some work that we've done suggests that the telehealth-only companies, there's just been too much uncertainty about what Medicare would pay for and how regs would change over time. And so they've been reluctant to put their toes in the Medicare fee-for-service order at least. So I think that could change a lot once it becomes clear what Congress is going to -- Medicare is going to do with telehealth.

And then there's the whole MA side of things, which I don't think we understand very well.

I'm concerned about telehealth-only providers for a number of reasons. I'll just take the time for one now, and it's the one that you guys have already brought up, which is clearly the cost. Again, I'm on the non-behavioral health side. Clearly, the cost of providing telehealth-only services is much less than the cost of maintaining brick-and-mortar facilities, and there's no question that this could hurt like, for example, primary care brick-and-mortar a lot if the payment rates are the same for telehealth from telehealth-only providers and from

bricks-and-mortar providers.

I also happen to think that you're going to get higher quality from your primary care physician at your brick-and-mortar provider in a telehealth visit than you're going to get from someone who you've never talked to before and you're never going to talk to again.

So I think tracking telehealth-only providers in non-behavioral health's really important and then the issue of payment parity for telehealth-only providers.

Non-behavioral health, I'm not so concerned. I share other Commissioners' views that we want to get as much access as we can to behavioral health. And yeah, there isn't so much cost for behavioral health providers, for brick-and-mortar, so it may be less of an issue there.

And I do want to also just second the idea. I think the in-person visits requirement, certainly for behavioral health, telebehavioral health, and even for anything, really, I think is probably not a good idea. Monitoring for outliers is a better idea by far, I think.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I really appreciate the chapter and the comments of the other Commissioners.

I'll just augment, perhaps, some of the things that others have said, including Larry. I'm a big supporter of audio-only because of the access for rural, as well as people who really can't manage that complexity.

One thing that I haven't heard come up today, though, is how we differentiate between a service that should be reimbursed and the many phone calls that many of us spend all the time. When I was working as a nurse practitioner, admittedly, a while ago, I probably -- I can't tell you how many hours I spent on the phone each day. And how we differentiate that, I don't know, but I think it's not insubstantial.

I'm very pleased that telehealth is really coming into being, and I agree with others that innovation is really important and not stifling it.

In terms of behavioral care via telehealth, I think it does get rid of, potentially, some of the stigma of having to go to a certain place or be in the waiting room. But I'm very concerned about any disincentives or financial disincentives for inpatient visits, and I'm not suggesting we have the required visit. But I think it is different because you see the person walk into the room.

You see their gait. You see if their appearance has changed. Are their fists clutched versus not? And so, so many things can be done really well virtually. But I'm very concerned about really creating disincentives that harm the brick-and-mortar places that have all that overhead and infrastructure.

I strongly support Stacie, Cheryl, I think Larry said, others perhaps, the additional scrutiny for the outliers. And I don't know if it should even be just additional scrutiny or even the potential for some penalties. But it does link to me with the other recommendation, which I haven't heard anybody say, which is prohibiting the incident-to billing. And I strongly support that, at least in our program and many others.

The enrollment in the psych-mental health nurse practitioner is absolutely off the charts. That is where people are really wanting to go. But I'm not sure yet how many of them are incident-to under someone else versus really being able to track the costs and outcomes of their own care. So I think this is really an important space for so many reasons.

So yeah, thank you. Good work. Appreciate it.

MS. KELLEY: Jonathan.

DR. JAFFERY: Thanks, Dana. And thanks. This is a great chapter. Really important work.

I just want to comment on -- so I would echo what other Commissioners have talked about in terms of the negative potential of providing the -- of requiring an in-person visit. But I think what I would add to that is I think it goes beyond behavioral health. I think there's a tremendous amount of benefit in a lot of situations for this chronic disease management, which was something, especially immediately post-pandemic, that I did a whole lot of for people with complex chronic diseases that really, I think, able to make much stronger connections more consistently with people with, in my situation, advanced chronic kidney disease, pre-dialysis requiring it.

I think there's a couple advantages to being able to do that. First of all, you can see things in people's houses. Sometimes it gives you information. If there's a big bag of potato chips, you learn a little bit about sodium consumption that you might not otherwise get.

There's also the fact that a lot of Medicare beneficiaries, especially people with chronic or multiple

chronic diseases, don't come to the doctor's appointments themselves. They're brought by family members who are then taking off work, and even if they aren't, this enables family members to sometimes join those calls, including family members who don't live nearby. And so that can be really helpful, and it actually really helps set understanding expectations as disease progression occurs and people reach more end-of-life decisions and things like that.

And then, finally, just a word on efficiency. You know, we've all, I'm sure, experienced a situation where you have an appointment with a provider, and you might not walk into the room exactly at the time when your appointment was. And the one thing I found in my experience when I would have a half day of telehealth visits with patients was that it was actually a lot easier to stay on time and keep focused on things.

And so to the extent that that's not only helpful for patients to have that expectation and that convenience and efficient for the practice, I think there's also a provider wellness. I mean, for me, I always felt like that was a much less stressful afternoon if I felt like I was

staying on schedule. So just probably not the most important reason here, but I do think it matters a bit. So thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: I want to be supportive of the technology of telehealth and the access that allows us, you know, specifically with regard to behavioral health.

But it seems like every time we add technology or reimbursement, it gets abused, and so having guardrails and being very clear about that from the beginning, I think, when we can is a good thing.

Working with an agency that does conduct home visits, I just really want to emphasize how important that I think going into the home of people can really matter and be a very positive thing, not so much for behavioral health am I talking about, but also for that, but also just for seeing the environment that people live in, whether it's potato chips or not, how critical that is really to the care and the health of the individual. So as much as we can make sure that that's still accessible, that that's still an option for people who truly have multiple chronic conditions, homebound, that we're supportive of that.

In the intervals, yes, maybe telehealth would be fantastic. But I do want to make sure we're continuing to support home visits in a significant way. Thanks.

MS. KELLEY: I think that's all I have for Round 2, unless I've -- oh, Tamara, please go right ahead.

DR. KONETZKA: Yeah, just wanted to add a couple things to what I said earlier.

First, I failed to comment on your alternative strategies. You know, I said I'm in favor, as many others are, of not requiring the home visits for behavioral health televisits. But I think this -- as Stacie mentioned, I think just looking at sort of outliers in the billing seems like a good strategy. Also agreeing with Scott that, like, you know, the emphasis shouldn't be on regulation here. We're still more concerned about access in that space. So I think that option sounded good to me.

And the other thing I wanted to say, building kind of indirectly on a few things people said, is when I think about behavioral health, those visits can be very different if it's a prescribing provider and not a prescribing provider, you know, the sort of talk therapy versus just sort of monitoring for medications, et cetera.

And I think it would be interesting in future work to try to look at access and divide out visits by those two types of providers. Thanks.

DR. CHERNEW: And now I think that was the end.

So thank you for a terrific chapter and a great set of comments. There's a few things that are very clear. One is that the behavioral health space and the non-behavioral health space are different.

I will take a second to reframe perhaps what Scott started on prioritizing access. I think it's certainly true that access is the key value here, and there's a lot of places where telehealth can provide access. The question very much in the spirit of what Gina said a minute ago is, how do you prevent the most abusive practices that could exist or how you prevent organizations that come into the program with less pure hearts from finding ways to use these programs in deleterious ways?

What I take from this work -- and it's actually not going to be a chapter next, but we are going to continue to work on this -- is at least the worst fears that we had when these regs were being made were not realized.

Now, that doesn't mean if there was more certainty about what would happen, I think some people know that these couldn't be realized, but it was not the case that we let telehealth in and we over-relaxed things, that there really was a preference, I think, from individuals to see their physicians or others in person. And we didn't see the abuse that perhaps some people feared.

So where we are now is I don't think we're over the hump on not having to worry about these, and I think we always need to worry about program integrity. But the sort of overarching fear that I think people had that if you permit this, there's just going to be rampant abuse, really, when you look at these numbers, didn't materialize, which I think gives us a little bit of leeway to be a little more permissive on the side of permitting innovation and not worrying quite as much about what's going to happen.

So I think that in everything we do, we have to worry about program integrity, and I actually think you need to worry about that in advance. I think once it gets out, it's really hard to figure out what to do, but nevertheless, my concerns and the concerns that I think the

Commission expressed in some of the early discussions, which, just to be clear, were in the unique situation, prioritize access, I think that was the Commission view. But don't just throw the gates wide open. You have to worry about these things. I think those concerns, while still valid to me, are less salient. I'm less worried about that now, and so we'll see where things go.

So just to level set where we are, this particular stuff is not going to be -- this particular thing is not going to be a chapter right now, but this is a continued area of interest in monitoring, and we will continue to report on what's happening in telehealth. And I think many of you know, as the telehealth audio-only discussion is, there's actually a range of technologies that we are now able to apply to health care, which what we call telehealth is one. There's a range of other things, remote patient monitoring, how we pay for portal messages, a whole bunch of AI things that Brian mentioned.

I think understanding the bigger-picture issue of how technology is improving care and access and quality, which we're all supportive of, is important, but how we pay for it and prevent abuse of those things also is always top

of mind. And I think we're going to continue that and, to the extent that we can, both monitor it and think about where policy should go going forward.

But that's our status of where we are in telehealth. So I will again end with just a thank-you to Ledia and Brian, and we're going to take about a five-minute break, I think, and then we're going to turn to rehab facilities. So thank you.

[Recess.]

DR. CHERNEW: I think we're live. We are live. For those of you that don't know we're live, we're live. So welcome back. We're going to continue our morning session, and I think Carol said she was starting. And so, Carol, we're going to talk about rehab facilities. Go ahead.

DR. CARTER: Great. Hi, everybody.

Today we'll present options for lowering payment rates for patients with select conditions in inpatient rehab facilities, or IRFs.

Before I get started, I want to remind you that a PDF of the slides is available in the webinar's control panel on the right side of your screen.

Here's a roadmap of what we'll cover. First, we'll provide some background on IRFs. Then we'll summarize our comparisons of the patients treated in IRFs and SNFs and compare their outcomes. Next, we'll discuss three approaches to pay-for-select conditions. And finally, we'll outline activities the policymakers could undertake that would help minimize how frequently Medicare pays for inappropriate care in IRFs and would lower program spending for it.

This project was motivated by a few factors. In the Commission's report last year on a unified payment system for post-acute care, the Commission said it would look for smaller-scale opportunities to narrow Medicare's payments across payment differences or cross-pack providers. This work follows up on that idea.

Another factor was the high Medicare margins in this sector. They've been in the double digits for over 20 years and in 2022 were 13.7 percent.

Further, there is evidence that IRFs treat some cases that do not meet medical necessity requirements, and similar patients are treated in SNFs at much lower cost to the program. This combination led us to evaluate

approaches to lower payment rates for patients with conditions that typically do not require IRF-level care.

Medicare requires that IRFs must primarily provide intensive rehabilitation. The Congress has identified 13 conditions that typically require this level of care and requires that 60 percent of all IRF cases have one of them to be paid as an IRF. We refer to these as "compliant conditions" because these cases count towards the 60 percent compliance threshold. Other cases with other conditions can make up 40 percent of admissions and we refer to these as "noncompliant" because they do not count towards the compliance threshold. All admissions must meet IRF-specific coverage rules.

We appreciate that IRFs and SNFs differ in the services provided, and we've discussed these differences before. A few are listed on the slide. IRFs are licensed as hospitals, while SNFs are licensed as nursing homes. IRFs provide intensive rehabilitation services and closer medical supervision.

Medicare has different coverage rules. Notably, a beneficiary admitted to an IRF is expected to tolerate, participate in, and benefit from intensive rehabilitation

and require supervision by a rehabilitation physician.

We appreciate that the level of service is higher in IRFs. The question is whether Medicare should pay for this level of care for patients with conditions that typically do not require it.

In considering a targeted approach, policymakers would identify cases that do not require intensive rehabilitation and lower payments for them. However, identifying the cases is difficult.

First, discharge planners told us they considered many factors, not all of them clinical, such as patient preferences and proximity to family. Also, differences in clinical judgment can result in clinicians coming to different conclusions about a patient's care needs.

Second, work by the Office of Inspector General and CMS found that many claims do not meet medical necessity requirements.

Last, the list of compliant conditions is imperfect. Physical rehabilitation experts told us that not all patients with compliant conditions require this level of care, and conversely, some patients with noncompliant conditions do.

Without medical record review, identifying cases that require intensive rehabilitation is hard. While imperfect, we use noncompliant conditions as a proxy for patients who do not require IRF-level care and use this definition to assess the impacts of lowering payments for a select set of conditions.

Now we'll turn to comparisons of patients with select conditions treated in IRFs and SNFs.

To give you some sense of the conditions that are compliant and noncompliant, this chart shows the high-volume clinical conditions treated in IRFs and the mixes of compliant and noncompliant conditions in them. Compliant cases are in light orange and noncompliant are in black.

While some conditions, such as stroke, include only compliant cases, others, such as debility, are mostly noncompliant. And many conditions include a mix.

In October, we reviewed our comparisons of patients with non-qualifying conditions who were treated in IRFs and SNFs, and here we'll just give a high-level summary. And the details are in the paper.

In our comparison of beneficiaries with noncompliant conditions, we found that most beneficiaries

received care in SNFs even in markets with IRFs.

In terms of patient characteristics, compared to SNF users, IRF users were generally younger, less likely to be disabled, had lower median risk scores, and had similar median motor and cognitive scores, but SNF patients were more variable in their abilities. IRF patients were less likely to have comorbidities and impairments. However, IRF users may not be less costly to treat because IRFs provide more intensive services.

And now Betty will walk us through comparisons of the outcomes.

DR. FOUT: Thanks, Carol.

Ideally, we would compare functional outcomes between our group of IRF and SNF patients, but functional status at admission is used to set payment rates and may reflect differential coding, not differences in outcomes.

Instead, we compared claims-based outcome measures that are publicly reported by CMS. We computed the measures using the population of IRF, noncompliant cases, and comparable SNF cases. The measures were risk-adjusted using a similar set of covariates, as used by CMS, with some adjustments made for this population. More

information on these measures are in your meeting materials.

The differences between noncompliant IRF cases and comparable SNF cases were large for the most part but not for all the measures we examined.

As shown in the first row of the table on the left, the rates of re-admissions after discharge was not different between our IRF and SNF groups, but there were substantial differences between the IRF and SNF groups for readmissions during the stay, discharge to community, and the Medicare spending per beneficiary measure.

For readmissions during this day and discharge to community, IRFs performed better, with lower readmissions and higher rates of discharge to the community. Medicare spending per beneficiary was higher for the IRF group than the SNF group.

There are reasons to expect differences between IRF and SNF populations, so we cannot draw definitive conclusions on quality. Even with risk adjustment, differences in outcomes are likely to reflect underlying differences in patient populations, not necessarily the result of the care patients received. Moreover, IRFs have

hospital capabilities and can treat the worsening of many conditions that SNFs cannot. This would make hospital readmissions during the stay less likely for IRF patients. Also, IRF cases are much shorter than SNF cases. Thus, the time during which a readmission could occur is shorter for IRFs, and we would expect lower readmission rates for them.

Differences in discharge to community can also be explained by IRF coverage rules that restrict the types of patients who can be admitted as well as the preferences of IRFs to admit patients who are likely to go home.

For the Medicare spending during episode of care, almost all the differences are due to the higher payment for the IRF stay. So while we observe differences in outcomes, they are unlikely to be solely due to the care patients received.

Now we turn to alternative approaches to paying for IRF noncompliant cases.

IRF Medicare payments for noncompliant cases were substantially higher than costs. As shown in this graph, median Medicare costs for IRF noncompliant stays, as shown in the left bar, were about 20 percent lower than IRF payments, shown in the right bar.

The dotted line shows the median Medicare payment made to SNFs for comparable cases. The SNF payment is 40 percent lower than the IRF payment and, in fact, lower than IRF costs.

We explored three approaches to lowering IRF payment rates for patients with noncompliant conditions.

In the first, rates would be lowered to those paid to SNFs. We considered this option because many patients with noncompliant conditions were also treated in SNFs. To compute the lower payment, we calculated the aggregate differences between simulated SNF rates and current IRF rates and lowered IRF rates by this difference. More details on how we simulated SNF payments for noncompliant cases are in your meeting materials.

In the second approach, IRF rates would be lowered by a percentage, so that aggregate payments equaled aggregate costs. For each noncompliant stay, a reduction would be applied to the IRF payment rate.

In the third approach, payment rates for noncompliant cases would be a blend of current rates and costs. We modeled a 50-50 blend. So for each noncompliant stay, a reduction would be applied to the current IRF

payment that is halfway between current IRF payments and costs.

Our modeling did not assume any behavioral changes, such as IRFs modifying their admitting practices or their costs, or any changes to the list of compliant conditions or the compliance threshold.

We assessed the impacts of the three approaches on Medicare payment rates and profitability.

In the first row on this table, it shows that currently the payment-to-cost ratio for noncompliant cases and for all Medicare cases is 1.22; that is, payments are higher than costs by 22 percent.

Approach No. 1 would pay SNF rates for noncompliant cases. This would result in a rate reduction of 66 percent for noncompliant cases and would make them highly unprofitable. However, across all Medicare cases, noncompliant and compliant IRFs would break even.

In Approach No. 2, IRF payment rates for noncompliant cases would be lowered so that in aggregate, they equal the aggregate cost of care. This results in an 18 percent rate reduction and a break-even payment-to-cost ratio for noncompliant cases. But across all Medicare

cases, IRFs would still be very profitable.

Under Approach No. 3 would be a 50-50 blend of IRF payment rates and costs for noncompliant cases. This results in the smallest rate reduction of 9 percent and the highest profitability for noncompliant and total Medicare cases.

Approach No. 1 with the largest rate reduction is most likely to affect admissions of noncompliant cases and the care they receive, while Approach No. 2 with modest rate reductions is likely to have medium effects on access to care and the care patients receive. Approach No. 3 with the smallest reductions to rates would be least likely to result in IRFs changing their admitting practices and the care provided.

Now I turn the presentation back to Carol.

DR. CARTER: A more targeted approach to rate reductions for select conditions would be an alternative to the Commission's standing recommendation to lower payment rates for all cases. It also would lower program payments, but because it focuses on a subset of cases, it may yield fewer savings to the program depending on the design.

On the other hand, it could be a more acceptable

policy to policymakers.

Our work showed that lowering payment rates need to be done cautiously to help protect access to IRFs for beneficiaries who require this level of care and to minimize any negative effects on the care they receive.

Regardless of an approach taken to lower payments, there are several improvements policymakers could make to minimize how frequently IRFs admit unnecessary cases.

First, the Congress could direct CMS to regularly evaluate the list of compliant conditions, adding and deleting conditions as warranted, and consider how these might affect the compliance threshold.

Second, CMS could improve ways to prevent unnecessary admissions. For example, it could clarify its facility and coverage rules so there is less ambiguity about which patients qualify for care.

Monitoring questionable admission patterns may also point out areas for further clarification.

CMS could enhance its education and training of providers and claims reviewers, and it could expand its auditing of claims, so this is likely to take more

resources. These activities would be good to do regardless of what policy makers decide to do about the level of payments.

The Commission has recommended an across-the-board reduction to all cases. Policymakers can consider targeting payment reductions for select cases.

CMS could regularly review the list of compliant conditions and the effects of any changes on the compliance threshold and improve ways to prevent unnecessary admissions.

We're interested in your thoughts about both topics, and with that, we'll turn things back to Mike for your questions and discussion.

DR. CHERNEW: Great. Thank you very much, and I think we'll go through Round 1. I'll make a quick comment when we go between Round 1 and Round 2, but I think the first person in round one is Stacie. Stacie.

DR. DUSETZINA: Thank you very much for this work. I really enjoyed the chapter a lot, and this was a great presentation.

I had a clarifying question around the three-day hospital stay requirement, so that's for SNFs only. So

IRFs, if you didn't stay in the hospital for three days, your only option in fee-for-service is an IRF if you need this type of care. Is that accurate?

DR. CARTER: So the three-day requirement you write is only for SNF.

I think about 90 percent of IRF cases have a preceding hospitalization, but they're not required to.

DR. DUSETZINA: Okay.

DR. CARTER: And we did hear from our interviews with discharge planners that when patients haven't had the three-day stay, they will go to an SNF because -- I mean to an IRF if they qualify because they don't have the qualifying requirement for SNF.

DR. DUSETZINA: Got it.

I guess one of the things that brought up to me was wondering how much of the noncompliant cases might be somewhat contributed to by that three-day rule. It sounds like most people are going to meet the three-day stay, but it seemed like a space where knowing how often it was, that there weren't really other choices that you could make. That would maybe be something worth exploring.

DR. CARTER: That's a good idea.

DR. CHERNEW: Brian wants to say something.

DR. MILLER: Yeah, just a quick thing. A lot of those patients who don't meet the three-day stay are patients like grandma or grandpa who fell at home, didn't break a hip, but is too weak to get up. They're brought by the ambulance to the hospital. The hospital doesn't find a way to admit them as an admission, and so they're under an observation stay.

So that's how they obviously don't qualify for SNF care because they don't have a three-day stay. Those are the types of patients who frequently get to an IRF. If we implemented a three-day hospital stay, those beneficiaries would have nowhere to go.

DR. DUSETZINA: Yeah. I mean, I think that's exactly part of the point, though, is that the goal is to have this intensive level of care at the IRF, and we might be accidentally, by our policies, just, like, not giving people any options. We don't want to close out any option for them, but we also don't want to necessarily put people in that position of having a more intensive and expensive stay when we should be doing better things for them.

DR. CHERNEW: Okay. I think Tamara's next.

DR. KONETZKA: Thanks.

And just on that point, the other response is often that the hospital just gets a lot of pressure to keep that person for three days, even though they don't need to be there.

So my question -- and forgive me -- first of all, let me say thank you. I thought this was excellent work in a very muddy space, where we don't know a lot, and you guys drew out some really important conclusions and options. So thank you for that.

Forgive me if I should know this, because we've had several IRF discussions since I've been here, but the definition of compliant and noncompliant conditions, you know, I understand that it's compliant are those conditions that would typically require that level of therapy. How is that determined? How is this typically required? Is that expert opinion, or is that like an actual, like, quantitative analysis where you sort of look at the variation of people getting therapy and you have to meet a certain threshold?

DR. CARTER: I would say it's mostly expert opinion. The original -- I think it was eight -- was

developed using a panel of experts. Then I think in response to stakeholder comments, that has been added to over time. The paper includes a bit of the history.

I think, Brian, you had asked Stacie a little more about the information of things that have been added, what things had been considered. So CMS -- the stakeholders have put forward many more ideas about what should be added than have actually been adopted, but it's not through any data analysis.

I mean, they look in the literature for conditions that appear to benefit from intensive rehabilitation. CMS does that, but they don't -- I don't -- I haven't heard that they do any data analysis.

MS. KELLEY: Greg.

MR. POULSEN: Thanks.

Could we go to slide 9? This is a little bit of a continuation of the discussion we're just having here, and there we are. As we look at this, I mean, something that puzzled me as I read the chat -- I shouldn't say puzzled me but stood out is the people who end up in the IRFs are younger, healthier. I mean, it seems like they should be less expensive, and yet they're not.

And from what we see here, the thing that -- I guess it's kind of called out in that very bottom bullet. Although the IRF patients appear to be healthier, they may not be lower cost because they're required to receive more services.

The implication is one of two, I think, and I just wanted to get your thoughts on this. Does that mean that they are getting better care because it's required, or are they getting unnecessary care because it's required compared to what they'd get in a SNF? I mean, that seems like very different results on that.

And if we look at -- if we go forward two slides to slide 11, the slight implication is -- and I think it came out in the chapter even more distinctly -- is as we look at the readmission rates and a few other things -- and these are all for noncompliant. This isn't all patients. This is noncompliant patients. The IRFs would appear to have a better outcome. They're going home more frequently. They're not being readmitted; it feels like a better outcome.

So anyway, I just wondered if you'd just discuss briefly what your thoughts are. Is the treatment in IRFs

actually better in resulting in this, or is it over-treatment that's more expensive but not necessarily yielding a better outcome?

DR. CARTER: Well, they're getting the care that's required, so they're getting three hours of therapy. Now, whether they need it or not, I don't think we could say, and I don't know that even -- well, actually, so we know -- from the OIG and CMS work, we know from looking at medical records that some of those admissions look like they didn't need to be there. They didn't meet the medical necessity requirements.

I know that Mike has often asked the question: What are we getting for what we're buying? And here, you know, the quality results, except for -- I mean, I guess I would say the readmission after 30 days during that post period is pretty similar, and that's kind of an apples-to-apples comparison in some ways, because they're not in the institution anymore, right? And so those outcomes look pretty similar.

As Betty said, ideally, you would want to be looking at changes in function because that's what this is all about, and we're just not really trusting the data on

that.

And then, of course, you've got massive selection effects because who's getting in the door in part is because of who IRFs are required to admit. So, I mean, sometimes in other settings, we talk about selection as having negative connotation, and here, it can be as much, because they're -- I mean, the IRF industry has told us they, you know, only accept certain cases because of what they're required to do. So --

MR. POULSEN: Thank you.

DR. CARTER: Tamara use the word "muddy."

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks for a great chapter.

I just want to plus-one what Stacie and Brian said of trying to understand, you know, what type of cases actually that are noncompliance.

But somewhat relatedly, I was kind of curious. Do we know anything about the relationship between SNF bed availability in these communities? Like, are there differences in IRF use in communities based on the availability of SNF beds?

DR. CARTER: We didn't look at that specifically.

I mean, every IRF market has SNFs, and in some markets, the occupancy rate in SNFs is on the low 80s. But in some markets, it's higher than that.

The IRF occupancy rates are considerably lower, and most of them have capacity to admit patients that would qualify to be there. But we didn't look specifically at what you're asking.

Corinna, you might have done some work. Is that right?

MS. CLINE: Not bed days, specifically.

DR. CARTER: Yeah.

DR. CHERNEW: I think in some sense, you could ask the opposite question.

DR. CARTER: Sure.

DR. CHERNEW: How much is SNF use affected by the availability of IRFs? I think there's a lot more variability in the availability of IRFs. Is that basically right? There's markets where there's not a lot of IRFs --

MS. CLINE: Yes.

DR. CHERNEW: -- and then there's some where there are IRFs.

MS. CLINE: Yes.

DR. CARTER: And, of course, some IRFs really specialize. So let's say you're a brain injury patient, and your placement in a SNF could be much more limited than the run-of-the-mill IRF admission. I don't mean that in a derogatory way, but some of those cases could be treated in a much broader range of SNFs than some of IRF patients that would be much more restricted in the types of appropriate placements and SNFs.

DR. DAMBERG: Okay. Thanks.

I had one other question. Can you say more about how CMS audits cases? Do you know if they focus more heavily or do targeted reviews where there's a higher rate of noncompliant cases?

DR. CARTER: This is an area we could do a little more work in. We only know that they audit a very low share of claims, and I don't think they focus on noncompliant conditions.

Now, whether they target providers that have suspicious kind of things that they're seeing in the data that are questionable, I'm not sure.

DR. DAMBERG: Okay. And do you know if there's been any consideration of applying penalties to IRFs that

have a pretty high percentage of noncompliant cases?

DR. CARTER: I don't think so, and I will say that assessing penalties, which seems like a good idea, it would take a more protracted process for those to kick in. I think you would need to see patterns of behavior. I don't think it would be like, oh, this guy didn't -- you know, first of all, they're not auditing that much, but I think it would be -- it would need to have a deliberative process around it, I suspect, but that could be an area for further work because we didn't hear anybody. I mean, CMS is not thinking about that, and we didn't talk to people about that, really.

DR. FOUT: Let me clarify. That wasn't for compliance with the 60 percent rule but for admission criteria for the IRF auditing?

DR. CARTER: Oh, yeah. Right. The audits aren't done -- I mean, they're done just for if a patient was meeting medical necessity. Yeah.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks so much for this work.

In particular, I think it's really important that we get stakeholder feedback, and so I really appreciate

that you did the interviews and get into the field and hear what's on the ground, so thank you for that.

Because I'm not even sure -- my father lives in a small hometown. I'm not even sure where an IRF would be nearby. So can an IRF be in the same building as a SNF?

DR. CARTER: Yes. And about half of the industry is hospital-based.

MS. UPCHURCH: Right. I knew a lot of hospital-based. I didn't know if it could be co-located with the SNF.

So you may not even know if you're the consumer whether you're an IRF or SNF, or is that somehow -- I mean, you would when they tell you get out of bed. You got to work three hours a day.

DR. CARTER: You would move beds. So if you were in a preceding hospital stay --

MS. UPCHURCH: Different. Okay.

DR. CARTER: -- the IRF would have a unit. So you would be moved.

MS. UPCHURCH: Okay. And this gets to a question that was asked earlier about the access to IRFs. So do we know, like, what percentage of the U.S. Medicare population

is within an hour of an IRF or something where family members could come visit? Is it --

DR. FOUT: We didn't look at distance. I mean, we looked at markets, and it was -- I think it was about 30 percent of markets had an IRF, but those markets covered 70 percent of the population, Medicare population.

MS. UPCHURCH: Okay. So everybody didn't have -- so just to get back to that three-day rule, then, I think that's really important for people who don't have access to an IRF, but they need the care that Brian was describing. I think it's -- you know, it's a policy that we need to be thinking about in a broader sense.

So then my question is, you know, the IRF compliant -- you know, you're going to -- five days a week, for some. Two days, you don't need to maybe do anything, but then three hours every day, is that, like, they've tried two hours, and it didn't really work? Then they tried four hours, and that was too much, or is this just sort of come to be from -- for no apparent reason?

DR. CARTER: That's kind of the standard, but there is variation around it. If a patient can't tolerate three hours a day, they might get therapy on the weekend.

So there's flexibility around. It's not three hours on Thursday, Monday through Friday. There is flexibility around that.

UNIDENTIFIED SPEAKER: [Speaking off microphone.]

DR. CARTER: Yeah. And it can be, right, between two sessions.

MS. UPCHURCH: But there's no standard sort of reliable, valid measure that this is what really improves care? It's just more the practice and the way it's played out and what people can handle, just more practical?

DR. CARTER: I think it was, you know, thought as how do we distinct -- I mean, this all came out of, how do we distinguish IRFs from hospitals, and so they wanted a definition of intensive rehabilitation, and I think that was the shorthand.

And there's been a little bit of work on whether the three hours of therapy, the patients who actually got three hours of therapy, look like they're better, and I think the evidence on that is mixed. But where it came from, I think, was just, you know, a shorthand for what do we mean by intensive therapy.

MS. UPCHURCH: Okay. Thank you.

MS. KELLEY: Brian.

DR. MILLER: Since we're in Round 1, I'll save most of my questions for Round 2.

Just a couple things. Did we include Medicare Advantage versus fee-for-service compliance -- or qualifying conditions pardon? Because that would be something that could be interesting to see.

DR. CARTER: No. And, you know, I think most of the MA analysis is kind of in the future, as we get a better handle on the encounter data, so no.

DR. FOUT: The compliance threshold for 60 percent includes MA too.

DR. MILLER: Right. But I'm saying, did we demonstrate if there's any differences between how beneficiaries who are in fee-for-service, the compliance threshold for qualifying conditions is 60 percent if MA plans are higher than that or lower than that, compared to the fee-for-service population?

DR. FOUT: The compliance threshold is -- you know, covers MA and fee-for-service.

DR. MILLER: Right. But --

DR. FOUT: And it means that hospital IRFs will

be paid as an IRF, rather than the hospital.

DR. MILLER: Right. But I'm saying for the --

DR. FOUT: So I think you're asking --

DR. MILLER: I'm asking about the percent. So the 13 qualifying conditions has to be 60 percent of the population in an IRF. I'm saying, is MA -- in some circumstances, is that compliance? Are MA plans operating with a higher compliance threshold, operationally?

DR. FOUT: I think we can --

DR. CHERNEW: Let me try and ask a clarifying question.

DR. FOUT: We know that for the --

DR. CHERNEW: You could envision the MA plans have an 80 percent compliance threshold.

DR. MILLER: That's what my question is.

DR. CHERNEW: And the fee-for-service has a 40 percent, and it averages to 60, and they're fine. Or you might think that if they're 62 percent, whatever compliance is, both fee-for-service and MA are the same. And I think that's what Brian is asking.

DR. MILLER: Right. Because the question is MA is supposedly more aggressive about utilization and --

DR. FOUT: Right.

DR. MILLER: -- or management. Did we look and see that maybe they're operating at functionally a qualifying condition --

DR. FOUT: I think --

DR. MILLER: -- compliance threshold of --

DR. FOUT: -- if you look at the --

DR. MILLER: -- like 80 percent?

DR. FOUT: -- MA beneficiaries using the IRF data, they tend to have more compliant cases.

DR. MILLER: So we should probably add that in, because that will give us good information about how these services are used differently across the two components of the program.

DR. CASALINO: Let put it another way. If you're an MA patient, are you less likely to be admitted to an IRF if you're noncompliant?

DR. MILLER: Yeah. That's, yeah, same question, different wording.

MS. KELLEY: Our work in the past on this issue has shown a pretty marked difference in the types of conditions that are admitted under MA versus fee-for-

service, so many more stroke -- a much greater share of stroke patients, for example, than in fee-for-service.

DR. MILLER: So we should include that information here.

And then my second question, is our goal to talk about appropriate payment, higher payment, or lower payment? It was unclear to me from the chapter.

DR. CARTER: We modeled three ways of lowering payments for select conditions. So --

DR. MILLER: Well, I guess what I'm trying to get at is, as we talk about lowering payment -- and I'm all for making pennies bleed. I realized today one of the buckles on my shoe is broken, and I still want to wear them and get it fixed. But it might be better for us to talk about appropriate payment, and that appropriate payment should be lower, as opposed to just starting out the chapter by talking about lower payment.

DR. CARTER: I see. Thank you.

DR. MILLER: Thanks.

MS. KELLEY: I think that's a really good point, Brian, and just to contextualize that for our audience at home, the Commission has recommended that payments to IRFs

in aggregate be reduced. So I think we were sort of starting from the premise that payments were too high, but we should definitely make sure the chapter reflects that. Thank you.

DR. CHERNEW: And one of the issues that will come up in Round 2 -- I was going to say this between, but I'll say this now -- is there will be a question about how much resources we should devote to continuing down this path, or if we should stick in our update approach, which does have an appropriate payment orientation, to sort of an across-the-board recommendation, or whether the nuance that's kind of discussed here should move forward.

But the appropriateness is sort of the backbone of how one thinks about this. The question is whether we want to say something differentially between compliant and noncompliant cases. And I will avoid dwelling on the definition of appropriateness for now.

So I think who's next is --

MS. KELLEY: Scott.

DR. CHERNEW: Is it Scott? Yeah.

DR. SARRAN: Yeah. So I similarly had questions on how good is our data in MA, comparing MA to fee-for-

service, and I just think that's really critical that we're able to do that, given the financial incentives in MA and the recently pretty well-documented and highly publicized abuses of algorithms to guide the use of post-acute care. The naviHealth thing has gotten a lot of appropriate attention. We really want to make sure we're able to do a credibly deep dive on MA versus fee-for-service.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. So one thing that I don't think we've brought up is, have you guys thought much about -- if one of the three models was adopted, how would that interact with the annual payment updates that we suggest? I mean, I think the answer may be obvious, but I'm just kind of interested in your thinking about that. Presumably, we would recommend less draconian cuts in our annual updates if we adopted one of these three models.

DR. CHERNEW: I'll just make a comment on that. Our annual update exercise -- our annual update exercise is rather prescribed in how it plays out. So if we did anything here, we wouldn't change our updates unless they acted.

Once they acted, we would then apply our criteria

in the annual update, the way we do, but the numbers would all be different because they acted. So we are not -- we aren't going to tie things together in that specific way, but they would interrelate depending on what policymakers decide to do.

DR. CASALINO: That's a good answer. I agree.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. I just had a clarifying question on slide 13 where you have, I think, the cost on the left-hand side. Is that cost all-in cost or variable cost or also contains fixed cost? If you could just comment on that.

DR. FOUT: Medicare cost, which would include the fixed variable.

MS. KELLEY: Betty, do you have a Round 1 comment -- or question, rather?

DR. RAMBUR: I have a question. I think this is Round 1. Why did the -- so the threshold for compliant was 75, and it dropped to 60. And there was an intention to move back up, and that didn't seem to happen. So is there more that we should know about the story on that? Because it seems like some of these problems would be ameliorated

with a higher threshold. So, it was during the phase.

DR. CARTER: So it was during the phase -- so it was 75 percent, and then CMS -- I think there was a period where basically nothing was being really monitored, and it wasn't a particularly effective threshold. And so they put that on hold, and then as they started to really reexamine the compliance of actual providers, they decided to phase that back in because that was new. They were now really being required to meet the threshold. So they decided that they would phase in back to 75 percent, and then the Congress interceded partway through that and stopped it at 60 percent.

DR. RAMBUR: Okay. That's what I thought.

And then the other question I had, the slide that talks about discharge to community, what's all in the aggregate of community? Is home health in there? Do people ever leave an IRF and go to a skilled nursing facility? What's the definition of community?

DR. CARTER: So it does include -- discharge to home would be a successful discharge.

We also included beneficiaries who were previously living in a nursing home, and they went back to

the same nursing home, because we assumed that that was effectively their home.

DR. RAMBUR: So it is home. So nobody from an IRF ever leaves an IRF and goes -- I mean, it's not common that they would then go to a skilled nursing facility.

DR. CARTER: It happens, but it's pretty low.

DR. RAMBUR: Okay.

DR. CARTER: And I forget the share, but it's less than 10 percent.

DR. RAMBUR: Okay. Great. Thank you.

MS. KELLEY: That's all I have for Round 1 -- oh, my gosh. Really? Okay. Lynn or Kenny. Kenny, you go ahead.

MR. KAN: Can we go to slide 15, please? I have three clarifying Round 1 questions.

Am I reading this right? Option one, that the rate reduction, if you were to lower the IRF to equal the SNF payments, it's a 66 percent reduction? So this would suggest that IRF are like three times paid higher than a SNF for a similar noncompliant procedure. Is that a fair interpretation?

DR. FOUT: Very much. Yeah.

MR. KAN: Do we believe that we've captured the observed and unobserved costs appropriately?

DR. FOUT: We simulated payments, SNF PDPM payments for IRF cases using the IRF characteristics. There are a lot of assumptions that need to be made, because IRFs collect a different sort of data than SNFs collect, and adjustments have to be made. So I don't think it captures everything that there would be to capture, but we've done our best.

MR. KAN: It could be worth highlighting in the report what is not captured and what's not observed, because that's one of the trickiest part of the exercise here on this slide for me.

Can we go to page 9, please? It's on a slide. Sorry.

On this study here, it says that it's lower median risk score. Do we know how much lower it is? Okay.

DR. CARTER: It's in the paper. I'm looking it up.

[Pause.]

DR. CHERNEW: If need be, you can --

MR. KAN: Yeah, yeah. Then let's move, and

actually, the reason I --

DR. CARTER: And I've talked with Andy in the past about sort of would that be a notable difference, and the answer is yes.

MR. KAN: Yeah, that's what I was wondering. Okay.

DR. CARTER: Mm-hmm.

MR. KAN: And I have a follow-up question as a result. If I go to page 11 now, to move it along --

DR. CARTER: Mm-hmm.

MR. KAN: So the difference between a $34,000 and a $20,000 Medicare spending per beneficiary is about 19 percent. Is that number risk- or case mix-adjusted?

DR. CARTER: The spending number?

MR. KAN: Yes.

DR. FOUT: Yeah.

DR. CARTER: Yes, it is.

MR. KAN: It is, right? I thought it is.

DR. CARTER: Yeah.

MR. KAN: Okay. Thanks.

MS. KELLEY: Go ahead, Lynn.

MS. BARR: Great. Let's stay on that slide,

please. That's my slide too. Thank you.

So can you compare -- let's see. It's on slide 11. Are we on slide 11?

But can you compare the two programs with greater specificity by impairment group, and so -- or are all the -- so these are the noncompliant patients. I just wondered can, you know -- are there subsets where this makes sense and subsets where it doesn't? Do you get what I'm saying? So when we're trying to compare the SNF patients to the cost of the noncompliant SNF patients to the noncompliant IRF patients -- the SNF patients to the noncompliant IRF patients, can we categorize that by orthopedics and stroke, you know, by the impairment groups to just see if that's across the board or there's certain subsets? That's my question for future work.

DR. CARTER: I think we could do that.

MS. BARR: Thank you. If boss says it's okay.

DR. CHERNEW: Great. I think that's the end of Round 1. We're about to launch into Round 2, and I just want to do a little bit of level setting.

Oftentimes when we see options, it's tempting to say -- and appropriately to say I like one, I prefer three,

whatever it happens to be. In this case, there's an added wrinkle, which is we are not necessarily going to pick any of these options. We may just stick with our annual update recommendation and worry about appropriate and not worry about the compliant -- the noncompliant issues. So a lot of these options address what to do about noncompliant -- payment for noncompliant cases.

And as Larry asked in his question, that's on top of this regular update recommendation. And it is reasonable to believe that the update recommendation is sufficient, and we don't need to go further down these particular options.

So, as you go make your comments, just keep that in mind because we may not -- there's trade-offs in the type of work we do and other things we can do. And so as we begin to think of the trade-offs, the question is the level of enthusiasm for continuing down this path versus just letting this rest on our annual update approach and then focusing on other areas in this space, of which there are many, and our staff time is valuable.

So, with that said, I think Stacie is the first Round 2 person.

DR. DUSETZINA: All right. Thank you.

So, first, I'd just like to say that the tone of this chapter, I really like because it feels very much like we don't really know which of these is a better place. We do know that one place we're spending more money for people who might be able to be treated in both, but I really appreciated the way you all outlined that.

It also was clear to me that it's really hard to know for sure who could benefit from IRF care. I would imagine that's hard for families, the person, the care team, everybody at the time of discharge. So I think it's important that you guys do a great job of acknowledging that as well throughout the chapter.

In thinking about other places to maybe dig in a little bit, one of the other things I was wondering about is for the noncompliant admissions, if there is a pattern or any increase in those. If, for example, you're assessed over the course of a year or on a consistent time frame, do you see that start to ramp up to fill in the gaps? You could maximize your revenue by bringing on more and more to get up to that 60 percent threshold. So do you see any kind of patterns where -- before they're going to be

assessed, do you see a ramping up that might look a little bit more like gaming more than we would like, so bringing in more noncompliant cases?

DR. CARTER: So I will say one thing. We did hear in our interviews -- which isn't exactly answering your question, but we did hear from an IRF that on any given day, a patient might or might not be admitted depending on where they were in the compliance threshold. But we don't have any data on that.

DR. DUSETZINA: Is it assessed at a very specific point in time, like when you're assessing the 60 percent threshold? Is it like over the course of a year or over the course of -- like, so they could have a better sense of that, especially later in the year, knowing kind of what their averages have looked like?

DR. CARTER: Yeah. I think it's done on an annual basis.

DR. DUSETZINA: Anyway, that just struck me as a place to maybe look for where there might be particular gaming of the noncompliant admissions in particular.

The other thing regarding the options, I do like the idea of kind of emphasizing a more targeted payment

reduction. I think that's a smart way to do it, recognizing that IRF care for people with compliant conditions is really -- seems very valuable.

And I liked your Option 2 on just thinking about paying costs. The Option 1 just seemed a little bit too far, given that we're not quite sure who could benefit, but I appreciate that exploration. I do like the idea of a more targeted payment change, a reduction.

Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: So I think we know a couple of things for sure, or we can all agree on a couple of things. One is that we know that IRF profit margins are really high on average. We also know -- I think we'd probably all agree -- that there are probably people going to IRFs who don't need to be in IRFs, and we're spending too much money on them.

Beyond that, I'm finding this all a little too muddy. I know that we make decisions and recommendations in life in general and in MedPAC based on incomplete evidence all the time, and one has to do that.

But a couple of things here I find just sort of

too important that we don't know about, one is just we know very little the unobserved differences between people who go to IRFs and people who go to SNFs for similar conditions, and I think that came out in your qualitative interviews.

It's very clear that above and beyond what we can control for in the data, that these people might be very different in their ability to benefit from this therapy, and so I really hesitate to make dramatic changes without knowing a little bit more about those differences.

The other things we don't know is I find the sort of definition of compliant and noncompliant pretty slippery, not evidence-based enough, right? That if we're going to move ahead making new policy, I'm not sure this is the grouping we want to hang our hat on.

And the third thing we don't know that I find alarming is, just what are the benefits from having that additional therapy? Right? There was that whole paragraph on page 28 where you looked at the literature from -- at the outcomes from therapy, and we don't even know this for the compliant conditions. I mean, this is similar to Gina's question earlier. Like, we don't really know if

three hours is the right amount. We don't know that. I mean, so the idea that people require three hours of therapy a day and that three hours is the right one and that it's better for an individual to get three hours versus what they're going to get in the SNF, like that's all based on very thin or no evidence, right?

And so if we put all of these together, even though we know that probably there are people in IRFs who shouldn't be there and that we're spending more money on it, it makes me very hesitant to want to move forward with any of these policy options, right? Or at least for now. I feel like the motivation is to do something about that and use these dollars efficiently, but I feel like we're just not there.

So what I would love to see is to table this for a year or two and focus on a couple of things. One is strategizing around how to get that research done. I know that you've tried to do what you could in this space already, but some good quasi-experimental design that would really try to get at the unobservable differences between IRF patients and SNF patients, you know, it won't be perfect, but get us closer.

And then the other thing to strategize around is -- and we've talked about this many times -- is, like, getting better comparable, functional measures, so we have the outcomes we actually want to look at.

So I feel like if we really focus on getting better research, this is one of those areas where I think just sticking with the across-the-board recommendation to cut margins that we do in our payment chapter is the right way to go for now.

MR. MASI: Just to jump in real quick, I just wanted to say thank you so much for that set of comments, Tamara. That's very helpful, both in thinking about this block of work and how it might move forward.

And I would say I think the muddiness you described really echoes a lot of the conversations that we had back at the shop. So we really appreciate you giving voice to that, and I think we would agree that there's a lot of interest in doing something here. But there's a lot of muddiness, and it's hard to point to the thing.

MS. KELLEY: Scott.

DR. SARRAN: Thanks for excellent work. I particularly, as others have mentioned, appreciate the

incorporation of stakeholder insights.

I'll try to be real brief because it's largely going to be a reinforcement and a little expansion on Tamara's points.

I think the outcome of all the muddiness should be that we should all have a lot of hubris about our ability to shoot from the hip and make the right financial decisions in this challenging space.

And I just want to reinforce some points. First, painfully little data, as people have noted, painfully little data on the true costs, all-in costs, 90 days, 120 days out, long-term care supports, et cetera, versus true functional outcomes. And again, research area, I think we all agree, needs to improve, but right now, it's painfully little data on that.

The nuances that go into this space -- and I can speak as a physician who did a lot of this work hands-on as well as CMO and MA and SNF plans -- the nuances that go into making the right decision for a particular beneficiary, nuances around cognitive impairments, overall frailty, other comorbidities, I mean, those are really tough. And they're not transparently available in claims

data, right?

And then I also think we do have to be concerned about this space, which we agree is more than adequately compensated today, in future Medicare. But this is going to be a particularly important space for benefit for us in this country over the next many years with the aging population, particularly the old, old population, the increasing capability of acute care settings to cure somebody from their immediate acute care issue, whether it's surgical or medical, but leave a beneficiary with significant impairments, right, as they leave the hospital. People are getting out of hospitals who didn't used to get out of hospitals, are getting out of the hospitals more impaired, as well as the reality that we -- appropriately, as baby boomers age, we expect more from the system in terms of delivering ourselves and people to the right functional outcomes.

So, all that said, I think we want to be really careful about potentially over-tightening the screws here. I'd be comfortable personally with Option 3 if we had to choose, but I'd be very comfortable taking the stance that let's just keep gathering data and not do anything more

than what we've already recommended.

I'm also comfortable on your slide 17, the points about how we can continue to try to make better and better decisions. Absolutely. I think those are no-brainer and well articulated. Thanks.

MS. KELLEY: Brian.

DR. MILLER: Two global questions and then two specific ones. I'll make them quick.

One is, I noted on the global perspective, we're talking about profit margins. I agree that profit margins are high. I'm curious how we decide what our evidentiary intellectual policy standard is for deciding profit margins are high. Different businesses have different margins. Jim Donald ran grocery stores for a long time, which have routine margins of 1 percent. 1.5 percent would be a banner year. Microsoft developed software and then stamped out -- I'm old enough to remember when they stamped out CDs, but now it's all in the cloud, and you download it. Their margin would be 95 percent. Ninety percent would be considered a failure as a business.

How do we decide what is the right margin and make a judgment? Do we have a standard or a policy for

that?

DR. CHERNEW: That might be a Michael question, unless you want to take it. Feel free.

DR. CARTER: I'll just say the Commission has always been reluctant to say what an appropriate margin is.

DR. MILLER: Right. So --

DR. CHERNEW: Yeah. In our update -- this is true in our update sessions all the time, and the general sense is there's multiple criteria of which margins are just one. So we're not targeting a margin. Our update recommendations don't target a margin across any sector.

We look at access to capital, access to care, all the other --a whole lot of other things, and then we tend to be in situations like this -- again, statutorily, we have to make an update recommendation. and we don't know -- I don't think there's any particular easy way to know what the right payment is, and of course, margins are in many ways endogenous to how you pay.

So we make a judgment call based on where we are about paying a little bit more, paying a little bit less, paying a lot less, paying current law. And that comes up in the update recommendation chapters, but it's not

formulaic.

DR. MILLER: I guess what I'm saying is -- so I look at this, and I see that the profit is high. My instinctual response, as someone who makes pennies bleed, is that payment rates should be lower. But I wonder for intellectual consistency, knowing that different businesses have different margins, it's unclear to me what ground we are on when we say that outside of us feeling that profits are too high, which, as I said, I would be inclined to agree with.

The second thing I wanted to note on a global perspective before I get into the specific details of the IRF is that we have recommended the chapter notes as zero or negative updates since 2007 -- or sorry -- 2009, which is when I bought these shoes that are broken. And since then, I have completed multiple residencies and graduate degrees, and Congress over 15 years has still not taken our recommendation, which sort of gets me to Tamara's point that we should sort of go back, try and get better evidence before we make recommendations, given that our recommendations seem to have limited support and then have not been implemented for 15 years.

So to my technical question -- and I spent a little bit of time trying to become an IRF expert, which is challenging for me because it's not my normal space. So I saw that the 13 qualifying conditions -- I want to make sure I understand that, that to get admitted to an IRF, you have to clinically benefit from the IRF services, the three hours of therapy from two modalities of therapy, physical therapy, occupational therapy, speech language, pathology. So all the patients who admitted to an IRF are deemed by the physiatrist who has seen them in the hospital setting, the hospitals or surgical service that's discharging them, the physical therapists, occupational therapists. They are deemed to clinically benefit from IRF services if they go to an IRF, correct?

DR. CARTER: That's the requirement, and then the question is, did that actually happen?

DR. MILLER: So I'll get to that.

DR. CARTER: Okay.

DR. MILLER: And then that 60 -- from the IRF perspective, 60 percent of the admitted patients must have one of those 13 qualifying conditions.

So I went back and looked at the letter that we

got on October, which unfortunately -- from the IRFs, which is unfortunately not posted on our website, which noted that we are misinterpreting it by saying that -- and I think that this is how this chapter is written, and we're making sort of a fatal mistake -- and that we're saying 60 percent of diagnoses, 60 percent of patients qualify and are compliant, and the other 40 percent shouldn't be in the IRF. That's how our chapter reads, and that's not correct based upon the discussion we just had.

DR. CARTER: We'll go back through the chapter. We actually scrubbed for that on this draft about exactly this point.

DR. MILLER: Because there are multiple sections within the chapter where it looked like we were saying the patients don't clinically qualify to be in an IRF, but they do clinically qualify, otherwise they wouldn't be admitted.

And I agree that OIG has great regulatory suggestions, such as pre-payment claims editing, education efforts, post-payment of review, appeals process involving CMS, but our chapter is written such in a way that looks like we're saying 40 percent of patients don't belong in IRFs, which is not actually correct.

DR. CARTER: We were trying to thread a needle and say this is a proxy. We were very clear that we know that patients that don't need to be in IRFs, that don't meet medical necessity, are probably sprinkled across --

DR. MILLER: And I agree that they don't --

MR. MASI: Can I jump in here for a second? And, Brian, I think you're pointing to a thing where it's really important for us to be clear in the chapter about these different ideas about clinical appropriateness and admissions.

DR. MILLER: Correct.

MR. MASI: So, as Carol said, we'll take a scrub to make sure it's clear.

DR. MILLER: And I'd like to finish my comment without interruption, please, Paul.

My comment was -- is that there's a difference between a problem being that they don't meet the qualifying condition and that the qualifying conditions, meaning that the 60 percent threshold that an IRF has, 50 percent instead of 60 percent, but the -- we need to be careful in saying that all the patients who go to an IRF are clinically appropriate or deemed to be clinically

appropriate when they leave the hospital.

Now, I agree wholeheartedly that some of those patients probably aren't clinically appropriate, and that's why like those five OIG regulatory suggestions I thought were excellent. But our chapter is written such that we're saying 40 percent of the patients, and there are several instances in there where we say they're not clinically appropriate, and they're not compliant. And that's not actually correct. So we should correct that.

DR. CARTER: We'll take a look through the draft. I hear you.

DR. MILLER: And we should post the comment letter online, which addressed this.

Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: So I appreciated the tone of the chapter as well in terms of the challenges with trying to get at what are a lot of un-observables in this space and really understanding differences between patients and sort of how they end up in different locations.

And, you know, I would support some of what Tamara is suggesting in terms of, you know, being humble

and thinking about what other information we could bring to bear to inform this discussion and any future decision-making.

And I agree that I think the evidence around the benefits of therapy is relatively thin and understanding, you know, what represents appropriate care in the space.

I guess if I had to -- so I agree. I think the work that we've done around payment updates sort of addresses a part of the problem, but I think we're still in this space where we think some subset of these patients probably shouldn't be in this setting. And so we're overpaying.

And across the different options that have been put forth, I think Option 2 is directionally correct. You know, it leads to some amount of reduction. It still pays them for their costs, and, you know, it, I think, would sort of help mitigate some of the negative impacts we're seeing on the cost side in this space. So I would be supportive of doing some more exploration in that space.

And then in terms of the other improvements, I think those are all things that could potentially help in this space. Obviously, they take resources to do, and so

we always have to be mindful of, you know, the resources that CMS has to bring to bear on those type of things.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. By the way, I want to say I agree with Gina that it's great that you put in the evidence for the interviews. That was very helpful, I think, and gave me some nuance to what's going on and showing the good intentions often of the people who are making decisions about who can be admitted or not.

I'm actually a little disappointed in the way the discussion has gone in the last 20 minutes. I usually almost always agree with Tamara and Scott, for example. But here, I think we're talking about muddiness and lack of evidence. I agree there's muddiness about -- for any individual patient whether they should be admitted to an IRF or not, and yes, there's a lack of evidence about, you know, should they have three hours of therapy a day, so on and so forth.

But I don't think that -- I don't want to confuse that kind of muddiness and lack of evidence with muddiness and lack of evidence about profit margins. I mean, 19, 22 -- what is it? -- 22 percent this last year, pretty big

profit margin. It's true MedPAC is not and cannot be in the business of deciding what's an appropriate profit margin, and that's why, as Michael was implying, when we do our annual payment updates, we look at access. We try to look at quality. There's no evidence at all, I think, that there's an access problem with IRFs, right?

And so that would lead me to believe that the profit margin, which has been extremely high for 20 years or so, is too high, right? So I don't see any muddiness there, and I don't see any evidence that we need to wait around for it to get less muddiness to have some comment on that. And we have annually recommended pretty big cuts.

So I would suggest really a three-pronged approach. One is, I think Option 2 is, as I think Cheryl just said, directionally correct, something like that. But even with that, I think you estimate a margin of 19 percent, if I -- but it would be at least a start in moving things in the right direction.

And then we have our annual payment update recommendations we make. So the annual payment would be the second part of the three-pronged approach.

But the third, I just want to enlarge a little

bit on what people have said about audits earlier in the discussion today. I think I would make this as a kind of general comment about CMS, not just with IRFs. But we spend a lot of money on things, and we could recoup some of that money that is inappropriately spent by paying for more audits, right? I mean, it's penny-wise and pound-foolish to say, oh, we can't afford more auditors. The future auditor is going to bring in many multiples of what it costs to have them.

So I think we don't want to make audits burdensome. I don't think we need a very high percentage of audits, but I think there should be a low percentage of audits, possibly targeted in intelligent ways, where we think there most likely to be trouble, but still not very many audits. But the penalties would be fairly strong. So you would not want to get audited and get dinged. I think that would be cost effective and probably effective at reducing inappropriate admissions, to the extent that they do happen.

So I think that three-pronged approach could go a long way and a very fair way without needing any more evidence at all to reducing what seem to be excessive

margins, given the very good access to IRFs, as far as I can see.

MS. KELLEY: Kenny.

MR. KAN: Thanks very much for this very informative chapter.

Of the three policy options, if we do end up pursuing additional work in this, I'm probably in favor of Policy Option 2, with maybe a three- to five-year phase-in.

That said, while I appreciate Larry's comments, I do concur more with Tamara and Scott that it appears that the evidence, you know, has some muddiness on how to analyze the issue.

So given the limited bandwidth that staff has and the interest of me and my other fellow Commissioners to pursue other work streams, like, for example, workforce, you know, I would prefer that we probably redeploy the resources on this and use this for more of directional insights and reflect that in the payment update chapter.

MS. KELLEY: Lynn.

MS. BARR: Thank you.

Yeah. This -- it is -- it is muddy. I do agree. But, you know, based on what I can see, I would agree with

most of the other Commissioners that Option 2 would be a good route forward.

I'm intrigued by the idea that when the IRFs come up to the compliance threshold, they start turning away the admissions. And I think I would strongly recommend we increase the compliance threshold, because that would give a natural -- you know, then let the doctors decide. And I feel like, you know, that's the thing that we could do that would have less -- the least amount of harm, because I think if an IRF feels this patient has to be here, then they will figure out how to make that done and maybe reject the next patient that doesn't need it as much.

I believe you said that there's different reporting requirements between IRFs and SNFs, so that it's very hard to compare quality. Is that -- did I -- did I get that right?

DR. CARTER: The patient assessment tools are different, and so there is different information gathered.

MS. BARR: So to Tamara's point about, you know, let's get better data, I believe that unifying the assessments between the two organizations so that we could actually understand better what we're getting, and, you

know, in some future date, then we might be more likely to make them -- to be able to, you know, really go with Option 2 with much more confidence. So I think that would be very important.

And again, thank you for your wonderful work.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you very much. I really appreciate this work and the comments of my colleagues.

I found this chapter to be very disheartening. It really made me sad to think that we have this kind of -- I don't know what you'd call it -- disparity going on.

The profit margins to me are a concern because that's paid for by taxpayers and beneficiaries. So I see it very different than an industry where it's not a vulnerable purchase, et cetera, et cetera.

And I agree that these definitions of compliant and noncompliant are not precise.

And I'm also -- I've always been bothered by therapy being essential three times a day for five days a week but not on the weekends, right? Another thing about the health care system that's all about the convenience of the providers.

Lynn brought up the issue of bringing the threshold up to 75, and that was really part of the heart of my Round 1 question. I don't know if there's unintended consequences. I don't know if there was reasons for that in terms of capacity, but I think that's a very interesting opportunity perhaps.

You talk about education of providers on page 40. I think -- I expect there's many subjective factors that go into this decision-making, and I don't think education will change behavior unless there's some sort of financial penalty or repercussions. So I'm not sure education will help all of those providers.

So in summary, my initial response was if we're going to do something, Option 2 is more workable, but I also agree with Kenny and I guess Tamara and others that getting some more information and then being able to make a clearer recommendation might be a good use of time and focus on other things like workforce. But thank you.

[Laughter.]

DR. RAMBUR: And my discouragement was not about the report. I thought you all did a beautiful job. It's just I think we as a society can do better than this in

terms of protecting our beneficiaries and our taxpayers. Thanks.

MS. KELLEY: Jaewon.

DR. RYU: I would echo a lot of the comments already made.

I think the only additional one I was going to make is we use the word "heterogeneity" a lot. I think that's what this whole area feels like to me, and it's very tough to discern based on the characterization of compliant, noncompliant.

But I think the other dimension that's worth looking at and seems a little bit lacking or missing from the conversation, something that Cheryl mentioned, I think some of this is environmental. What are the other options for patients that fit into this bucket?

I think we spend a lot of time focusing on the patient and the case, so to speak, and I think that makes sense. It's got to be there. But the reality is also where is it playing out and are there other viable options, and it may not just be SNF. It may be that the SNF has to have a sufficient level of capability to accommodate. And many do, and many don't. But it feels like if we can get

some line of sight on that, I think that would further fine-tune.

Between the options, I do like 2 or 3 because it seems like a softer dipping the toe in the water as opposed to jumping all in.

MS. KELLEY: Greg.

MR. POULSEN: Okay. I'll be really quick because a lot of people have said the same things.

I think because of the difficulty of defining what is an appropriate reason to admit what we're now calling a noncompliant person; we don't know everything about that person. The physician who makes that decision might know more than we do.

And it troubles me to get into the degree of micro-definition that any of the options would. I think they're all well founded and well thought out, but I think given the amount that we know, my inclination would be to suggest that we do it through the update overall and that we take that approach.

That said, I recognize we've been making that recommendation, and it hasn't been approved. I think that's a different issue than what we should recommend. So

the fact that we didn't get an uptake on the recommendation that we made, I don't think should make us go in a different direction in terms of the way that we provide the recommendation.

DR. CHERNEW: So thank you all for all these comments. It actually is very instructive.

And so a few quick summary comments. The first one is, just so folks know, we statutorily have to make a general update recommendation for IRFs, and we're going to do that. And we're going to do that without all the information we would like to have because we don't have all the information we would like to have. And quite honestly, for a range of reasons, it's unlikely we're going to get all the information we would like to have, and we're going to have to do that.

Because of that, which is true across all the sectors, our updates are essentially judgment calls in a range of ways, and if you look at what we've done, we have tried to balance sort of a level of uncertainty, concern about access, concern about margins that seem very high. And we can have that discussion when we have our IRF update discussion.

This discussion has really been about thinking through whether or not a -- so we're going to do that. No matter what we do here, we're going to have an update recommendation, the magnitude of which will depend on the status quo when we make that recommendation.

The sort of topic here was might there be some value in trying to think through some targeting, and I think we've heard some differences of opinions. But I think a lot of real, actually common -- people may come down different ways, but I think there was actually a lot of agreement broadly on what the challenges are.

And I would add to that mix, there's just a cost to try and spend a lot of time to, you know, bring clarity where the evidence is hard, and the question is not just should we do that, but is it worth the sort of just opportunity cost of where we go? And we will take that back under consideration. But I very much appreciate that.

So I'm going to leave it there, and if you have other comments, please let me know.

For folks at home who also may have comments that we would love to hear, please reach out to us. There's many ways to do that. One is meetingcomments@medpac.gov.

On the website, you can send us letters. We do want to hear from the public about how they feel about this discussion, and then we will decide going forward about where this actually plays out. But the comments have been valuable, and so I appreciate it.

We are now going to take a break for lunch. We will be back, I think, at 2:15. We will be back at 2:15, and we will start with a discussion of the physician fee schedule.

So, again, for those at home, thank you for joining us, and we hope to have you back in a little more than an hour.

[Whereupon, at 1:07 p.m., the meeting was recessed for lunch, to reconvene at 2:15 p.m. this same day.]

AFTERNOON SESSION

[2:15 p.m.]

DR. CHERNEW: Hello, everybody. Welcome back to the afternoon MedPAC session.

I think it is probably a fair characterization to say that MedPAC -- and for that matter probably the country as a whole -- has struggled with aspects of the physician fee schedule, and while we talk about the physician fee schedule every year as part of our update process, we know that that update process is somewhat prescribed in how it goes and that there's need for a deeper dive into aspects of the physician fee schedule. So we plan to do a lot of work in that area going forward, and the session that we're about to start now, I think, is really the beginning of setting the stage for where we may go.

So I'm going to turn it over now to the team, and I believe Brian is starting.

MR. O'DONNELL: Good afternoon.

Today we'll discuss approaches for updating payment rates under the Medicare physician fee schedule. This information, along with any modifications based on Commissioner feedback, will be included as an informational

chapter in our June report. Viewers can download a copy of this presentation in the handout section of the control panel on the right-hand side of your screen.

We'll start the presentation with some background on the fee schedule, the Commission's principles for assessing the adequacy of fee schedule rates, and the Commission's past findings with regard to beneficiary access to care. We'll then discuss some concerns with current fee schedule updates which Commissioners highlighted during our October meeting. Next, we'll discuss some policy approaches to address those concerns. We'll end with Commissioner discussion and feedback.

It's important to note that we're still relatively early in the process of developing policy approaches, and one of the main goals of this meeting is to get feedback from Commissioners that we can incorporate in this line of work, which we anticipate continuing next cycle.

First to discuss some background. Payment rates for fee schedule services are determined based on RVUs, the conversion factor, and other adjustments. RVUs are broken down into three components: work, which accounts for

factors such as the time, effort, and skill of the clinician furnishing the service; practice expenses, which account for costs such as staff wages, rent, equipment, and supplies; and professional liability insurance.

Fee schedule services vary substantially in terms of the share of RVUs associated with work, practice expenses, and professional liability insurance. RVUs are multiplied by a conversion factor to calculate the payment amount. Medicare has updated the conversion factor differently over time, and the Commission's discussion today focuses on approaches to change updates over time.

Current updates are largely based on MACRA, which I'll discuss in the next slide.

There's a lot of information on the slide, but I want to draw your attention to a few main points. Looking at the top row, you can see that with the exception of one-time payment increases from 2021 to 2024, which are noted in orange text, fee schedule updates are below 1 percent per year and are directly specified in statute. This means that updates don't automatically adjust to changing economic conditions, such as increases in inflation.

In addition, beginning in 2026, updates will vary

based on whether a clinician is in an A-APM or not, meaning there will be two conversion factors, a lower one updated by 0.25 percent per year for clinicians not in A-APMs and a higher one updated by 0.75 percent per year for clinicians in A-APMs.

As seen in the second row, MACRA provided annual bonus payments to clinicians who participate in A-APMs, but the magnitude of those bonuses is declining over time.

And the third row shows information about MIPS. This is a pay-for-performance program through which clinicians who are not in A-APMs have their payment rates adjusted up or down based on performance measures. The Commission has concluded that MIPS is ineffective and burdensome and has recommended repealing it.

In assessing whether Medicare's payment rates are adequate, the Commission looks at relevant measures with regard to three principles: ensuring beneficiary access to care, promoting high quality of care, and ensuring payments are adequate to meet the cost of relatively efficient providers.

The Commission's goal is to identify rates that will ensure both beneficiary access and good stewardship of

taxpayer resources.

Since the SGR was repealed in April 2015, the Commission has largely recommended implementing current law updates. However, in response to increased levels of inflation and other issues in 2023 and 2024, the Commission recommended updates of current law plus 50 percent of the growth in MEI, which is a common inflation metric that measures the average price change for inputs involved in furnishing clinician services and safety net add-on payments for treating low-income beneficiaries.

As I mentioned in the previous slide, ensuring beneficiary access to care is a key factor in evaluating the adequacy of fee schedule rates, and over many years, the Commission has found that beneficiary access to care and provider acceptance of Medicare have been comparable to the privately insured.

For example, survey data suggests beneficiaries' access to care is comparable to that of the privately insured. Clinicians accept Medicare at similar rates as commercial insurance, despite lower payment rates than commercial insurance.

Volume and intensity of care per beneficiary has

increased over time, and other longer-term indicators of access have also remained positive.

By their nature, these data are historical, and as the Commission discussed in October, there are reasons to believe that beneficiaries may face greater challenges accessing care in the future than in the past.

In the next few slides, I'll go over three concerns Commissioners have expressed about the future fee schedule updates, starting with the issue of inflation.

MEI growth outpaced fee schedule updates by just over 1 percentage point per year for the two decades prior to the pandemic. However, from 2025 to 2033, the projected annual difference between MEI growth and fee schedule updates is larger, 1.7 percent for clinicians in A-APMs and 2.1 percent for clinicians not in A-APMs.

While full MEI updates have not been necessary in the past to ensure beneficiaries maintain access to care that is comparable to the privately insured, the concern is that a larger gap between MEI growth and updates could negatively affect beneficiary access to care in the future, as clinicians may choose to treat fewer Medicare beneficiaries or not participate in the program altogether.

The second concern is site-of-service payment differentials. Medicare generally pays more for the same service when it is performed in the HOPD versus a freestanding clinician office.

Medicare payments for clinician work are similar across sites of service, but payment differences for practice expenses can be large.

Medicare updates contribute to growing site-of-service differentials.

Under the fee schedule, annual updates are specified in law. Under the hospital OPPS, annual updates are based on the hospital market basket minus a productivity adjustment.

Site-of-service differentials is one factor that encourages vertical consolidation, although the effect might be modest. Vertical consolidation can increase both Medicare and private insurance spending.

A third concern is that the differential updates specified under current law will provide a weak incentive to participate in A-APMs in the late 2020s. This could result in top-performing clinicians exiting A-APMs for MIPS.

This could be a problem because the Commission believes A-APMs hold promise, and we've had enough concerns with MIPS that we recommended repealing it in 2018.

The reason we might see clinicians exiting A-APMs is that participation bonuses will no longer be available after 2026. Differential updates will take over as a way to help incentivize clinicians to participate in A-APMs starting in 2026.

Over time, the difference between payment rates for clinicians in A-APMs and the rates for all other clinicians will grow, eventually producing a potentially untenable large incentive in the 2040s.

But in the late 2020s, the difference in payment rates will be small, so top-performing clinicians might be able to earn more money by staying out of A-APMs and participating in MIPS.

Although in the past, the largest MIPS adjustments have only reached 2.3 percent, current law allows it to be as large as 9 percent.

I'll now turn it over to Geoff to discuss our policy approaches.

MR. GERHARDT: Based on input provided by

Commissioners at the October meeting, we developed two approaches for replacing the current law updates, which I'll walk through in the next several slides.

After I review the update approaches, Rachel will discuss an approach for incentivizing participation in advanced alternative payment models.

As we discussed in October, there are concerns that site-of-service payment differentials may be incentivizing consolidation between clinicians and hospitals. To help address this, the first update approach would annually increase the practice expense portion of fee schedule payment rates by the hospital market basket minus productivity.

Implementing this approach would probably require two conversion factors rather than a single conversion factor used today. One conversion factor would be used to update payment rates attributable to practice expenses for each service, and the second conversion factor would apply to the work and malpractice insurance portion of rates.

The practice expense conversion factor would be updated each year by the hospital market basket index minus productivity adjustment. The work and insurance conversion

factor would not be updated automatically, although the Congress could develop an update policy later or make one-time adjustments.

A motivation behind Approach 1 is to address differences in how practice expense payments are updated in different settings. Under current law, physician fee schedule payments are projected to increase much less than payments to hospital outpatient departments. Having payments for practice expenses grow at the same rate in both settings could reduce incentives to consolidate.

In addition, measures that track the supply of clinicians and beneficiary access to care suggest that payments for work are currently sufficient and do not need to be increased at this time.

By applying an annual update to only practice expense payments, the financial effects of Policy Approach 1 would vary across different services and clinicians. Where practice expense represents a large portion of total payments, services would see larger updates compared to services where practice expense represents a smaller share of the total.

The variation in updates across services means

the financial impact of Approach 1 would vary depending on the mix of services and the setting for those services.

So the clinicians that tend to furnish high-PE services in an office setting would see larger increases in aggregate payment rates. Clinicians that furnish low-PE services, as well as those who furnish most of their services in a facility setting, would see smaller increases in payment rates.

Using a combination of claims data, fee schedule payment rates, and projections of hospital market basket, we estimated how much average payment rates for each specialty would increase over time.

Our analysis indicates that under Approach 1, payment rates for the average clinician would be 11.4 percent higher in 2033 compared to rates in 2024.

As mentioned on the previous slide, the impact would vary across clinicians depending on mix and setting.

We estimate that aggregate rates for those specialties in internal medicine, the largest primary care specialty, would increase by an average of 10.8 percent.

As shown on the left side of the table, we project that cumulative increases for specialties like

immunology, radiation oncology, and vascular surgery would average more than 15 percent.

Cumulative increases for specialties shown on the right side of the table would increase by an average of 5 percent to 7 percent.

This slide presents some pros and cons for Approach 1. One pro is that this approach would help ensure the payments for practice expenses keep pace with inflation. Equalizing growth in payments for PE costs between the non-facility and HOPD settings may reduce incentives for clinicians to sell their practices to hospitals or shift services to the HOPD, and creating two conversion factors would enable policymakers to increase payments for practice expenses and work by different amounts.

On the other hand, this approach would exacerbate revenue differences between clinicians who specialize in primary care, behavioral health, and other specialties, which could contribute to problems accessing those clinicians.

Over time, payment rates for PE and work would become increasingly disconnected from each service's PE and

work RVUs. This could undermine the process for setting RVUs and ensuring that aggregate RVUs reflect the distribution of costs of providing care in freestanding offices.

Also, not increasing work costs may not be sustainable over time and could require additional congressional action.

Finally, the policy could incentivize clinicians to furnish more high PE services.

Ensuring that fee schedule RVUs are as accurate as possible is always important but especially so when PE and work RVUs would be updated differently.

One way to improve the accuracy of RVUs would be to reform the way 10- and 90-day global surgical codes are valued. There's evidence that RVUs for these services assume more time is being spent on follow-up visits than actually is occurring. So payments for these codes are overvalued.

Taking action to address the overvaluation would require payment rates for these -- or would reduce payment rates for these codes. The resulting reduction in spending could be used to increase payment rates for other codes.

In addition to addressing the 10- and 90-day surgical codes, the Commission could also pursue other policies for improving RVUs, some of which the Commission has already recommended.

The second approach is to update fee schedule rates each year by the Medicare Economic Index minus 1 percentage point. This policy would be applied to a single conversion factor so that payments for PE, work, and liability insurance all increase by the same rate.

To prevent updates from being too low and potentially being negative in times of low inflation, this policy approach would include a floor on updates equal to half of MEI.

The rationale behind this approach presumes that both PE and work costs increase over time, so Medicare's payments for both types of costs should increase.

The MEI is a measure specifically designed to track weighted input cost trends, including work and practice expenses, in physician offices. So it's a good indicator of how those costs are increasing.

This approach also reflects the fact that physician fee schedule updates have averaged around MEI

minus 1 percentage point for the two decades prior to the pandemic.

Despite updates being somewhat less than inflation, MedPAC has consistently found that clinician participation for most specialties has been stable, and beneficiary access to care has been similar to the privately insured.

This approach to updates is also likely to be more predictable and stable than previous approaches to updating the fee schedule.

There are a number of pros and cons to consider for Approach 2.

Among the pros, Policy 2 preserves the relative value concept of the fee schedule by increasing all three RVUs at the same rate. As such, the effects on payment rates would be evenly distributed across services and specialties. Growing payments at the same rate would not exacerbate differences in revenue and compensation between primary care and behavioral health clinicians and other higher-paid specialties, and it would reduce the chances that policymakers would have to take action to address growth and work costs in the future.

On the con side, measures of clinician supply and beneficiary access to care indicate that payment increases for work may not be needed at this time. In addition, Policy 2 does not directly address site-of-service payment differentials, which can incentivize vertical consolidation.

Finally, additional policies may be needed to address low PE payments for certain services and to discourage vertical consolidation.

The figure on this slide shows projections of how updates under the two policy approaches compare to each other and how they compare to current law updates.

As shown in the purple line, we estimate that under Approach 2, payment rates for all services would be 12.7 percent higher in 2033 than they are in 2024.

As shown in the aqua blue line, under Approach 1, we estimate that average payments rates would be 11.4 percent higher in 2033.

Cumulative current law updates are shown in the orange and dark blue dotted lines.

There are several important takeaways from this comparison. Average updates under Approaches 1 and 2 are

similar to each other and substantially larger than current law updates, and while there is no variation in updates across services or clinicians under Approach 2, there would be substantial variation in updates under Approach 1. Depending on the type and setting of services, a clinician could see aggregate payments increase less than they would under current law for A-APM participants.

This slide compares current and future total Medicare payments for a high- service, the removal of skin lesions, when furnished in a freestanding office in a hospital outpatient department.

As shown in the figure, in 2024, total Medicare payments are $238 higher when the service is furnished in an HOPD compared to when it is furnished in a freestanding office.

We project the site-of-payment differential would increase under both update approaches, although the increase would be somewhat less under Approach 1. By 2033, we project that payment differential would be $298 under Approach 1 compared to $306 under Approach 2, a difference of $8.

It's difficult to know what impact the two

approaches would have on incentives for vertical consolidation, but by continuing large site-of-service payment differentials, it is possible that neither approach would have a substantial impact on those incentives.

Implementing site-neutral payments, as has been recommended by the Commission, could be more effective in addressing financial incentives for consolidation.

As with Approach 1, Approach 2 has drawbacks that could be addressed through additional policies that would improve the valuation of practice expenses.

A policy that could be used in conjunction with Approach 2 would be to rescale RVUs to reflect the most recent MEI data about the distribution of work and PE costs. This rescaling is done periodically to ensure that aggregate work and PE RVUs reflect up-to-date information about how those costs are distributed in clinician practices.

Updating the RVU scaling, which CMS has not done recently, would increase practice expense RVUs, which could reduce incentives for consolidation.

There are also additional ways to improve how cost data is collected and used to calculate RVUs, some of

which are discussed in your mailing materials.

I'll now hand things over to Rachel.

MS. BURTON: We now pivot back to talking about how to incentivize clinician participation in A-APMs.

As noted earlier, the differential updates scheduled to start in 2026 may not be the optimal way to incentivize participation in A-APMs, since they will produce a weak incentive to participate in A-APMs in the late 2020s.

Since the two approaches for updating rates that were just presented would replace current law's differential updates, an alternative way of incentivizing participation in A-APMs over MIPS could be to repeal MIPS per our 2018 recommendation or to extend the current A-APM participation bonus for a few more years.

An extended A-APM participation bonus could help maintain clinician participation in A-APMs in the late 2020s, given uncertainty about what the top MIPS adjustment will be and how attractive MIPS will be to top-performing clinicians in the coming years.

Once MIPS's future direction becomes clearer, policymakers could reassess the need for the A-APM

participation bonus. If the A-APM participation bonus is extended, follow-up questions to consider are what size to make the extended bonus, whether to freeze the current payment and patient participation thresholds, and whether to restructure the bonus.

Historically, A-APM participation bonuses have always been larger than the highest actual MIPS adjustment paid out to clinicians, which is shown on the left side of this table. This has provided a clear incentive for clinicians to prefer A-APMs over MIPS. However, MIPS adjustments may become larger than A-APM bonuses in the future, as shown on the right side of this table.

Current law allows CMS to award MIPS adjustments of up to 9 percent, and CMS recently proposed a top MIPS adjustment of 8.8 percent for 2026, although it ultimately settled on 3 percent.

An extended A-APM participation bonus would be most likely to attract clinicians away from MIPS if it, plus whatever payments a clinician received through their A-APM, always exceeded the highest MIPS adjustment. But it's difficult to predict what amount would be needed to achieve that goal, and a bonus worth this amount could end

up being costly for the Medicare program.

We seek input from Commissioners on what might be an appropriate size for an extended A-APM participation bonus. At a minimum, continuing the 1.9 percent bonus that will be in effect in 2026 would provide some stability and signal support for A-APMs, while limiting the cost of this approach.

In evaluating a bonus extension, there are pros and cons for Commissioners to consider. A pro is that an extended bonus could prompt some clinicians to participate in A-APMs rather than MIPS. Some cons are that an extended A-APM participation bonus might not prompt clinicians to prefer A-APMs over MIPS if the bonus is set too small. Extending the bonus could also be viewed as inequitable by clinicians who are unable to participate in A-APMs due to a lack of models in their geographic area or geared toward their medical specialty or other circumstances.

If the A-APM participation bonus is extended, an additional question for policymakers is whether to freeze the two participation thresholds that are used to determine if a clinician qualifies for the bonus.

The first threshold requires at least 50 percent

of a clinician's payments to be associated with an A-APM. Currently, the average clinician in most A-APMs exceeds this threshold, but this is not true for clinicians in Medicare's two main episode-based payment models. This threshold will increase to 75 percent in 2027 under current law, which will result in the average clinician in all of Medicare's ACO models also now failing to qualify for the bonus.

The second threshold that can be used to qualify for the A-APM participation bonus requires at least 35 percent of a clinician's patients to be in an A-APM. Under current law, CMS will be allowed to raise this threshold from 35 percent to some higher percentage starting in 2026.

A pro of freezing the current payment and patient thresholds at their current levels is that many clinicians would continue to qualify for the A-APM participation bonus who would otherwise stop receiving it. The continued availability of the bonus could increase A-APM's ability to attract top-performing clinicians, which could in turn increase the chances of A-APMs generating net savings for Medicare.

A con of freezing the thresholds is that

clinicians who already exceed the thresholds would not have an incentive to increase the share of their payments or patients in A-APMs.

A final question for Commissioners is whether to restructure the A-APM participation bonus. Currently, the bonus is calculated as a percentage of a clinician's Medicare payments for fee schedule services. This incentivizes clinicians to increase the amount of fee-for-service Medicare spending they generate. This incentive runs counter to A-APM's goal of delivering care more efficiently.

Instead, the bonus could be based on the number of fee-for-service Medicare beneficiaries in an A-APM who are attributed to a clinician. This would incentivize clinicians to increase the number of fee-for-service Medicare beneficiaries in A-APMs that they treat.

CMS would need to develop a new algorithm and formula to calculate the bonus for each clinician, and the bonus would need to be risk-adjusted to prevent clinicians from having an incentive to maximize the number of beneficiaries they treat by seeking out healthy beneficiaries and turning away sicker ones.

A pro of restructuring the bonus is it would eliminate the bonus's current incentive to increase the amount of Medicare spending a clinician generates. It could also increase clinicians' incentives to accept Medicare patients.

A major con of restructuring the bonus is many specialists would lose access to the bonus since patients in A-APMs tend to be attributed to a primary care provider rather than a specialist.

Another con is that using a different basis for the bonus would make it harder for clinicians to compare their expected bonus to their expected MIPS adjustment when they are weighing the costs and benefits of these two options.

This brings us to your discussion. As Brian noted at the start, the approaches we presented here today are initial ideas for consideration and are open to modification. We plan to come back to you with refined versions of whatever approaches interest you in the fall.

Today we seek feedback on the two approaches for updating payment rates and on the idea of extending the A-APM participation bonus for a few years.

We'd also like input on how large a bonus might be appropriate, whether to freeze the payment and patient thresholds used to qualify for the bonus, and your thoughts on restructuring the bonus.

With that, I'll turn things back over to Mike.

DR. CHERNEW: Rachel, thank you. Everybody, thank you. This is a feast of information, maybe a fire hose of things to talk about. Figuring out how to structure this conversation is --

UNIDENTIFIED SPEAKER: Like 340B discussions.

DR. CHERNEW: You know, there are very few things that make 340B discussions easier. I don't know. But anyway -- so let me just say a few things that I had said earlier.

We are at the very beginning of this. Often when we're at a stage where there's options, you somehow feel like in a few months we're going to come back and vote. We are nowhere close to that, and so I really strongly encourage you not to get hung up on what I would consider to be relatively small differences between the options, because many of those can be addressed or smoothed over.

I'm interested sort of in broad philosophical

questions about what -- you know, what you prefer sort of conceptually, what you think the biggest risks are, which way we might go, because we're not going to pick -- no matter what comes out of this meeting, we're not necessarily going to pick a particular direction. So that's sort of my preamble before we jump into this.

I'm going to ask one Round 1 question, because I think it's important to get it on the table, and then we'll go on to the real Round 1, which I think Brian is going to start.

So my question is, my understanding is that in the MEI, there's also a professional, like a physician component. Is that basically right as to how the MEI works?

MR. O'DONNELL: Right. So the way the MEI works is that they have kind of a bucket of data that says these are all the clinician expenditures, and they chop it up into about -- basically half is about practice expense, and about half is clinician work. And so that's the -- that's how they chop that up.

And then there's a price proxy to say how fast do clinician compensation grow, and the price proxy is kind of

professional and related occupations. So it's a list of things like mathematicians, computer scientists, and so on and so forth. So that's the price proxy for clinician compensation.

DR. CHERNEW: I understand. So they're not looking at actual physician compensation. They're looking at non-physician types of labor.

MR. O'DONNELL: So I think clinician is included in a big, long list that they use, but yes.

DR. CHERNEW: Yes, I understand. Okay. That was clarifying.

So with that, I think, Brian, you are up for Round 1.

DR. MILLER: Although I'd defer to Larry, if he has -- okay. So I have a very simple --

DR. CHERNEW: Larry has got to get in the queue himself. Like, Larry doesn't get, you know --

DR. MILLER: Well, Lynn gets automatic queue for rurals. So I think Larry gets automatic queue --

DR. CHERNEW: No, she doesn't. No, she does not.

DR. MILLER: -- for physicians.

DR. CHERNEW: No, she does not. She has to

write. She can write, but she has to write in.

Anyway, you're up, Brian.

DR. MILLER: You're a complement to our two advocates on the Commission.

So I really enjoyed this chapter. I think the three of you did an excellent job. I read a -- the 93-page chapter, and I was -- found myself wishing it was longer, which is something that will -- I will probably not say for the rest of my time here. I was very -- it was -- I enjoyed it immensely. So thank you for the hard work that you guys did.

I particularly liked the Table 2 on page 41, which compared the PFS and OPPS. I thought that that was very helpful to sort of make those differences clear.

And so my thought was on page 21 in Figure 1, where we're talking about fee schedule updates, MIPS updates, and then A-APM updates, could we add what the OPPS updates were during that time?

Excellent chapter. Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Geoff, Brian, and Rachel, for a great work here.

So my question is actually a little bit related to Mike's question in a sense. So I'm curious, because MEI, for example, does include some notions of work in it. And so I was curious if other updates in other payment schedules, so OPPS, IPPS, et cetera, across the Medicare program that automatically increase with inflation, their inflation linked in some way -- do any of those also include a clinician labor kind of work component in them?

MR. O'DONNELL: So to my knowledge -- and my colleagues can correct me -- the answer is no, because the fee schedule is the pathway through which we pay for clinician services. But under different market baskets, we certainly do pay for labor. So like in the hospital market basket, it's about two-thirds labor, but that labor is largely nurses and things like that

DR. NAVATHE: Okay. That's really helpful. Thank you.

And that being said, that is in contrast with even the -- the practice -- sorry -- the PE portion, the practice expense. That includes some portion of work in it. Is that correct?

MR. O'DONNELL: So the practice expense component

of MEI includes staff labor. It does not include physician labor. So the physician labor is just under half. The practice expense is right around half, and of that half, it's PE. There are kind of nurse labor, kind of clerical workers, things like that. But there's no physician labor in that bucket.

DR. NAVATHE: Great. Perfect. Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: As others have said, this is really excellent work.

I have a quick question about the 9 percent MIPS bonus. So you say in the chapter, it's like -- could go as high as 9 percent, but that it's been more like 2 percent. So I wondered if there's any -- like, is it more likely to get to that 9 percent in the future? Or is there -- I guess I just wondered if that was something that we shouldn't worry that it's going to be that large.

MS. BURTON: I think we really can't tell. It could go either way. It could go really high or really low, as we mentioned in the chapter.

MS. KELLEY: Jonathan.

DR. JAFFERY:

DR. MILLER: Can you guys go to slide 21 for a second? I think that's the slide number. Yeah.

So this is the current set-of-service differential for the different approaches into the future. But what if neither option were adopted? What would the baseline projection be by -- what would the difference be in 2033 if we didn't do anything, either of these? Do you know?

MR. GERHARDT: I don't know off the top of my head. It's something we can easily calculate. Presumably, the differential would be even larger because the updates to the fee schedule payment portions are lower and smaller. So that is my assumption about how that would work.

DR. JAFFERY: Okay. It might be useful to have as --

MR. GERHARDT: It's certainly detail --

DR. JAFFERY: Yeah. Because these two options don't seem like -- I mean, they're only $8 apart.

MR. GERHARDT: Right.

DR. JAFFERY: So it would be good to know if that was a lot different, but okay. Thanks.

MS. KELLEY: Gina.

DR. CHERNEW: Let me say one thing about that. If you thought that the challenge was a magnitude issue, you could take, say, Option 1 and just change the magnitude or take Option 2 and change -- like, we could change -- there's a principle about what you're doing, and then there's a magnitude thing. Right now, we're not wedded to the magnitude of those things.

MS. UPCHURCH: Thanks for trying to make a very complicated process as streamlined for our understanding.

The table that Brian was questioning, Table 2, which is not -- you don't have a slide about it. It was on page 41, Table 2. If I look at it and it's defining what's the payment if someone's in a clinician's office versus outpatient hospital, they both start out with physician work, non-facility PE, practice expense, professional liability, and then with hospital outpatient, it says payment to clinician, physician fee schedule. Weren't they just paid in the physician work up above? It seems -- I don't -- and then the next one is payment to the HOPD. So I'm just confused. How is the clinician -- it looks like they're being paid twice in that scenario.

MR. O'DONNELL: So I do think that the thing is

that when a service is performed in the OPD, it generates both a fee schedule bill and an OPD bill, and so we sum them together. It's not as though you would get the top row, the non-facility rate plus the OPD. It's that you would get a smaller fee schedule payment plus the OPPS payment. That's the -- that's for Column 1, the office visit.

MS. UPCHURCH: Right. It just -- if we're defining, you know, physician work is already paid for and then we say payment to clinician, it just seems redundant. So I'm --

MR. O'DONNELL: Payment to clinician for the practice expenses and other things.

MS. UPCHURCH: Well, practice expense has its own line, so I'm just very confused.

But anyway, that's -- yeah, it may just be the way it's been set up, but --

MR. O'DONNELL: Yeah. We can clarify that.

MS. UPCHURCH: Yeah, that'd be great. Okay.

So then the second one is -- so we counsel Medicare beneficiaries, and we hear complaints about facility fees. So, you know, Medicare pays facility fees.

But if you have fee-for-service traditional Medicare, you know, it pays 80 percent. You still owe 20. If you have a supplement, fine. But if you don't, you owe 20 percent of that. If you have a Medicare Advantage plan, many of them cover facility fees.

Do you hear -- do we hear about complaints about facility fees? And one of the ways that we think about it and trying to explain it to people is they're often -- these clinics are often the ones training the young providers. So we're like, oh, I guess it's helping train the providers. I mean, are you hearing anything from beneficiaries about facility fees being a problem? I'm saying no.

MR. O'DONNELL: So I do think when we hear in our beneficiary focus groups that cost is an issue, I do think the thing that often we hear is they just don't know that they're going to experience this facility bill.

MS. UPCHURCH: Right. They're annoyed, very annoyed by it. Yeah.

MR. O'DONNELL: To their perception, it looks quite similar to a physician's office.

MS. UPCHURCH: And they literally could be on

different floors of the same -- yeah, it's very confusing to people.

So the 5 percent, the bonus, does that go to the -- if you're a provider and you're trying to decide whether you're -- do you have the decision to make that whether you're going to be in A-APM or whether you're going to be in MIPS, or is it your practice decision? And does the money flow to the practice or to the provider?

MS. BURTON: Normally, in an A-APM, your practice participates.

MS. UPCHURCH: Okay.

MS. BURTON: So I think the clinicians in the practice would get together and decide if they're going to participate in MIPS or in A-APM.

I believe the bonus is paid to the TIN and not the NPI, but I'd have to double-check that.

MS. UPCHURCH: Okay.

And just related to that, do the providers that are part of A-APM or MIPS, are they given specific individual provider feedback, how they're doing compared to other providers, or is it your practice compared to other -- what's improving the quality? Are you comparing

yourself, or is your practice being compared to other practices?

MS. BURTON: I think different A-APMs have different reporting approaches, so I couldn't tell you a blanket answer.

MS. UPCHURCH: Okay.

And my last question is just that 10- and 90-day global payment that we're talking about. Is that follow-up in that payment model, the way that it's designed now, with the surgeon who did it, or is it with like your primary care provider?

MS. BURTON: It's with the surgeon.

MS. UPCHURCH: It's with the surgeon. So you still would have access. Okay.

Thank you.

DR. CHERNEW: I just want to try to take another stab at your first question. The row payment to the clinician, payment to the -- right -- that is the sum of the three rows above it. That's not an added payment. That's just the sum. So the reason why it -- right. I hope that helps.

MS. UPCHURCH: So it was redundant. I got it.

Yeah.

Thanks. Yeah. Okay. Thanks. That was really suspicious.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I really appreciated this work as well.

I have a question on slide 27. That's the side that the pros and cons of freezing and the current thresholds used to qualify for A-APMs. The cons, the clinicians who already exceed the threshold would not have an incentive to increase the share of their payments to patients. I see in the document the range of bonuses, et cetera, but I was curious how much of a con this is. Maybe it's inherent, and I didn't see it. What proportion of participants actually exceed the thresholds?

MS. BURTON: It's like the very last two graphs of the paper will be the answer to this question.

DR. RAMBUR: Oh, okay. Let me just look. Because I think that's important to discern how much of a con it actually is.

MS. BURTON: So I'm looking at it now. So right now --

DR. RAMBUR: Page what?

MS. BURTON: Page 83.

DR. RAMBUR: Got it.

MS. BURTON: So this is showing -- the top graph is showing for the average clinician in each of these A-APMs, what percent of their payments are in an A-APM. So the little dotted line is the current threshold they have to exceed. So you see in most of the models, they're exceeding the current 50 percent threshold, but the two episode-based payment models at the top are well below it.

DR. RAMBUR: Okay.

MS. BURTON: And then the bottom just shows the same thing but for a share of patients instead of share of payments.

DR. RAMBUR: Right. I appreciate that because I didn't put that together. So thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you very much for this important work. A lot to unpack here.

I had a question about Figure 2 in the document, and this shows the number of clinicians who qualify for the A-APM participation bonus each year. It says it's modest but increasing, and it looks like it's increased threefold.

And I was kind of curious. Are there particular models that are driving this growth, and what are our expectations about what the end game is here? Like, how many people, physicians, practices should be in these models, and how close are we to that end game?

MS. BURTON: I don't know what the goal would be. I know CMS wants like everyone to be in an A-APM eventually, but it's sort of a subjective judgment call -- not really. It's like above my pay grade.

DR. DAMBERG: Yeah. And then, I mean, do you know whether particular models are driving sort of this growth and who qualifies?

MS. BURTON: Oh, MSSP is the elephant in the room. There's an enormous amount of people in that program.

DR. DAMBERG: Okay, thanks.

MS. KELLEY: Larry.

DR. CASALINO: Really magnificent chapter, one of the best I've seen in my time on the Commission. It provided great resource to people. I really -- it's a privilege to read it, really. The history section is fantastic. There's so much detail and a very careful

assessment of the pros and cons of the options that you discuss, which fortunately is in your slides. So, very, very, really terrific.

Three quick questions. I want to make sure I understand Option 2 correctly, the MEI minus 1 inflation update. That would essentially work as kind of negative compound interest over the years. Is that correct? So in year one, you're paid 1 percent less than inflation. In year two, you're paid 1 percent less than inflation for year two, but on top of that 1 percent and so on. So just as compound interest in your, hopefully, investment will go up substantially over the years, even if the numbers are small, the percentage is small. It's the same in the opposite direction for this.

MR. GERHARDT: Yeah. If you think about a world where you would assume MEI is 2.5 percent every year, essentially the conversion factor would increase by 1.5 percent each year, and it would compound over time. We're not talking about a scenario like where the Congress said recently, they put an update on and then it went away and then there was another update the subsequent year, and so it doesn't really build.

In both of these options -- it should be clear -- whatever the update is for a given year compounds and is there for the next year.

DR. CASALINO: So just to put it crudely -- let me make sure I understand it right -- if there was 1 percent less than MEI each year for 10 years, it wouldn't over the 10 years be that payment rates would increase by 10 percent less than MEI. They would increase by something more than 10 percent --

MR. GERHARDT: A little bit more, yeah.

DR. CASALINO: -- because the compound --

MR. GERHARDT: The compounding effect, yeah.

DR. CASALINO: Okay, thanks.

And then I just want to make sure that I understand this and that everybody else does too. The size of the MIPS bonus depends heavily on how the poor performing physicians do, right? Because the good performing groups, they complain that the bonuses aren't big enough because CMS makes it too easy for anybody to score okay on the MIPS measures. That's a correct understanding. Is that right?

MS. BURTON: That's absolutely right.

DR. CASALINO: And that's why the bonuses for MIPS have been so small over the years is because, again, the high performers are complaining that the low performers don't get -- yeah, okay.

And then the last question is I thought that in OPPS payments, that the professional fee that's paid for the physician does not include -- so let me start the other way. In independent practice, you see a patient in your office. You get paid one fee, and that includes your work, your practice expense, and your malpractice. I thought that in OPPS, the professional fee that's paid in addition to the facility fee does not include practice expenses. But there was some place -- I can't find it right now -- in the written material we got where it seemed to say, no, no, the professional fee that's paid in OPPS does include an estimate of physician practice expenses. But there actually are no physician practice expenses because the physician is employed by the facility. Have I got that right?

MR. GERHARDT: Well, so this system was devised at a time when very few clinicians were employed by hospitals, and the working assumption was a physician would

go into the hospital to do certain things, but they still had to maintain an office, and that office had certain overhead and fixed costs that still needed to be paid no matter where the clinician was furnishing the service.

So the practice expense is much lower in most cases for the clinician when they furnish the facility-based service, but it's not nonexistent because, again, the theory is they're still paying some fee cost.

Now, that may not be actually true as much in this world where a lot of physicians are actually employed or working, you know, it's owned by the hospital, whatever the situation is, and that is something that could certainly be looked at again, that assumption.

DR. CASALINO: So just to make sure I have it right, if you're a gastroenterologist, say, who's doing colonoscopies in an HOPD, your professional fee there will include a bit of practice expense.

MR. GERHARDT: Correct.

DR. CASALINO: But that will also be true if you're a gastroenterologist who's employed by the hospital or a primary care physician who's employed -- they will still include some practice expense, even though there's no

basis for that. There is a basis in the one case, as you say, historically. There was more of that than that, but not in the other case.

MR. GERHARDT: Yeah. so --

DR. CASALINO: And to correct --

UNIDENTIFIED SPEAKER: [Speaking off microphone.]

MR. GERHARDT: Right. So the question comes up, who is actually -- yes, there are practice expenses, no matter what the financial arrangement is, no matter where you're practicing, but the question is, who is actually paying for those practice expense costs? Is it the --

DR. CASALINO: Yeah, you could argue that if --

MR. GERHARDT: -- clinicians themselves?

DR. CASALINO: -- their physician is employed by the facility, the facility is paying those administrative expenses, for example.

DR. CHERNEW: Right. And it would be in the OPPS. If it's a -- the OPPS is --

DR. CASALINO: Yes.

DR. CHERNEW: Right.

DR. CASALINO: But they're also getting paid for practice expenses that are nonexistent for the physician in

a professional fee.

DR. CHERNEW: Yes. Okay. So I think you were on -- you got the understanding exactly right. This is a portion of the discussion that we could -- it's a smaller portion, something that we could also revisit.

But to your clarifying question, the practice expenses in the PFS, if it's furnished in an HOPD, go down, but they don't go down to zero.

DR. CASALINO: Right. And to just -- right, that's helpful. And to just clarify the clarifying question, if -- to fix that, if you wanted to fix it, you would actually have to know not just was the service performed in the HOPD, but was the physician employed by the facility or not? Is that correct?

MR. GERHARDT: Yes. Right now, the only distinction that's really made is the location, the setting of the service. So it's either facility or non-facility bucket.

This discussion that we're having, if we want to go down that road, we'd have to have a much better understanding of the ownership and financial relationships --

DR. CASALINO: Yeah.

MR. GERHARDT: -- between the facility and the clinician.

DR. CASALINO: Great. Thank you.

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

DR. CHERNEW: No, that is what I have as well, and I think I have Jonathan kicking off Round 2.

DR. JAFFERY: Great. Thank you.

And thanks to you guys, to Geoff, Brian, Rachel. This is clearly a very comprehensive chapter, and you've actually weaved together a whole variety of things talking about incentives for quality and value and affordability, access, consolidation. There's just a whole number of things.

And so, with that in mind, I sort of want to start off talking a little bit about access and the framing of it, partly because it's probably my last chance to talk about access and partly because -- I mean, I'll talk about it at home, but my kids don't really pay any attention.

[Laughter.]

DR. JAFFERY: And partly because I think it's so

foundational here.

So, as you've heard me say before, I have some concerns about our measures of access and access adequacy, and they've never felt quite like they line up with the experience that we see as providers or as patients or as family members.

And the comparison to commercial insurance, while a useful data point, doesn't feel like it's adequate. when we do know that there's, you know -- I think Brian referenced the number earlier, 100,000 physician workforce shortage projections and so forth. And we know that in lots of geographies for lots of specialties, it takes a very long time to get in to see people, and so I think the key thing here is recognizing all that.

We really don't want to be in a position where access is a real problem. We don't want to be behind the eight ball on this. So I think that's something to keep in mind.

In the chapter around page 30, there's a section on the measures of access and clinician supply, and you mentioned three things: incomes, medical school applications, and the number of clinicians pulling the fee

schedule. And you referenced how, you know, decades ago, there was some erroneous concern about physician oversupply, which is absolutely true. And so that actually led to some changes and approaches to funding training and things like that.

And so I guess that my point here is that that increasingly seems to be the bottleneck as there have been more and more -- as medical schools have expanded their class size, there have been lots or more new medical schools, particularly DO schools, but not entirely.

We're seeing more physician supply in terms of graduating from medical school, and as you point out, we're seeing continued interest through applications. But I guess I'm concerned about the bottleneck being the training portion.

And so we've talked about that before a bit, but it feels like in the chapter, it's sort of buried in the text, this reference to it, when you're talking about those three things.

So in terms of getting to the options -- so, you know, in talking about Option 1 versus Option 2 in particular -- so I appreciate the logic behind Option 1,

but I do worry that it has the potential to exacerbate a lot of our underlying distortions in our fee schedule. And so, for that reason, I don't recommend it. It's not my preferred choice.

And I would lean more towards Option 2, combining this with some of those improvements in payment accuracies that you pull out in Option 1 and sort of reference can be an Option 2. But I think those are -- and again, that's sort of along the theme of how can we try and decrease the distortions that exist underlying our payment system that drive so many other things and then keep us trying to figure out how to fix them. And I recognize that that doesn't -- there is continued vertical integration concern, but --

And then on Option 3, which feels not mutually exclusive from Option 1 and 2, I think a couple things. So in terms of what would the structure look like, you talked about the current thresholds. You talked about should it be based on number of participants and things like that. And something that I think may have come up in a discussion in past meetings would be to consider basing the payments on the number -- continue to base the bonus payments on the

payments that providers receive, but rather than on the whole book of business, the whole book of Medicare business, base it on the patients that they see that are in advanced APMs. So that would eliminate the need for thresholds, which increasingly are very complex for people to try and figure out when you're bringing in non-Medicare. I mean, I'm still not sure logistically how that works very well, and it's very administratively complex.

It would allow specialists to continue to participate to the extent that they're seeing patients in advanced APMs, and it would still -- it would actually still preferentially, almost by definition, the way the models work, impact primary care more. They'd be eligible for presumably a larger book of business.

And so absent that, I would freeze them because I think it's increasingly difficult to figure out how to even measure them, and I also think that it becomes an increasingly big problem for specialists in multiple ways, including organizations that have -- large integrated organizations that include specialists in their advanced APM models who are struggling to meet those thresholds with them in, because they see lots of other patients from

outside the system. And so they're either dropping out of these programs, or they're taking those providers out. And you're sort of losing the whole aspect of being integrated for the purpose of the advanced APM.

I do think that -- I think there's some importance to maintaining them for now. It certainly becomes a big problem, I think, if MIPS is so much larger.

I think it misses a little bit of the point of why people are really attracted to them, and you've heard me say this before. But I think a lot of places use these not necessarily as "Well, here's my revenue maximization," but as I'm really interested in continuing to invest in my ability to advance and stay in advanced APM and stay at the cutting edge and the forefront and follow the signals that CMS is giving us, and yet there's so much uncertainty that I need something to kind of mitigate that risk. And there still is. Maybe it's a little bit better than it was 10 years ago, but these program models are constantly changing.

I'm hearing lots of stories about at least academic health systems who had been very successful and a number of the models dropping out of reach because the

models are expanding or developing in ways that they have trouble understanding quarter to quarter and until it's sort of too late.

So anyway, that would be my series of recommendations, but again, appreciate this. It's sort of an opus of work that ties together so many great things, and thank you for the opportunity to comment.

DR. CHERNEW: I want to ask Jonathan a question quickly. You said very early on that you thought the bottleneck to access was a lot of things related to training, I think, if I heard you correctly.

DR. JAFFERY: Well, the bottleneck to the physician supply.

DR. CHERNEW: Right. And so is the converse of that, the bottleneck is not payment? In other words, it's not physician fee schedule issues. It's a bunch of other education and other issues?

DR. JAFFERY: Well, I don't think people aren't going to medical school because physician compensation isn't good enough, if that's what you're asking.

DR. CHERNEW: Yes. Okay.

DR. JAFFERY: It may impact their choice of

specialty.

MS. KELLEY: Brian.

DR. MILLER: Thank you.

Just to focus a second on page 30, as Jonathan did, before I get to the comments, I know we measured corporate employment. As I said before, I think corporate employment reflects the salary that corporations pay. It doesn't reflect the -- or I'm sorry. We measured a salary. It does not reflect the adequacy of the PFS. Rather, it reflects the salaries that corporations pay employed physicians.

We also looked at medical school applications. I'd note that that market is a controlled market with licensure and certification. Not saying that that is a good or a bad thing. That might not also be the best measure.

And then when we do measures of access for Medicare benes, we're looking at qualitative measures. We're asking them. And as I've said before, if you're retired and someone says can you come at 10:30 a.m. two weeks from now on a Tuesday, your answer, more likely than not, is going to be I could probably make that work. If

you're employed, you have to get time off work. You have to potentially arrange childcare, coordinate with a partner. So I think we should switch to quantitative measures of access as opposed to qualitative, and I think if we do switch to quantitative measures of access, like Jonathan and Stacie have mentioned in prior meetings and prior sessions, that our specialty access will probably be a lot worse than the numbers are currently telling us.

I think something else that we should be thinking about is payment parity for different practitioner types. So if someone is delivering the same service, they should probably be paid the same rate. I know that that has been a longstanding concern in the Medicare program for certain professionals that have often been ignored or treated as second-class citizens by the program, even though they're providing equivalent value in a variety of settings.

Looking at our three options, I think Option 1 has many of the problems that my colleague, Jonathan, enumerated. While I tend to think that Option 2 -- or Approach 2 is probably a little on the rich side, I do think that the floor of half of MEI is good. And I think that having an update of less than MEI is a good idea, and

many of Larry's comments in prior meetings about the challenges that what the physician profession face have influenced my thinking in that.

And I'd also add I know that the Commission has historically supported site-neutral payment, and if we are supporting site-neutral payment, that means that many of those practices that health systems own would eventually convert to the physician fee schedule, and so if we are narrowing that gap and we're narrowing the gap by cutting and turning HOPDs into PFS and we know that PFS is inaccurate and -- I'm sorry -- inadequate in addition to being inaccurate across coding and services, then PFS probably needs to have a more significant increase in order to account for the implementation of site neutrality, our inadequacy of measure of physician compensation, and what is likely worse clinical access than our current data suggests. It's a long way of saying I'm a fan of Option 2.

Looking at Option 3, I think there are a lot of problems. The Congressional Budget Office scored CMMI as increasing spending. Looking at it, the CBO score from 2011 to 2020, we went from $2.8 billion in savings to $5.4 billion in expenditures. That's not good.

And then the projection for 2021 to 2030 went from, I think, $77.5 billion in savings to $1.3 billion in expenditures. That suggests that our $10 billion over 10 years that we're spending on alternative payment models, it's probably not very effective at reducing costs.

I can say that alternative payment models have certainly increased administrative burden for small physician practices and also large integrated health systems, and I think that the last thing that we want to do is increase the paperwork burden for physicians, nurses, and administrators and executive leaders at health systems, large or small, practices, large or small.

I don't think that we should be excited by sort of minuscule improvements in quality or cost that you might see with some alternative payment models. It's very hard for me to get excited about a 0.2 percent spending decrement or a 0.5 percent spending decrement with massive administrative overhead behind that.

And accountable care organizations, which seem to be a recent obsession of the health policy community, have not proven to be effective, and I think that we need to be more aggressive when we look at ways to save costs and

improve quality. And so instead of doing technocratic policy tinkering with alternative payment models, I think we need to think bigger, and we need to think more about risk-adjusted capitation and risk corridors.

I'd note that while the chapter shows a more positive view of A-APMs and the APM bonus, which I, as you can imagine now, do not support extending the A-APM bonus, there was a letter from Paragon Health Institute in October of last year sent to us, which unfortunately is not on our site, which denotes a variety of concerns about extending the APM bonus and notes other publications about CMMI and costs by Avalere and also the National Taxpayers Union.

So as a consequence, I think we need to think bigger about alternative payment. We need to stop technocratic policy tinkering. We need to think about big savings and big quality improvements, and I would say for the APM bonus, 14 years is a long enough trial. And it's proven that it doesn't work, and it's time to sunset it.

Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Geoff, Brian, and Rachel. I really appreciate this work. I think I echo my other

Commissioners' comments that it's really amazing how you've taken a very complex history and a complex topic and distilled it to something that we could understand across less than 100 pages.

So I also note this is a very important and tough issue, right? It's something that Congress obviously has been wrestling with year after year, and there's a lot of resources that end up getting allocated to the doc fix of the time. And so I think I'm very happy that we're surfacing some of the really important issues here and trying to take them on and try to offer some potential paths forward.

I also just wanted to echo Jonathan's points that access is something that's certainly complicated. I think Brian also in part mentioned some of them. And I think we should just be mindful that we don't perhaps have the best leading indicators of what's happening, and I think, in particular, there are parts that we know, that we know from our data that have challenges with access, such as behavioral health. And I think we should really keep that in mind as we pursue our work going forward.

Okay. So jumping into the approaches, I favor

Option 1 more from a conceptual reason perspective than an operational. In fact, I think there's a number of operational reasons that could make it challenging.

One of the reasons I asked about this question around what do the other updates look like that are inflation-linked, I think they're kind of analogously practice expense-oriented in some sense. They're the input part of how the payment works, and so I think that's conceptually more appealing in some sense. I think it relates to site neutrality. Perhaps it's related to consolidation, although I do understand that the deltas we're talking about here are relatively small, relative at the -- deltas between the options, I should say, are small relative to the delta levels that actually exist.

And I also understand that as this were to happen over time, the wage element would become a problem because it would become much smaller relative to the practice expense.

What I wonder to some extent, is the way that Option 1, in some sense, creates issues for how wages look relative to practice expense and how they might relate to RVUs over time -- is that a feature and not a bug? Maybe

the way that the RVUs are currently constructed and, probably more importantly, the way that the fee-for-service rates are constructed off of RVUs is something that could be improved.

And so I think if Option 1, to some extent, sort of stimulates thinking from us and perhaps others on how we might create a rational path forward, that is more in keeping, in some sense, with the way the rest of the Medicare program works from a payment perspective. Maybe, again, that's a feature, not a bug.

That being said, I understand the operational considerations and complexities here, at least I think I do. I probably don't understand them fully. And so, you know, should the Commission move in the direction of Approach 2, I would also support that. I just sort of have a preference for Option 1. I think the distributional results are certainly more reassuring relative to Option 1. I think that's notable, you know, particularly, again, with respect to areas like primary care and behavioral health, in particular.

I will say, you know, as a MedPAC policy principle, especially as we've done work across multiple

sectors in the past, we've generally held this principle that we shouldn't try to achieve a secondary policy objective through, you know, tweaking a different policy. And so I feel a little bit of consternation in some sense about viewing the distributional effects when we're thinking about really addressing inflation in some sense.

But nonetheless, I think, given the pragmatic realities, I certainly feel like, you know, I could support Option 1.

To Approach 3, so I strongly support extending the A-APM bonus, and I also very strongly support Jonathan's suggestion around restructuring it. You know, it's striking, I think, to many who are working in the space who are participating in APMs and A-APMs nationally. It's hard work, but also there's, generally speaking, a dearth of specialist participation. It's hard to get specialists to participate, even though there's a lot of dollars there.

And I think if we could structure this in a way -- and I think Jonathan's suggestion is a very good one -- which isn't, you know, you meet a threshold, and then you get a bonus across your entire panel of patients,

regardless of whether those patients are actually in the APM or not, it actually doesn't make that much sense. And it sets up all these big threshold effects that the Commission has previously said threshold effects are not good for, I think, very good reason. And so I would very, very strongly, again, support Jonathan's suggestion of extending the A-APM bonus but restructuring it in the way that he suggested.

So thank you again for your excellent work. I really appreciate the Commission taking this on.

MS. KELLEY: Stacie.

DR. DUSETZINA: All right. Thank you very much.

And I always hate when I'm landing on a different side than Amol's comments, because I think I'm like, okay, what is wrong with my thinking here? But I'm going to go for it anyway.

[Laughter.]

DR. DUSETZINA: So I think, in general, on the policy options, I really like that Option 1 tries to rebalance between facility and non-facility. I think that's really important.

But I think the issue you brought up around the

potential, you know, disproportional benefit for primary care and behavioral health made me really not like Option 1, and I also just don't have a good sense. I guess I was skeptical about the possibility of revaluing the fee schedule in the RVUs. Like, that sort of felt like a big leap to get all the way there.

And for those reasons, I think I felt a little bit more inclined to say Option 2 seemed maybe more achievable, and also that it wouldn't create those inequities for the primary care and behavioral health.

I think the other thing that I just struggled a little bit with -- and in the chapter on page 37, you show -- and 38, you show this great figure of, like, the updates, the MEI, and then spending per beneficiary. And it sort of seems like the elephant in the room here is, like, we've had such a growth in volume and intensity, that it's kind of made up for this lower level of updates, if I'm reading it correctly.

So I guess when I was looking at that, I was thinking, okay, so if we do start to increase payments, how do we avoid this from getting even worse? Because the volume and intensity, I don't think will come down unless

you do more alternative payment models. So I think you kind of have to reconcile those.

And I wonder if, like, drawing a more direct line to those, you know, like this is one of the potential benefits of alternative payments is it reduces the incentives for this intensity and number of services -- I just felt like it was only kind of dawning on me during the initial parts of this discussion that this does make Option 3 feel really important as a combined factor.

But I think this is great work again. I really appreciate it.

MS. KELLEY: Kenny.

MR. KAN: I'm very enthusiastic about this excellent chapter. Thanks very much, Geoff, Brian, and Rachel.

I prefer Option 2 to Option 1 due to its administrative and distributional simplicity.

I do, however, remain concerned about the current distortions because I think PCPs remain underpaid, and I'm also concerned about, you know, basically ensuring that we have a good access of safety net clinicians.

You know, MedPAC, the Commission, has done a lot

of good work, you know, with the MSNI. So I'd like to propose for future work on this to possibly consider a modified Option 2, which will help to mitigate some of its distortions.

The framework I'm going to throw out, I would view that more as directional and focus less on the details, but it's more directional construct. Could we possibly consider the following modified Option 2? So for 60 percent of MEI for all safety net clinicians, 50 percent of MEI less half a percent for non-safety net clinicians who are PCPs, and then 40 percent of MEI less 1 percent for everyone else. Again, focus less on the details and more on the general directional construct to help address some of the payment distortions.

Thank you.

MS. KELLEY: Lynn.

MS. BARR: Thank you for an excellent chapter.

I am in favor of Option 1, but I would -- very similar to what Kenny's saying, I would do something differential for PCPs and behavioral health specialists.

So when I looked at that, I said, well, certain specialties should get the top amount. So you just give

them, say, whatever. You know, all PCPs get whatever that top amount is that we're paying to everyone else, and that would help create more parity and I think solve the number one problem with Option 1, although there is certainly administrative burden, but it seems much more fair.

I would also consider -- if I understood correctly, physicians have lost 20 percent payment since we've started with MIPS, and over time, their actual versus inflation is down 20 percent. And you could start this by giving a one-time 20 percent adjustment just to PCPs and behavioral health by justifying that their actual purchasing power has dropped by 20 percent since we've implemented MIPS, and they are certainly underpaid.

Related to the A-APM bonuses -- so, Brian, to your comments, CMMI -- A-APMs are just a tiny little blip. So when we talk about the A-APM bonuses, we're really talking about the Medicare Shared Savings Program, and I believe you made a comment saying that the MSSP has not been shown to actually improve quality or lower costs. And I believe that -- oh, you said A-APMs. Okay. You said A-APMs, and it is almost all MSSP. And I do want to make sure that -- unless there's been some new research

published that I missed, it's actually saved quite a bit of money for the government.

I know for in our case, we saved the government more than $500 million, and we got less than half of it back. And they are definitely in the black. And so I do think we want to continue to encourage providers to participate in the Medicare Shared Savings Program.

I do agree with your comments about CMMI and kind of the return on investment on CMMI is not really panning out, but that is a separate situation.

I would definitely say that, Jonathan, you get the award for the best idea of the cycle --

[Laughter.]

MS. BARR: -- of saying let's just pay them on the patients that are actually attributed to them. So that -- because it was incredibly hard to recruit specialists, because none of them could make the threshold. So this would give them money, and then I would continue to pay the 5 percent because the PCPs will get 5 percent on most of their patients, right? And that again starts narrowing the gap.

I do really like the fact about Option 1, that it

does narrow the gap between physician payment and hospital payment, and I know we're not supposed to, like, hit multiple policies at once, but I find it's actually quite efficient, you know. And if this encourages hospitals to move towards the physician fee schedule, because the burden on the patient of getting two bills and the fact that the hospitals are getting complaints all the time, is they would trade something off for that. And if you can narrow the gap between these two, then we might be able to actually solve site neutrality in a more reasonable way.

Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. Great work. I tried to think of the right analogy for my experience reading through this, and I decided it was jumping off a high diving board. You go deep pretty quick, whether you want to or not, and it takes a certain amount of work to get back up to the surface.

[Laughter.]

DR. SARRAN: So I'm a little out of breath when I do that. So, hopefully, that will keep my comments short.

All right. So I tried to think again through the

lens of prioritizing what we're trying to solve, and then I modified that to think we're not -- we don't have enough money in play here to solve any of the big-ticket items. So it's more, I think, around directionally what signals can we send to the market. So through that lens, how do we adjust for inflation, because I think we all agree we want to do something in that, I thought trying to address what's a really egregious, clear-cut problem, which is your costs of running the practice go up with inflation, it's not under the docs' control, versus the work component. You know, that's squishy. And, you know, some work gets harder, some gets easier. Some new work gets harder, but it's got new CPT codes. So that led me towards Option 1 for that reason.

And also, do away, as you suggested, with the global surgical fee. That's just easy money to be saved, because it makes no sense.

Then in terms of the A-APM and the MIPS piece, I looked backwards from what CMS has already said, which I fully agree, which is we got to get to a world where somebody's accountable on both the MA and the traditional Medicare side of the table, and that requires essentially

global participation in A-APM.

And so the simplistic -- and again, I try to think simplistically, especially if I'm wet and short of breath, et cetera -- is let's do away with MIPS. Whether we have to phase that out or do it, you know -- or rip the Band-Aid off, do away with MIPS. Put all of that money into an A-APM participation bonus, because I think that, again, it's a necessary -- the global participation is a necessary -- admittedly insufficient but necessary step to get to the world we want to be in, primarily, by the way, driven by the reality -- and we've discussed this in other sessions -- of an increasingly aging population with a lot of chronic diseases and the total round peg/square hole of fee-for-service medicine for dealing with beneficiaries with chronic disease.

Thanks.

MS. KELLEY: Larry.

DR. CASALINO: A lot of very interesting thinking from the Commissioners, I think, and a good session.

I tend to favor Option 2, and I'll come back to why in a couple of minutes.

I do want to say, before I forget, there's a

couple of slides labeled additional proposals that are mostly around kind of trying to get payment right, trying to reform the RUC, get RVUs right, eliminate the global surgical fee. I think those are all really important, and I hope we'll keep hammering away on those.

The first thing I want to say about Option 2 is that there is a slide, in the written materials, at least, that shows between 2000 and 2022, inflation as measured by the NBI was 48 percent, right? And the increase in the physician fee schedule was 12 percent. So, you know, you look at the diversion lines, and it's pretty stunning. And so if you're a physician, you look at that, and you think this is manifestly unfair. How can anyone be talking about, okay, we're going to go forward, we're going to do 1 percent less than inflation every year, and that's going to compound? So I do think that's the way almost all physicians see it, and probably, the kind of average person just looking at this would think, whoa, this is really unfair.

But what has taken me a while to understand, since I've been on MedPAC, is that our job really isn't to evaluate fairness, because we can't. I mean, Brian was

talking about earlier, in an earlier session, who can say what a lawyer should get paid or what a physician should get paid or a nurse practitioner or, you know, what a pharmaceutical company should earn? We can't really decide that.

And so the MedPAC -- I think MedPAC long ago figured that out and has adopted a policy trying to say we shouldn't pay more than we need to pay to get the access and quality we want, whether it's physician services or any other kind of services. And so that's our response to looking at that graph, 12 percent versus 48 percent, saying this is manifestly unfair. And I think our response is, well, we can't really judge that, but we think we're getting the access and quality we want, and therefore, what's being paid to physicians under the fee schedule has been okay.

No, the catch in that is, I think -- like I and other Commissioners have brought up at other times is that we probably can't measure access as well as we come across as measuring it. The kind of secret Chopra study, that pretty big study that I circulated a couple of weeks ago, shows that access really isn't so good. And I think,

anecdotally, a lot of the Commissioners feel like it isn't. Now, that doesn't mean it's worse in Medicare, than fee-for-service, but it's just not that good. So I think we want to keep trying to improve on our way of measuring that and thinking about that.

And quality, of course, is even worse. I think we're not just paying what we -- we don't want to pay just what we can pay to get access. We want to pay what we have to pay to get quality. Quality is really hard to measure, and so this is a problem.

I mean, I think there are reasons to believe -- and I've said this before as well -- that if you have a group of people who are directly responsible for taking care of people and they feel like they're being treated, year after year after year, extremely unfairly, it's not too much of a stretch to think that the effort they put in and the amount of time they'll give to patients is not going to be the same as if they felt they were being treated more fairly. So, again, I'd like us to kind of try to keep that in mind.

Partly, it is a framing issue. I mean, I think we could do a better job of framing. Our job is not to

decide fairness. Our job is to decide what we need to pay to get what we want from people who provide medical care, and I think we could do a better job on that, because it took me at least a while to get my mind right.

Okay. Enough preamble.

[Laughter.]

DR. CASALINO: That makes it sound like I have a lot more to say, but actually I -- no, no. What I have to say now will take less time than what I already said.

So why do I think Option 2 makes good sense? And I can be quick about this. I think it's simpler than Option 1. It's easier to understand. It will make things more predictable, and at least in the short run, it shouldn't have major effects on access or quality, I don't think.

But I think that it's best not -- I think leaving the physician work updates as something TBD is not a good idea, and that's what Option 1 does. I think it is really our responsibility to address how do we address inflation in the context of physician work. So that's another reason that I like Option 2 more than Option 1.

I think in terms of framing, by the way, that we

do say it in the written material that both Options 1 or 2 would lead to higher physician payment over time than current law. So we're not -- again, in terms of physicians' thinking, this is unfair. We're not actually making things worse than current law. Either option would make things better, for what that's worth.

By the way, Stacie kind of indirectly alluded to this. I think the fact that volume has increased a lot is partly due to the fact that physicians do work faster, I think, when they feel like they're getting paid less.

Then the last thing I have to say is Option 2 does not deal with the site-neutral physician office versus OPPS facility problem, and I think that is a huge problem, even aside from its effects on vertical consolidation. And the effects are huge. I mean, again, in the written materials we have, you do a 99214, you know, moderate level of work, visit in your office as an independent physician. Medicare pays $128. You do it in an OPPS, and the total Medicare payment is almost double, $218. I mean, that is really, really, you know -- I know that there are justifications for some difference, perhaps, but that can't go on.

So I do think if we do move at some point to advocating some form of Option 2, we do need to combine that with recommendations, not only to reform the payment rates, the RVUs, but also to look at -- to try to reinforce our support for some form of site-neutral payments and moving in that direction.

And as promised, that's all I have to say.

Oh, I should just mention A-APM bonus. Actually, I defer a lot to what Jonathan, in particular, and other people have said about this. I do think that some bonus for some more years makes sense. I don't know that it needs to be 5 percent. I mean, Jonathan expressed reasons why it's worth giving some money, basically to give people some assurance that they're not going to just spend a lot of money to try to do something and not get anything back.

But on the other hand, the counter-argument is I don't think government -- I do think A-APMs are somewhat desirable, but I don't think government should put its thumb on the scale too heavily. I mean, really, if they're so good, they should be able to be so good. And Brian is agreeing with me on this. They should be able to make money, right? They should be able to do enough for quality

and spending to make money, and that should be the reward, not year after year, government just giving a subsidy.

That said, though, I do think that giving a couple percent a year for some years to come makes sense. The long discussion in the materials we have of how the potential MIPS bonuses kind of complicate the thinking about bonuses for A-APMs is just, to me, another reason to get rid of MIPS. And I hope we'll double down on thinking about that and making recommendations about that in future years.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. Thank you very much for this great chapter and this interesting conversation.

I'm going to start with Approach 3, because I see it not being mutually exclusive. I view -- even though it's been a number of years that A-APMs are not fully mature, and it takes a lot of transition in provider behavior to really make this happen. So I do support the bonuses for a number of years, and at the 5 percent, just because, you know, to make it less confusing.

And I love Jonathan's idea that's been supported by Lynn and Amol and others, that on the patients in the

model and eliminating the threshold effects. I think that's really important.

In reading this, I initially was drawn to Option 1. I like the separation of facility and non-facility, and I can't help but thinking, of course, non-facility is often people, which are professional services. And much of the inflation is actually around the people that are staff in these organizations who are, as you can see with all the activity, the unionization, people just not willing to be putting up with not earning what they think they should.

But I'm not absolutely opposed to Option 2, and I would need to think more about Kenny's suggestions, which sounded very interesting, and also, the piece about site neutral I think is really important as well.

In terms of MIPS, I know before that I was on -- before I was on the Commission, it was voted that it's not supported. I just have to, again, say the one thing that I always thought was so positive about MACRA and the APM and the MIPS model is, one way or another, providers would be taking on financial risk for cost of care. And whatever we do, I would like us not to lose that because at least the literature I look at talks at when you're taking on risk,

you start thinking about waste, unnecessary care, efficiency, innovation. So that's a piece I would really like to hang on to.

I support Brian's comment on payment parity. I think that's absolutely essential.

And, Jonathan, if I understood you correctly, the bottleneck that you're seeing is in the clinical training aspect? The clinical training is the bottleneck? I just want to also broaden that comment to underscore that that's also true for nurse practitioners and PAs but also basic registered nurses and maybe others. I don't know. But organizations, hospitals, and others are so strained that they're providing less of this clinical supervision, that they were doing for free, right? They can't afford to do it. So students are less prepared. They enter the workforce. There's more turnover. So this issue of how we really think about the working surface of preparation isn't directly a physician payment piece, but it is within our lanes in terms of what we incentivize and what we do. So I think that's really important.

I'd also just say I recently read something that there's not a physician shortage. It's maldistribution,

too many specialists. This was in -- I can't remember -- Wall Street Journal or something, but burnout, unhappiness, frustration. And a lot of that relates to many things, including measurement and others. But we have the same situation with nurses. There's 5.2 million more than we've had, but we don't have nurses willing to work in the conditions that we have.

So I think when we're thinking about this, you know, I know it's a broader issue than is easily done here, but I think it's really important to think about all the tentacles.

So I think that's what I have to say. Thank you very much. That wasn't just my preamble. How did I do?

[Laughter.]

MS. KELLEY: Greg.

MR. POULSEN: Thank you. And let me just pile on with great work. Well done. Fabulous chapter. Thank you, guys.

I'm troubled by Option 1 for a number of reasons that have already been mentioned. I want to just combine a little. I think it runs the risk of increasing distortions that already exist and then exacerbating those. That

troubles me a lot.

And it also links payment to something that's outside of the real cost trends associated with physician practice, which I think has the chance of introducing additional distortion. So I think I would strongly prefer something that isn't No. 1.

And No. 2, I think goes pretty much to where I want to go. I do want to say, though, that while I don't want to create additional distortions, I think it would be a mistake to try and assume that we can fix all of our historical distortions with this process. I think this makes it really, really -- it would make it really, really complicated. So I think there are better mechanisms to do that. So with that said, I lean towards No. 2 in some form.

What I'm not wedded to in No. 2 is the minus 1 percent. It seems to me that what we could look at is -- the thing that led us to No. 1 one as even an option was trying to narrow some distortions that exist. I think we could accomplish the same thing by doing No. 2 and then saying, hmm, maybe it shouldn't be minus 1 percent. Maybe it should be zero. Or maybe over time, it should be minus

2 percent. But allowing that to go where the market requires us, as we head that forward, would be my prejudice there. So we can make it leaner or richer.

Big support for Jonathan's thought on linking Option 3 and Option 2 and strongly support the non-threshold concepts that he identified. I think that just makes tons of sense. I think we have repeatedly -- we, MedPAC, have repeatedly pointed out the problems of thresholds and how it can create distortions of their own, and so it'd be nice to avoid that.

And while I absolutely believe in the value of A-APMs and the pathway that they take us down -- and I agree with a number of the points that have been made -- we haven't gotten there yet. I do think that we're getting the path moving in the right direction.

I would like us to see -- and I don't think it's part of this, but I just wanted to state that to the extent that we can move more rapidly towards greater accountability that's associated with that -- and Betty just mentioned that. I think Brian mentioned that. -- I think that those are all very good things to do. But I think they're a little separate from this issue, and the

concept of making sure that what we don't do is discourage people from heading down the value enhancement path, and the accepting accountability for financial as well as clinical outcomes path, I think that would be a good thing. So I like the idea of mixing Nos. 2 and 3 accomplish that.

Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you.

So I realize we're trying to solve for lots of different problems, and I guess I feel like I want to go back to what I think are the core things, because to some extent, what's being proposed here feels like kind of a Band-Aid on top of some of the more core things that I think we have been talking about at many of the prior meetings, which is focusing on site-neutral payments if we really want to discourage some of the consolidation pieces, because those differentials are still large and I think driving a lot of behavior.

Secondly, I think we need to double down on improving the accuracy of the work RVUs. I agree with reforming or getting rid of the 10- and 90-day surgical codes. That's like a no-brainer.

And I would double down on repealing MIPS. It's creating all sorts of distortions and kind of creating challenges that we're trying to solve in this discussion. And I think the incentives on the MIPS side are too large. They're distortionary. I don't think it's been leading to quality improvements. So I would just support our continued push to repeal MIPS.

But I guess part of where I thought we were coming from is trying to think about the growth in inflation and trying to help physicians deal with that piece, and so as I look at the two options that were presented to us, I think I'm leaning more in favor of Option 2, both to maintain the balance between the different components in the physician fee schedule but also fewer distortionary effects.

And then I think with regard to the participation bonus, I'm very conflicted about that. I sort of feel like we're far enough into the game that maybe we shouldn't be doing that any longer. But I also understand that we're still in this evolutionary process and trying to get systems to transform, and so some continued payment to them to help them move in that direction, I think, is probably

warranted.

And I appreciated Jonathan's suggestion about how to fine-tune that by having more specificity around the participants in the A-APM as opposed to just their book of business within fee-for-service. So I think that's a really nice refinement.

MS. KELLEY: Gina.

MS. UPCHURCH: Speaking not as an economist but hearing some things on the ground, I think it's clear that we need to do something around inflation for provider practices, and I'm not sure exactly what that is. But, you know, it just needs to be addressed somehow, and it needs to be addressed in a forward manner so that every year there's not this congressional request that, you know, at the last minute, people have to go back and re-adjudicate things. That just seems so messy and so administratively burdensome to everybody. So I just feel like inflation needs to be addressed one way or the other.

Trying to promote value over volume and, you know, what we do now oftentimes, if you're going to decrease what you're going to pay somebody, they just do more of it to get paid. So, you know, how do you get away

from that? And it seems like A-APM is a good way to do that, but that requires some -- I love Jonathan's idea of the attribution. I have a question about it, though.

So if I'm a primary care provider and Scott is a specialist and Cheryl is a specialist, how does that patient get attributed? Fifty percent to me? Twenty-five percent there? Twenty there? I don't really understand how that would work if you did it proportionally.

DR. JAFFERY: So it's not an attribution of the patient. It's an attribution of the dollars. So if you're a primary care doc and you're billing Medicare, getting paid by Medicare for your patients in advanced APMs, which presumably is a primary care doc, you're probably -- it's the bulk of them.

MS. UPCHURCH: Right.

DR. JAFFERY: It's those payments. If Scott is a specialist and he sees people in an APM, in an advanced APM, and he's getting paid, you know, $10,000 for the care he provides to them, it's a bonus on that $10,000. So it's tied to the compensation you're getting.

MS. UPCHURCH: Okay.

DR. JAFFERY: It's not an attribution.

MS. UPCHURCH: Yep.

DR. JAFFERY: So that's not the number of patients. This gets away from that.

MS. UPCHURCH: That makes a lot -- and I really like that idea because it seems very unfair to have some providers who can't be a part of this bonus situation.

And that fits into my last comment which is if we want people to be innovative and we also need to hold them accountable, you need to give them some flexibility, even in the fee-for-service world. So I feel like this bonus payment, paying attention to inflation, gives the leeway within practices to be innovative. But we do have to hold them accountable in the end if there's more expense than should have been.

Thanks.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. So I think we are in the piling-on stage of the comments, and I'm happy to pile on. I agree with many of the comments already made.

I lean towards Option 2 because I think Option 1 does introduce more -- you know, some folks called it the "distortion effects." You know, the distortion there would

be based on practice expense and disproportionately hitting across some specialties versus others. And obviously, the concern especially is that it happens to disproportionately cut against primary care, which I think just feels like that's the wrong path to go down.

So Approach 2 makes a lot of sense. I'm iffy on the exact amount. I think Greg's comments are spot on, at least as I would agree with them. And I think that can be fluxed over time too, depending on, you know, where the situation calls for -- and maybe that's rolled into the annual payment adequacy section. I don't know.

As far as Approach 3, I also really like Jonathan's idea, but I'm also very supportive of maintaining the bonus. And I think it's probably for many years still. I think Betty, I would totally agree with her. You have an entire infrastructure of the health care industry delivering care in a way that we're trying to change, and we've been at it for, yes, a handful of years. But the way we got here happened over decades. I don't think the way we change happens over just a matter of years, and so I think those investments still need to be made, which is why I'm supportive of maintaining those

bonuses.

MS. BARR: Can you tell me what percentage of physicians participate in advanced APMs?

MS. BURTON: It's in the paper, kind of. So one in five clinicians who bill Medicare qualify for the bonus, but then there's another, like, 100,000 that are in other models that don't quite qualify for the bonus. And then there's, like, a chunk of clinicians who also don't qualify for the bonus.

MS. BARR: So roughly 20 percent. So we got a long way to go.

MS. BURTON: Yeah.

MS. BARR: So just wanted to make sure everybody knows that, that's watching from home, is we are not there.

MS. KELLEY: That was the end of Round 2, if my queue was correct.

Okay. So I'm going to say a few things, and then we'll see where that goes, depending on time. But as I said at the beginning, this is the beginning of a conversation, not the end of a conversation. So we're not going to resolve everything now.

I think this was a remarkably rich conversation

and really quite useful. I'm going to -- some combination of summarizing and giving my own thoughts on some of these things. I'm going to start with the A-APM bonus. So one of the core issues is, why are you doing it in the first place? And I think it's pretty clear that after a long time, the notion of we just like APMs, we need to give you money to stay in, at some point, that's got to sunset. We can debate what the point is, but the motivation of we need to compensate people for being in A-APMs, so then they can save us -- just doesn't seem to me a sensible way of going about it.

The motivation of balancing it with MIPS and making sure that people aren't getting distorted because of other problems, in many ways, makes more sense to me. And in fact, as I wrote in a message to you all, the idea of compensating for some issues with A-APM design also could make sense to me. That didn't really come up here, but what I've heard around the table is, sure, if you got rid of MIPS, my view on the A-APM bonus would be very different. I think that's a reasonable thing, and we have that recommendation. I think Cheryl's word was "double down."

But anyway, the other thing I'll say about the -- so I think thinking through our motivation for what you're doing, it turns to drive how you think about it. And I'm much more focused on the balance and the kickstarting kind of motivation.

I think this other issue that actually is quite important is by having the bonus be a multiple of your fees, it's a little bit odd that you're trying to get people away from a fee-for-service incentive. So if you're in the model where you don't get paid fee-for-service, we're going to increase your fee-for-service payment. So I think thinking about the form and the incentives matter, but to Jonathan's point -- and I think he is spot on -- putting on all -- it is clearly worse to try and get people out of fee-for-service than bonusing their fee-for-service payments on all of what they get. So I think we have some thinking about that structure, about how we can deal with the incentive effects and the balancing effects and doing things like that, and I think we will do that.

With regards to Options 1 or 2 in terms of the inflation update, I don't have a strong opinion, and this conversation was quite useful.

I will say a few things. I want to re-up on an Amol comment, which is I am less concerned about the distributional consequences of Option 1, because I believe that if that were my concern and even if we don't do any fee-for-service, we have to deal with the supply issues of behavioral health and primary care, independent of whatever we say here. And in fact, in some ways, if you did Option 2, the dollar amount -- if you're getting paid more and you get 1 percent more, it actually increases the disparity of the way that things play out. So we're going to have to deal with that distributional consequences, no matter what we do.

I think the bigger issue that I struggle with -- and, Larry, I have to say I was unbelievably happy with your preamble, because you captured the arguments that I would have said stunningly well, both the ones that I would have said and then your response to mine and then my response to yours. So let me try and just reiterate where that is.

There is this common argument that we have to do something about inflation because it's just wrong that physician fees are degrading because of inflation, and if I

wasn't sympathetic to that argument, we wouldn't be having this discussion. So as my preamble, I am very sympathetic to that argument.

That being said, it is not clear to me that fees in -- pick your year -- 2005, 2000 -- were right in any meaningful way. And it is the case that despite this degradation in fees and for I think a bunch of other reasons, access might not be good, but the evidence that has been deteriorating despite all of this has been pretty scant. We can certainly do a better job. I personally am not going to wait until we get better evidence to act. I think we're going to need to act before we get the evidence. But it is not transparent to me that this decline in fees has caused this huge problem right now, which leads to the concern that if we were going to get a 20 percent bonus, some other bonus, what are we going to get for it?

And that led to my question to Jonathan, which was there's a lot of workforce issues, as has been pointed out, and many of them transcend payment. And so the question is, if we were to pay all the extra money that we would pay if we did this, would we get better access, or we

just have a bigger bottleneck pressure because we aren't training things correctly? Not -- "correctly" is not the right word. We have to deal with other supply issues of both physicians and non-physician labor.

I don't know how to think through that quite well, and so, luckily, we're going to have time to sort of grapple with that.

I do worry a lot about what Scott said, and I wish I could say it as eloquent as you said it, Scott, which is there's this real obvious cost issue for the real practice expenses. I have to pay for my rent. I have to pay for my, you know -- and you're not compensating me for that, and that has problems. And that's a very tangible thing. There were some words you used. The word "cost," conceptually, is a much squishier comment. It's what do we have to pay in order to get the access. Larry, you said that quite well.

I don't know exactly the answer. So we need to think through that with the -- I'm going to funnel the staff. I get the privilege of talking to them a little bit more before is -- we're going to -- whichever of these we use, we're going to need patches. And the practice expense

process, how we measure it, what data we get, when we get the data, how we update it, how we allocate the indirect practice expense relative to the direct practice expense, how we build the professional component into the practice expense stuff that we were talking about, all that stuff is all very complex. And so the operational things, the operational aspects of Option 1 bother me much more than the distributional aspects, because I think the distributional aspects we are going to have to deal with anyway. But that being said, the operational aspects, I believe, are actually really real.

So the last thing I'll say on this before maybe a very quick Round 3 is that, just so everyone understands, we are not going to make a recommendation and avoid physician updates. What this is really about is what the default is, sort of what current law is. There will always be a situation that MedPAC will say, oh, you did MEI minus 1. You need to pay more than that because we see a problem. Or you did MEI minus 1, and there's not a problem at all. You should cut it. We are really just changing the default of how the update discussion would go, but we are not replacing the physician update discussion or the

discussion of MIPS or the discussion of practice specialty distribution or the discussion of any of the other things.

So that's kind of where I am, and I really appreciate many of the comments that were made around those points. We have a summer to come back and think about what we will do and how we will weigh some of these particular things. And if you have further thoughts, you should feel free to reach out.

I think we have time for one, at least now, Round 3, and Scott is in the queue.

UNIDENTIFIED SPEAKER: And Brian.

DR. CHERNEW: Oh, yes. Brian is in the queue and then Scott, and then we're going to move on. Brian.

DR. MILLER: I'll be even shorter than Scott, so Scott can talk to you.

I think an idea about PFS and site neutrality, one thing that we could think about, separate from this discussion as a separate discussion, is creating a facility-based bucket of services on the PFS that are slightly higher than PFS but still less than HOPDs or ASCs. That might help with some of the payment disparities between, say, vascular surgery and primary care, and that

way, the update might be applied differently, right, because it would still be the same update, but there would be a bigger practice expense component for a lot of those procedurally intensive services.

Shamelessly, not my own idea -- fed to me by an ophthalmologist over a year ago, and I think it's actually a very good one. And I first heard about it in the context of cataract surgery. So this might be something that we could explore broadly as a group if people are interested.

DR. CHERNEW: Just to say quickly, we did have a discussion about if you were going to do Option 1, Option 2, how would you deal with the inequity on real practice expense, and that is a version of that. And there's some indexing aspects of that. There's some measurement aspects of that that are important, and I agree with that completely.

Scott.

DR. SARRAN: Just a brief comment about A-APMs, and what I think we realistically should think about is the key marker of success for A-APMs, and I don't think it's about saving money for the following reason. I think what we really want A-APMs to focus on is improving the care and

outcomes for beneficiaries living with chronic diseases, either multiple chronic diseases or a single chronic disease -- for example, anything more than early stage heart failure, COPD, or dementia -- because the reality is it takes investments in an ongoing way into building true team-based care and using a variety of innovative approaches to keep those beneficiaries out of the hospital. So you're basically -- so revolving stream of money. You're saving money by keeping them out of the hospital, but you're spending that at the front end. So I just think we should think about how we frame, again, measures of success, because I don't know that it's realistically all that easy to save money in that population. I think it is absolutely achievable to drive better outcomes with the same net spend, though, and I think that's what we should be talking more about.

DR. CHERNEW: Thank you for that, and there was one thing on my notes that I forgot to say that's important to think about in this space.

Because of the role of conveners in the alternative payment model space, a lot of people can participate. We often think about the standalone practice,

and that's if they have to participate or not. There's an evolving ecosystem to allow people -- thank you, Cheryl -- because I can't speak, I need like a Gary to whisper in my ear what to say, if you know that reference. I do think we have to think about how the system is evolving as this happens. It gives people a lot more opportunities they might have if they were just a standalone practice, because they can be rolled up and work with others.

Anyway, that being said, we're going to take a five-minute break, and we're going to come back.

Oh, Amol is going to have a quick Round 3, and then I'm going to add his time by the way your Round 3's get added, and then we're going to take a four-minute break.

DR. NAVATHE: So my quick point is I'd be curious to hear, at a subsequent time, people's receptivity to the idea of actually having as part of our recommendation, explicitly calling out collecting better practice expense data and the other elements to make this whole thing work better, because I think it's so fundamentally important, that it could be in the language, but I think actually having it standalone together with the other parts of the

recommendation could be very good.

DR. CHERNEW: We're going to take a break. Come back in four-ish minutes.

[Recess.]

DR. CHERNEW: Okay. We are now going to bring the day home with our discussion of the encounter data and related ways to maybe improve it in Medicare Advantage, and I think we're going to start with Stuart. So, Stuart, you're up.

MR. HAMMOND: Thank you. Good afternoon.

This presentation is a follow-up to our March presentation in which we compared MA encounter data with independent sources of information about MA enrollees' use of services.

We'd like to thank Luis Serna for his work on the material presented today.

In today's presentation, we compare MA encounter data with other data submitted by MA plans. The material presented today will be combined with the material from March and included in a chapter of our June report.

Before we get started, I'd like to remind the audience that they can download a PDF version of the slides

in the handout section of the control panel on the right side of their screen.

We will begin today's presentation with an overview of the data that Medicare collects and uses to administer the MA program, focusing on encounter data, bid data, and HEDIS quality data. We will then present the findings from our comparison of the encounter data and other plan-submitted sources and discuss the implications of our findings.

MA encounter data contain information about the health care items and services provided to MA enrollees. Detailed encounter data are essential for oversight of the care provided to the more than half of Medicare beneficiaries who are enrolled in MA. Without valid and reliable data, there is limited understanding of how payments to MA plans correspond with service use, quality of care, and use of the extra benefits that MA plans offer.

In addition to oversight, complete encounter data could be used to inform policy discussions and generate ideas for improving Medicare as a whole.

Through reports and presentations since 2019, MedPAC has found the encounter data to be incomplete and

has concluded that the current incentives to submit encounter data have resulted in only incremental improvement.

In 2019, the Commission recommended additional steps to increase encounter data completeness and accuracy. The recommendation directed the Secretary to establish thresholds for the completeness and accuracy of MA encounter data, to evaluate MA organizations' submitted data, and to provide feedback to plans using completeness metrics.

In addition, under the recommendation, a payment withhold would be applied, and CMS would provide refunds to MA organizations meeting encounter data completeness thresholds.

Finally, the Commission also recommended establishing a mechanism for direct submission of provider claims to Medicare administrative contractors. If program-wide thresholds were not met, the recommendation would require all MA organizations to submit claims via the administrative contractors.

One way to assess the accuracy and completeness of MA encounter data is to compare the data with other

sources. This figure gives a simplified overview of the data that Medicare collects from health care providers and MA plans in order to administer the MA program, focusing on the sources that will be addressed in today's presentation and in our June report. I'll discuss each source in more detail in the next few slides, and additional details about the data are available in your reading materials.

When serving Medicare beneficiaries under the fee-for-service program, providers submit claims, i.e., billing information, directly to Medicare. Because claim submission is required for payment, providers have a strong incentive to submit claims, and claims data are generally considered to be a complete record of the services provided to beneficiaries under fee-for-service.

When serving Medicare beneficiaries enrolled in MA, providers submit claims to the enrollee's MA plan, and the plan adjudicates payment.

CMS, and therefore researchers, generally do not have access to MA claims data. Instead, starting in 2012, plans have been required to submit encounter data for the items and services provided to their enrollees. The encounter data include much of the same information that is

on claims. However, because the data submission process is separate from the plan's payment adjudication, the data might not be complete and might not have the information used to adjudicate payment.

There are several instances in which providers submit information about MA enrollees directly to Medicare. For inpatient and skilled nursing claims, an information-only copy of the claim is submitted to the plan and is also generated and submitted directly to CMS. CMS combines the information-only claims for MA enrollees with information for fee-for-service beneficiaries in the Medicare Provider and Analysis Review File, or MedPAR, which is used to determine DSH and graduate medical education payments for certain hospitals.

In addition, for post-acute care, providers submit patient assessments for both MA and fee-for-service patients. Assessments are collected through the Minimum Data Set, or MDS, for skilled nursing facilities, and the Outcome and Assessment Information Set, or OASIS, for home health agencies. Lastly, providers also report information about MA enrollees' use of dialysis services directly to Medicare for use in calculating risk scores.

Because the encounter data and the provider-submitted data both provide evidence of services provided to MA enrollees, we can assess the relative completeness of each source by comparing the sources with one another. This was the topic of our March presentation.

In that analysis, we compared data for inpatient, SNF, home health, and dialysis services. Across those four service categories, most beneficiaries with a record in the provider-submitted data also had an encounter record for that service during the year. However, we found that for each service category, the encounter data and provider-submitted data are missing records for some MA enrollees.

For inpatient and dialysis services, the share of enrollees with a record in both sources was relatively constant between 2017 and 2021. For SNF and home health services, the share had improved since 2017.

Because provider-submitted data is available only for a small number of service categories, we are limited in our ability to use these sources to assess the completeness of encounter data for important service categories such as physician services and outpatient care.

In the absence of claims data or an independent

data source, the best available approach for assessing encounter data is to compare the data with other plan-reported sources, shown in purple in the figure. These include bid data, collected as part of the annual MA bidding process, and the Healthcare Effectiveness Data and Information Set, or HEDIS, collected as part of the MA quality bonus program.

Comparing encounter data with these sources could be useful because they contain information about service categories for which we do not have an independent source. For example, the bid data contain information about all Medicare-covered service categories.

Comparing MA encounter data with other plan-generated data sources does not provide an independent assessment of data completeness and accuracy, but these comparisons can help flag potential underreporting and assess whether a plan's data processing is internally consistent.

We'll start by reviewing our comparison of the encounter data and plan's bid data.

For today's presentation, we focus on data for inpatient and skilled nursing facility care because these

are services for which we have an independent data source to provide context about the relative completeness of the data.

First, a bit of background about bid data. Each year, insurers submit bids to provide Medicare Advantage benefits. In their bids, the plans report information about their members' use of services during the preceding year, referred to as the base period, and plan spending for those services. As an example, for contract year 2023, plans submitted bids in June of 2022 that included information about their members' use of services in 2021. The bids include utilization rates for each service category, making it possible to compare bid data with utilization rates calculated from encounter data.

Plan bids are subject to review and audit by CMS, and CMS requires that the base period data match the MA organization's audited financial statements. We interviewed actuaries who prepare MA bids to learn more about the preparation of the data and gather their perspectives about the reliability of the reported utilization rates. They generally supported the view that the utilization rates are a reasonable source of

information, because they are typically derived from the same claims data used to populate the payment fields of the bid.

Several factors could lead to differences between the encounter-based rates we calculated and the utilization rates reported in plan bids. For example, incomplete encounter data may put downward pressure on the encounter-based utilization rates. On the other hand, the inclusion of encounter records for denied claims, i.e., services that were delivered but for which the plan did not make payment, would put upward pressure on the encounter-based rates. MA plans are required to submit encounter records for all items and services provided to their enrollees, regardless of payment, but such claims would be excluded from the plan bids. Overall, the direction of any difference is ambiguous and likely to vary by plan.

To ensure that other factors did not affect our comparisons, we limited our analysis to bids for HMO and PPO plans that submitted base period data and that were not participating in the CMS MA Value-based Insurance Design demonstration. We also omitted any bids for our enrollment data and the enrollment data in the bid differed by more

than 5 percent.

This slide shows the results of our analysis for inpatient care. We calculated the number of inpatient days of care per 1,000 enrollees using encounter data for 2021. We compared the encounter-based utilization rate with the rate reported in the 2023 bid data. Bids for 2023 include utilization rates for services delivered in 2021.

The figure shows the distribution of the difference between the encounter-based rate and the rate reported in the bids. The difference between the two rates is shown on the horizontal axis. Encounter-based rates below the bid-based rate are to the left, and encounter-based rates above the bid-based rate are to the right. The orange and blue bars show how frequently encounter-based rates fell within a given range. The blue bars show the share of bids with rates falling within the range, and the orange bars show the share of enrollees represented in those bids.

We found that the encounter-based rates were somewhat evenly distributed above and below the bid-based rate. For 37 percent of bids, covering 43 percent of enrollees, the encounter-based rate was within 5 percent of

the bid-based rate, shown in the gray-shaded region of the figure. Seventy percent of enrollees were in plans for which the encounter-based rate was within 10 percent of the bid-based rate. For roughly 20 percent of bids, or 12 percent of enrollees, the encounter-based rate differed by more than 20 percent in either direction.

This slide shows the results of our analysis for skilled nursing facility days, also measured as the number of days per 1,000 enrollees. We again found that encounter-based rates were somewhat evenly distributed above and below the bid-based rates. For one-third of bids, covering 43 percent of enrollees, the encounter-based rate was within 5 percent of the bid-based rate. Sixty percent of enrollees were in plans for which the encounter-based rate was within 10 percent of the bid-based rate. For roughly 30 percent of bids, or 24 percent of enrollees, the encounter-based rate differed by more than 20 percent in either direction.

Overall, for inpatient and SNF services, we found that utilization rates calculated from encounter data were frequently within 5 to 10 percent of the rate reported in plan bids. However, the encounter-based rate was more than

5 percent below the bid-based rate for roughly 30 percent of bids, or 20 to 30 percent of enrollees, which could indicate incomplete encounter data.

In addition to comparing utilization rates for inpatient and SNF services, we also assessed home health visit rates. However, we found that variation in how plans submitted data prevented us from drawing summary conclusions about the level of agreement between the two sources. More information about these findings is available in your reading materials.

For next steps, we plan to compare encounter data and bid data for other service categories, such as physician and outpatient services. We will continue assessing whether bid data can serve as a useful tool for identifying underreporting of MA encounter data.

Now I'll turn it over to Andy.

DR. JOHNSON: Thanks, Stuart.

We're next going to review our comparison of encounter data and HEDIS data. Luis Serna conducted the analysis I'm going to walk through today, and we'll do our best to respond to your questions or to follow up after today's meeting.

The Healthcare Effectiveness Data and Information Set, or HEDIS, was developed by NCQA and is a set of information used as the basis for several MA quality measures.

MA plans are required to collect and submit a person-level data file to CMS and a contract-level summary data file to NCQA. The summary data file is used to calculate certain quality measures contributing to an MA contract star rating, which determines quality bonuses and affects the level of rebate dollars received by a plan.

The person-level HEDIS data include information about MA enrollees' hospital stays. These data are used in calculating the plan all-cause readmissions measure.

For this measure, outpatient observation stays are included with inpatient hospital stays. The data include beneficiary and plan identifiers, hospital admission and discharge dates, and an indicator identifying all hospital stays as an index hospitalization or a readmission.

The measure requires the exclusion of some hospital stays from the data file in order to focus the measure on assessing a set of qualifying hospital stays.

We assess the consistency of hospital stay data in the person-level HEDIS and encounter files for 2021 dates of service among HMOs and PPOs.

To do this, we first applied the HEDIS measure specifications to all hospital inpatient and outpatient records in the encounter data.

HEDIS specifies that plans exclude stays for beneficiaries who enroll in hospice at any point during the year, had four or more index hospitalizations during the year, or were not continually enrolled with the same parent organization for a relevant period of time.

We found that HEDIS specifications excluded 45 percent of index hospitalizations and 71 percent of readmissions included in the encounter data.

For the remaining hospitalizations, we compared HEDIS person-level and encounter data by matching on beneficiary ID, MA contract number, and hospital discharge date.

First, we assessed data consistency by examining whether hospitalizations present in the HEDIS data were also in the encounter data. We expected that effectively all HEDIS hospitalizations would be in the encounter data.

However, we found that overall, 85 percent of HEDIS hospitalizations were in the encounter data, accounting for 90 percent of HEDIS hospital users.

To understand the reason for the discrepancy, we considered whether some HEDIS hospitalizations were excluded from the encounter data when we applied the HEDIS measure specifications.

After relaxing all HEDIS exclusions, we found that 96 percent of HEDIS hospitalizations were in the encounter data, accounting for 99 percent of HEDIS hospital users.

Our results suggest that nearly all HEDIS hospitalizations are in the encounter data but that HEDIS specifications are not applied consistently across plans.

Perhaps more concerning are the results of the reverse comparison, where we assessed whether encounter data qualifying hospitalizations, meaning with the HEDIS exclusions applied, were reported in the HEDIS data.

We found that only 73 percent of qualifying encounter data hospitalizations were in HEDIS, accounting for 78 percent of hospital users in the encounter data.

Breaking down these results by inpatient stay

versus outpatient observation stays, we found that 86 percent of inpatient stays and only 40 percent of observation stays were found in the HEDIS data.

Finally, we limited our analysis to beneficiaries found in both data sources and found that the encounter data had 11 percent more index hospitalizations and 19 percent more readmissions than the HEDIS data for these beneficiaries.

The large number of hospitalizations demonstrate that encounter data would be a more complete source than HEDIS for the plan all-cause readmissions measure, which will be used for calculating MA plan star ratings in 2025.

Now to summarize, in March, we compared encounter data to provider-submitted sources of MA enrollee utilization for inpatient, skilled nursing, home health, and dialysis services. We found that all services were somewhat incomplete, but generally have improved since 2017. It may be possible to conduct some assessments of MA utilization by combining multiple sources of MA data.

We again note that encounter data validation of physician and outpatient services is limited due to the lack of other sources of utilization information. We will

continue to assess whether bid data can be useful for assessing the completeness of the encounter data for these services.

We have concerns about the HEDIS data for MA hospitalizations, stemming from what appears to be inconsistency in the application of HEDIS specifications or exclusions.

And finally, we reiterate the Commission's 2019 recommendation, which we believe would address many issues with the encounter data and strengthen the incentives for submitting complete data.

That concludes our presentation. As a reminder, this material will be included in the June chapter, along with the March meeting material. We look forward to the Commissioner questions about these analyses and suggestions for future directions.

Now I'll turn it back to Mike.

DR. CHERNEW: Andy, thank you. Stuart, thank you. And if I have this right, Tamara is first.

DR. KONETZKA: Thanks for this great work. Also, a lot of messy stuff to go through, so I appreciate it.

I just want to make sure I understand in both

parts, the bid part and the HEDIS part. I want to make sure I understood exactly what you did, in that for the bid part, you first sort of excluded about half the MA bids and slightly half of all enrollment for other reasons, right? And then you took the subset of those where the enrollment figures matched between your administrative data and the bids, right? And you said you ended up with about a third, then, of bids after that, right? And that's a third of the whole, not a third of the half. Is that right?

MR. HAMMOND: That's correct.

DR. KONETZKA: Okay. So my question there is, why would the enrollment figures differ so much? I'm a little bit puzzled by that discrepancy, right? Like, shouldn't --

MR. HAMMOND: So there can be multiple reasons that the enrollment data would differ between what we have in our enrollment data and what is in the bids. I think the two leading contributions to that difference are -- the first is that there are just sometimes differences in the plan's internal enrollment data versus what ends up getting wrapped into the Medicare kind of administrative enrollment data for logistical reasons, and then the second piece is

that plans can reorganize their plan offerings between years. And the base period that is included in the bids is two years prior to the year for which they are submitting information. And they can crosswalk members, and so that requires two crosswalks. So in the case of a 2023 bid, the base period was 2021. So they're processing enrollment crosswalks from '21 to '22 and '22 to '23.

And as they -- let's say they are consolidating or changing a service area. That enrollment for 2021 can get split across different plans or combined into a single plan, and we don't have the way to process those crosswalks if that enrollment is split across multiple plans.

So generally, what we are able to do is match the enrollment to when kind of the whole plan stays intact across those two years. So that is another part of the enrollment.

DR. KONETZKA: Okay. That just seems like it was like, I guess, about 20 percent that you were excluding because of the enrollment not matching, right? And 20 percent of bids, and so that just seemed like if we know anything, we should know who's in the plan across data sources, right? And so that seemed big to me. But I guess

the crosswalking probably, that makes a lot of sense.

The other --

MR. HAMMOND: And I can say that for the group that did not meet those criteria, there is a good number of them that are just outside and are closer to a 10 percent difference. So it is not as if it does not match at all outside of that range.

DR. KONETZKA: Okay. Thanks.

My other question is about the HEDIS data, just make sure I understand this correctly. Conceptually, if we had complete encounter data -- we know that the HEDIS measures are based on only certain conditions and there are exclusions, right? But if we had complete encounter data, the HEDIS data and hospitalization should be a strict subset of the hospitalizations you would get out of the encounter data, right? There's no good reason for that discrepancy.

MR. HAMMOND: Right. That's right.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. You know, difficult work and so valuable. I mean, there's so little known really about MA plans and their performance, and now with the

availability of encounter data, all of a sudden for researchers, a lot of people who want to look at this. And we spend a ton of time thinking about and arguing about how much can we depend on the encounter data. So this is -- just yesterday I had a long discussion with a young faculty member about that. So this is so valuable.

My question is a two-part question. One is, if I understand correctly what you said, the difference between encounter data and HEDIS data for hospitalizations, with the HEDIS data showing fewer helps plan star ratings. Is that correct?

DR. JOHNSON: We don't know for sure whether or not it helps plan star ratings. I think the finding here is that the share of HEDIS hospitalizations should be a subset of the entire set of hospitalizations, but that the plans appear to be applying some of the exclusion criteria differently across plans, so that we found hospitalizations in the encounter data that were not in the HEDIS data and vice versa.

I think the idea -- was there another part to that question?

DR. CASALINO: Yeah. Well, overall, though, you

found fewer HEDIS hospitalizations of both kinds, correct?

DR. JOHNSON: They were fewer overall because of the exclusions. But I guess -- and you asked about the rates. We don't -- we didn't do the comparison of whether or not you included those excluded hospitalizations from the HEDIS. Whether or not those were indexed or readmissions would depend -- would affect whether or not the readmissions rates were higher --

DR. CASALINO: So if you can, it might be worth doing some more about that, because I mean, it certainly looks like there could be -- obviously, it could help plan star ratings to have fewer admissions, right --

DR. JOHNSON: It could, yes.

DR. CASALINO: -- in their HEDIS data.

And then the second part of the question was, if you can do what we just talked about, trying to look at it by type of plan, size, whatever, and see if there are systematic -- like are the really big ones better at excluding -- you know, having fewer HEDIS hospitalizations because of exclusions? Or is it the small plans that don't have as much administrative capacity that are missing, you know, involuntarily missing? You imagine different

pathways to having different numbers of HEDIS-relevant hospitalizations. So I think that'd be valuable if you guys can do it.

MS. KELLEY: Kenny.

MR. KAN: Thanks for the analysis, very helpful.

Question on page 21, just curious. The 40 percent observation stays, I was surprised at how low that was. Any rationale for that conjecture?

DR. JOHNSON: We don't have a good reason for that right now. But that's just to say that we did find a number of observation stays in the encounter data that we thought should be included in the HEDIS data, and they weren't there. But we'd have to do some more work to figure out why.

MR. KAN: How much of -- I mean, all those differences between HEDIS data and encounter data could possibly be due to like taxonomy differences between how plans interpret the data, and then you have such a diversity of plans. And despite the best intentions to interpret that as accurately as possible, that appears to still be variation.

DR. JOHNSON: There's probably some of that going

on. Yeah. It's hard to disentangle whether there's different interpretations of the specifications, or there's, you know, something else going on with the data.

MR. KAN: Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: So a couple of things. One is, you note that the bid data come from data that the plans receive directly from the providers, and in some of the work that I do in other spheres, you know, we note that different plans have different, what I call "cleaning algorithms" to process those claims that then feed into the encounter data. And so I suspect there's some loss along the way based on those cleaning algorithms or what they determine to be a legit claim. So I don't know if some of that accounts for the differences you see.

But the other thing -- and this may be less germane to hospitalizations, but we've been doing some work trying to look at the concordance between HEDIS and the encounter data for a handful of the HEDIS measures that we've been constructing with encounter data. And we've been doing interviews with plans, and they use very different data sources to construct those HEDIS measures,

and they rely a lot on -- and the HEDIS specifications allow them to do this, which is look at their entire book of business.

So if somebody aged into Medicare and was commercially insured by them, they're allowed to look back in that period and find that person, and so they're included in the denominator, so they show up.

So I think as you continue this work, trying to have these conversations with the plans about different sources of data that feed these different streams would be really important.

MS. KELLEY: Brian.

DR. MILLER: So it was really unfair of us to have you scheduled at the end of the day. I thought, mirror, mirror on the wall, which session is the nerdiest of them all? And I thought about this session, and then I saw that it was scheduled for the end of the day. And I said that's unfair to you guys.

This is phenomenal work, very interesting.

I think one thing that might help people navigate it, because not everyone is going to be a data geek -- I liked Figure 1, which was the flow chart of the different

types of data. I think that adding a flow chart for the population subsets, as we were talking about, would probably help readers a lot to figure out where the populations overlap and where they don't. We talked about HEDIS being a subset. I've probably been in way too many conversations about HEDIS metrics. So, for me, not a surprise, but for many of the policy and Hill staff, consumers of this, that would probably be very helpful.

But thank you for doing this chapter.

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

DR. CASALINO: I had a quick follow-up.

MS. KELLEY: Your microphone?

DR. CASALINO: Just a quick follow-up to what we've been talking about and what Cheryl was saying.

So tell me if this thinking is correct or erroneous. When you compare the bid and encounter data for SNF or hospitalizations, basically a little like a normal curve, right? Most were pretty accurate in the middle, but then you had kind of equal numbers of too many and too few, right? But I think if you were to graph the difference between the HEDIS data and the encounter data, you wouldn't

see a normal distribution, right? I mean, it would be skewed to the side where there were fewer in HEDIS than in encounter data, and there would be very little, I think, on the other side. Is that correct?

DR. JOHNSON: I think that's correct. The situations are a little bit different, though, where because the exclusion criteria apply to HEDIS, we're looking at a subset of the overall hospitalizations that should be applied to this readmissions measure. And so I think we would find some on either side that were included from the HEDIS, but we thought should be excluded based on the specifications and others that were excluded.

But you're right that the number included in the encounter data that were not included in the HEDIS was larger, but there was --

DR. CASALINO: It might be worth graphing that because -- again, correct me if I'm wrong, but it seems to me that if it was a skewed distribution and skewed in favor of fewer HEDIS hospitalizations compared to the encounter data --

DR. JOHNSON: Yes.

DR. CASALINO: -- that would imply not just kind

of random error or whatever you want to call it. It would imply systematic -- I don't want to say manipulation of the data, but systematic working with the data to have fewer hospitalizations. And that would be important to know, I think.

DR. JOHNSON: Yeah.

MS. KELLEY: Okay. I think that's the end of Round 1.

DR. CHERNEW: Who is first for Round 2?

MS. KELLEY: Lynn is first.

MS. BARR: Thank you. Excellent work.

So I want to just understand, because readmissions is sort of kind of a gold standard, right, of really judging the quality of a health plan or fee-for-service. I mean, it's one of the things that we really care about the most, and so what you're saying in this -- is it correct that -- and I apologize. This is a Round 1/Round 2.

I believe what you're saying is that we're calculating readmissions differently for MA plans than we are for fee-for-service, and we don't have the same criteria in fee-for-service, right -- or in ACOs, for

example, exclusion criteria.

DR. JOHNSON: I was about to start my answer with this is outside of my lane of understanding. I was going to say there is a hospital readmissions measure in fee-for-service, which is entirely different from the measure that is applied to MA plans.

I'm not as familiar with the ACO measure, but I think there are some intentional differences for the way that those are measured.

MS. BARR: This makes it incredibly difficult for consumers. That would be my -- yeah. I remember reading the exclusions for the MSSP, and I'm reading this. I'm going, why do we have two sets of rules? This doesn't make sense.

And also, I believe that with MIPS and with ACOs, we use 100 percent of our data, right? We're not allowed to support a subset of data, but in the MA plans, they're just reporting on -- they're not required to report on all patients. Did I get that right?

DR. JOHNSON: I think some of the discrepancy is because we are using the HEDIS data, which is collected for the purpose of calculating these quality measures, and it's

not necessarily collected for the purpose of identifying every hospitalization that occurred in MA. We are just trying to adapt the information we have about MA hospitalizations as a measure of how many utilizations we know about based on the HEDIS data and compare that to what's in the encounter data as sort of a different purpose of the data of trying to assess the completeness of the two data sources.

MS. BARR: Is this true of other? So again, in ACOs, we have to report on everybody, all patients. It's in the claims data. Nobody is excluded. I mean, you can do, like, exclusions, but, you know, to some extent. But is it true that in all the HEDIS measures that, you know, kind of you don't have to report on everybody? You know, without exclusions, you only have to report on a subset?

MS. TABOR: So this is Ledia. Hi. I'll jump in here. Good questions, Lynn.

So I will say -- so for the ACO readmissions measure, it is based on all beneficiaries, except for there are certain exclusions, like continuously enrolled, which is a good thing because you want to hold the ACO accountable for patients that they could control. And the

same idea is applied to the HEDIS plan all-cause readmission measure. So although the details in the exclusions may be different across ACOs and MA, conceptually, they're measuring the same thing.

And the HEDIS plan all-cause readmission measure does include all beneficiaries, minus those exclusions that are detailed in the paper, like those who are not continuously enrolled, those who are in hospice, those who had more than four outliers, which I know is not in the ACO measure.

MS. BARR: It's not in the ACO measure.

And who's most likely to get readmitted would be somebody that's been in the hospital four times in a year, is probably going to have five.

But is this also true across all HEDIS? So even in MIPS now, I believe that we have to report on all patients. Is this also true in other quality measures in MA that they don't have to report on all patients?

MS. TABOR: I will say it depends on the measure for HEDIS. There are measures that are based on administrative claims data only, and those are based on the entire subset of the population. There are also measures

that are hybrid measures, which you need chart review for. So an example of that would be controlling high blood pressure. So you need to actually go into the chart to see if a patient with hypertension actually had controlled blood pressure, and that is based on a sample.

MS. BARR: Okay. And so I guess to my Round 2 comment -- well, let me ask you one more question. So in the paper, you talked about there was a -- maybe it was a prior recommendation from MedPAC that the plans could submit -- or the plans could request that providers submit their claims through the MACs? Is that correct?

DR. JOHNSON: That was one aspect of our 2019 encounter data recommendation.

MS. BARR: So I'm just curious. I would recommend that providers would be allowed to choose to submit through the MACs, because it is an incredible burden for providers to have to -- like, a rural community now has an average of 27 MA plans, right? They have 1,000 Medicare beneficiaries, maybe 2,000 Medicare beneficiaries, divided amongst 27 plans. Then they have to deal with that, and that seems like an incredible administrative burden with the proliferation of 500 and whatever plans we have now,

that our providers are having to deal with all of this reporting.

And I would wonder if as part of our things we could consider as we move this work along is that providers could choose to submit all of their claims to a MAC. And, you know, if we're saying it's okay for the plan to say that, I think if you gave it to the providers, they would do that in two minutes. And we'd have all the data, right? Because it would be such a savings to them.

I just want to say that, you know, my critical access hospital, we had 25 beds, and we had 50 billers and coders that were working. I mean, I was like, why don't we just put one in every room, you know, and just write down what happens?

So I would just like to add that as a potential consideration for future policy. Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thank you.

UNIDENTIFIED SPEAKER: 1.3 nerds.

UNIDENTIFIED SPEAKER: That's right.

DR. MILLER: So the joke is right now my wife speaks French, and we're trying to speak HEDIS.

So to answer, to respond to Lynn's question before my -- or comment before my thoughts, instead of changing policy, we can think about the opportunity for tech and automation -- sorry to sound like a broken record -- to help with administrative complexity.

My friend works at a hospital in Florida, for example, and they are looking and experimenting right now with automation for notes, billing, coding. So that is in process. I imagine that that administrative burden on that small hospital could, in theory, be automated pretty quickly in the next couple of years, which would decrease that burden. I realize that doesn't decrease that burden today at almost cocktail hour for us, but it definitely could decrease that burden in the near future and make it much easier for small practices, small hospitals, and other small facilities to participate without changing the entire data infrastructure system.

So a couple questions, and I may reveal my ignorance, so I apologize in advance. On slide 14, I saw we had those tails for the distribution and difference, and I was actually pleased to see that it looked almost like a normal distribution, almost, not entirely. Was there any

difference in the characteristics of the plans that were at either end of the tail? Like, was it a big plan with old data infrastructure? Was it a small plan that was struggling?

DR. JOHNSON: So we've looked at the plans that fall under those groups by parent organization and did not see any obvious trend in which parent organization was kind of contributing those bids. We can look at the plan level and see if that reveals any other.

DR. MILLER: Because it's possible maybe there's a couple of plans that are using a contractor that's suboptimal, or there's some feature that we are missing here, or this is just what has happened. So I was curious if there's a problem that can be more easily fixed.

I noted that on page 20, we talked about 40 percent of enrollment and 30 percent of bids for encounter crosswalk, for the encounter to bids crosswalk, which is a little depressing. I'm not going to lie. And I guess the question is, is the big picture takeaway for all of us, that since there's lots of variation, that even if we have 88, 90 percent of encounter data, that maybe the answer is we need a little bit more in terms of complete lists for

encounter data? We're like we're almost there, but we're not there, and that the way to do it might be to have a requirement with a penalty as opposed to a bonus? Because I have to be consistent, because I was against participation trophies in the last session. So I still need to be against participation trophies with bonuses here.

DR. JOHNSON: I think our recommendation for the encounter data now does have a penalty involved in it, which would align with what you're saying.

DR. MILLER: But only a penalty in that we should not be thinking about bonuses.

DR. JOHNSON: Right.

DR. MILLER: As in either have it be a requirement for participation, maybe even separate from the MA star ratings.

DR. JOHNSON: Yes. We had described a payment withhold separate from the stars ratings that plans could receive back once they met certain completeness thresholds with their encounter data.

DR. MILLER: This might be seen as harsh, but I would be disinclined to give it back. My thought would be

is if they didn't meet the criteria for a year, that they should not get it back.

DR. JOHNSON: That's right. Only if they met the thresholds.

DR. MILLER: Okay. Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: Okay. Yeah. So taking a kind of mile-high view of this -- first of all, the motivation was to see if you could use other data sources to sort of cross-validate the encounter data, even though these were, in this case, also generated by the plans.

And when I look at these analyses, they're super interesting but probably not very useful for that purpose when I see it, because the bid data -- you know, you end up with 30 percent of bids that you're studying, 50 percent of enrollees, and I just don't know what subset that is. I don't -- you know, if you want to use that for some kind of sanction or penalty, you know, you can't be just using half the enrollees or half the sample out there. And so it was sort of an interesting exercise, almost as proof of concept, but I don't think we can sort of move forward and use that. Whereas, like, some of the things we did last

time, like the MDS and the OASIS, I feel like you're close enough that it's actually still really useful, right, or the MedPAR.

So I don't think it's very useful for that, but I think it's shown us this analysis. It was super interesting, and it's shown us a couple of really interesting things. You know, one, that we might really want to worry about the HEDIS measures and figure out what's going on there, right?

And the other thing, I think -- and, you know, sort of conceptually, I think this is a no-brainer. I know that there are practical difficulties, but to me, it seems clear from this that we should be using the same data for all of these things, right? Like, you would think that plans would prefer not to produce these data in three different ways, and perhaps, you know, like in many cases, if there are multiple uses for the data, especially if the incentives go in different ways, like sometimes you want to show sicker people, sometimes you want to show, you know, better care and fewer hospitalizations, especially if the incentives go in different ways, like using one data source for all of them just makes a lot of sense.

So, to me, the future directions that would be most interesting would be to explore what would take, you know, maybe through direct provider provision or submission of the data, but to sort of explore the options around moving toward using a single data source, which would have to be the encounter data, right?

DR. JOHNSON: Just to give a little bit more background on the bid data comparisons, I think we generally agree with your assessment that we're unsure about the ability of the bid data to provide some information about the completeness.

For several years, we had provided the Commission with feedback about the completeness of inpatient, skilled nursing, home health, and dialysis stays only, and we pointed out the huge number of services are in the physician and outpatient buckets. So we said, well, we're really looking for the best available thing, and we're finding out that it may not be that helpful. But we'll try it and report back to see what we find.

DR. KONETZKA: Yeah. And I want to make clear, this was in no way a critique of what you did. This is just saying, like, okay, this was an interesting

experiment, but I'm not sure it's that fruitful to spend a lot of time on moving forward when, you know, it's --

MS. BARR: We should be talking about workforce.

[Laughter.]

DR. KONETZKA: Yeah. We could be talking about workforce. Yeah.

Oh, and I would also like to plus-one the idea that we have hospitalization and rehospitalization measures for so many different purposes, right? The hospital readmission penalties for public reporting, you know, for HEDIS, for, like, you know, all kinds of different things, and most of the time, there's no reason these shouldn't be standardized, right? And so I think that would also be a long-term goal to move toward.

MS. KELLEY: Stacie.

DR. DUSETZINA: Okay. I first want to say a huge thank you for Figure 1. I think it is amazing, and it really helps to disentangle exactly where these data elements come from.

And I also want to say plus-one on Tamara's comments there about, you know, trying to use the same data source for multiple purposes. That would be great.

I guess in looking at Figure 1, going maybe to Lynn's comment, it's like it does feel like we should want those claims, you know? If the providers are already having to send them somewhere, I know they're not adjudicated, but it seems like that would be a great starting point. And if we can make it easier on providers to have it, like, to come through, that would be great, because every time we see these comparisons now of, like, how good or how confident should we be in the MA data sources we have, I feel somewhat less confident. And so I think whatever ways that we could get more of the complete data coming from the practices, we're better off. But huge kudos for Figure 1. It's fantastic.

MS. KELLEY: Greg.

MR. POULSEN: Thanks. Yeah, I love this great work too. It was lots of fun to read, and yeah, it was terrific.

Amol, this could be either 3 minutes or 30 minutes, with no in between, because I'm intending to color outside of the lines here just a little bit.

UNIDENTIFIED SPEAKER: Uh-oh.

MR. POULSEN: Yeah, uh-oh.

It sort of triggered it in the chapter when it talked about the strong incentive is there when it impacts risk scores, and that's where we get good data, right?

Cheryl made a similar point regarding HEDIS. Where it matters, it gets reported.

In commercial insurance, it's interesting that the entirety of the medical expense is the risk score. That's what people calculate from, and it's the grist for the actuaries mill.

And in my experience, this is a vastly better way to do risk adjustment than the current MA approaches for a number of reasons. First, it's less subject to gaming and all of the huge groups and expenses that are put together to maximize those risk scores and also of the occasional fraud that occurs with that.

Second, it's far more transferable when beneficiaries change plans. We can know what the risk was last year for a given person if we know what the data is.

DR. CASALINO: [Speaking off microphone.]

MR. POULSEN: Yeah, the total, the spending and where it came from.

The other mechanisms that can be used to identify

trends and enhancements to the reward -- in order to reward differential performance between plans, it's very much what happens today, by the way, in TPAs or other plans that demonstrate performance for commercial self-funded groups. They have to look at that. They have to analyze those things. That's how they know what the trend rate is going to be for next year. And then if they're able to achieve breakthrough performance, that modifies that trend.

So the incentives to provide complete reporting, I think, would be just -- if we were to start to do our risk adjustment based on all of those things, the incentive to provide complete reporting would be just as great as it is in fee-for-service. But because we encapsulate a period of time within a capitation, the incentive to overtreat diminishes or is entirely eliminated.

So, in my view, there's an opportunity that we have here to think about this differently, and it's not just data capture. It's actually the way that the plans start to be rewarded, whereas, right now, it's through a differential risk adjustment approach, which I think is remarkably perverse in a whole bunch of ways.

So I know this may well be a bridge too far.

Certainly, it's a bridge too far for this reporting period and what we're in, and I love the chapter the way it is. And if I didn't love it, I would have dived in and told you why I didn't. But I think it's really great. But I really would like to plant a flag that this may be an opportunity to get far better data in the future, far more comparability to fee-for-service, far better understanding of what works and what doesn't work that plans can look to each other and learn so that we start to have transferability of good performance.

This stuff -- I mean, I think my organization and a lot look at things like MedPAC and say, wow, we can learn a lot from what other people have done well. This would give us that multiplied by 10 in terms of learning capability.

So I think there really is an opportunity here -- and here's where we could talk for 30 minutes and shouldn't today -- to think about the way that we do risk adjustment, which would motivate us to do everything we want to do in this chapter and accomplish something else that's just as important or more important.

So thanks a bunch.

DR. CASALINO: Greg, I'm sorry. Would you just say one more time what you'd like to see done?

MR. POULSEN: I would love us to see --

DR. CASALINO: Scrap the current risk adjustment methods.

MR. POULSEN: Yeah. I mean, for a number of reasons. I think the current risk adjustment mechanisms are tremendously flawed, and they lead us to all kinds of bad outcomes. And it leads us in Medicare Advantage plans to focus on the wrong thing. I think everybody who's engaged in Medicare Advantage knows it's far more remunerative to focus on risk maximization than it is to focus on performance improvement in terms of improving people's health. That's wrong. And we could change that if we started to take that away and look at what is actually being done for these folks and use that as our mechanism for future projections, which is essentially risk adjustment.

Yeah, I'm talking about all of the information in terms of all the encounter data that we're talking about right here, the real encounter data. Yep.

DR. CASALINO: But you would -- so you would

substitute for the current risk adjustment, total spend, not risk-adjusted?

MR. POULSEN: Well, that's where you can start to use history as a projection for the future, and that's where you can start -- so it doesn't have to be that you just get paid what you got paid last year, but there are mechanisms to do that.

And again, my apologies, because this is where we could devolve into something for a very, very long time. But the actuaries of the world have mechanisms -- and some of us are vaguely aware of what those are -- that I think could allow us to use these very effectively for that.

DR. CHERNEW: Yeah. Luckily this is the beginning, not the end. We'll be able to revisit some of these things, but I will say the nuance behind some of these questions, like the real encounter data versus health risk assessment data, which is also in here, they're now using this data for risk adjustment. So the current system is predicated on this data. There's other changes.

MR. POULSEN: But only a subset of the data, which I think is important. I think you guys calculated that.

DR. CHERNEW: Let's save this for a broader conversation when we revisit risk adjustment and get back to how we're going to deal with the sort of topic at hand.

But yes, I don't want to be dismissive of the broader point, which is we have a lot of issues going on with how to deal with a growing Medicare Advantage program and what to do and how to get the data and how to make sure the data is right. And I agree with your fundamental point, which is once you start using the data for other purposes, the data seems to get better. I think that is a core point.

I think the next person was Scott.

DR. SARRAN: Thanks, guys, for great work.

So as I read through this, the question I kept asking in my mind is, is this good enough? Are we where we need to be yet? And I think the consensus, based on listening to people around the table, which is where I landed, is no, not for a program that has a spend of half a trillion dollars a year. We really owe ourselves, CMS, taxpayers, everyone, you know, better quality information.

And so where I've landed net of this recent discussion is sort of where Lynn, Tamara, Greg, everyone

else did. Trying to force better outcomes in terms of data completeness and accuracy through the same old messy, bifurcated, trifurcated processes is a fool's errand, right? It's like the process will continue to deliver the same mediocre levels of results it gets, process meaning of the fragmented data collection.

And so it seems to me -- maybe particularly because we're not at a recommendation stage, so we don't have to have it all figured out -- we should just -- we should just be saying, hey, if we really want policymakers to have accurate and complete data inclusive of comparing fee-for-service to A-APMs, to MA, then we're going to need in some way, shape, or form to step back and start looking for more common approaches to data collection that cross those sectors.

And we're recognizing we're very early in that, and we're not ready for a final recommendation. Thanks.

DR. CHERNEW: I had Scott as last.

So, yes, I think that is right. I think there's a bit of a chicken-and-egg issue, which is, do you wait until the data is good enough to build policy around the data, or do you build the policy and then assume that the

data will then, you know -- people report the data they need? I can see a world in which they report too much data if you use it in certain different ways, you know.

So I do think the data infrastructure that underlies Medicare is fundamentally important, And I think what is very appealing about this and the other work we've done is I don't think we spend enough time looking at how different data sources that purport to measure similar things do or don't compare. And I think, as many of the comments illustrated, you learn a lot of stuff, not always about the thing you were looking at, but about the comparisons you had. So some of the things about HEDIS is true.

So I'm not going to belabor that point. What I will say is thank you to Stuart and Andy. Thank you to all the Commissioners. I think it's really been a wonderful day writ large.

To the folks at home, please reach out and give us your feedback. We can be reached at meetingcomments@medpac.gov or on the website in a range of ways. We do want to hear what you have to say.

But again, I think for this and the previous

session, we are beginning to think about a lot of things, and we will continue along that path. So, again, thank you.

We will show up here tomorrow morning. I think we are on nine --

MR. MASI: Nine.

DR. CHERNEW: -- nine in the morning, and we will have a morning of drugs.

[Laughter.]

DR. CHERNEW: See, that's either funny because of how I phrased it or funny because it's wrong, and I never know which. But I am looking forward to tomorrow's session. And again, thank you to those of you at home that listened, and we will be back again. So thanks.

[Whereupon, at 5:25 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, April 12, 2024.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 12, 2024
9:01 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LAWRENCE P. CASALINO, MD, PhD
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
JONATHAN B. JAFFERY, MD, MS, MMM, FACP
KENNY KAN, CPA, CFA, MAAA
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

[9:01 a.m.]

DR. CHERNEW: Really good morning, everybody. Welcome to our Friday morning session, which is going to focus on a few issues related to prescription drugs, and we're going to start it off with Tara talking about some work we're doing on generic drug pricing, an issue of great interest to many people, not to mention the country.

So, Tara, go ahead.

MS. O'NEILL HAYES: Thank you, Mike. Good morning, everyone.

Shinobu, Pamina, and I will be sharing our findings regarding generic drug pricing in Medicare Part D, which we first discussed in October last year. As a reminder to the audience, you can download a PDF version of these slides from the handout section on the right-hand side of your screen.

We will begin with some background today, followed by motivation for our work, including a quick overview of some recent external studies examining generic price variation. Next, we will provide some high-level findings from our own analysis of Part D data. Then we

will discuss some key takeaways from the stakeholder interviews we conducted to gain deeper insights into the complicated interactions taking place between various stakeholders in the pharmaceutical supply chain. and then, as always, we welcome your feedback and discussion.

Let's begin. For years now, generic drugs have accounted for 90 percent of the prescriptions filled in Part D and 20 percent of gross program spending. Generic drugs typically cost a fraction of the price of their branded counterparts and, thus, have played an important role in moderating the growth in Part D spending.

Recently, however, generic price declines, shown in orange, have slowed, which has likely contributed to the uptick in overall Part D prices, even when generic substitution is accounted for, shown by the dotted line here.

Before moving on, it's important to level set so we all have the same understanding when we speak about prices. And while the price of a drug is different for each participant in the supply chain, what we are focused on here is the price to the Medicare program and beneficiaries, which is the pharmacy reimbursement.

The pharmacy is reimbursed by the patient filling their prescription, if cost sharing is owed, and their insurance plan, or PBM. This reimbursement consists of a payment for the ingredient cost, a dispensing fee, and, particularly in Part D, a pharmacy fee. More often than not, these pharmacy fees are payments from the pharmacy to the plan sponsor, reducing the pharmacy's net reimbursement amount. Until January of this year, these fees have been made after the point-of-sale and referred to as post-sale pharmacy fees. Because our analysis is based on 2021 data, we will be referring to these as "post-sale fees," but want to acknowledge that they are now paid at the point of sale, not after.

The next important distinction is the difference between gross price and net price. The gross point-of-sale price includes the ingredient cost and the dispensing fee, but the net price, which more accurately reflects the total reimbursement received by the pharmacy, includes the pharmacy fee as well. However, while these pharmacy fees are reported to CMS, they are not publicly available.

Now let's quickly review some recent studies which were part of our motivation for this work. Numerous

studies have been published recently comparing the prices paid for generic drugs by Part D with prices available at various retailers where patients may pay cash instead of using their insurance. These studies found that Part D pharmacy reimbursements were higher than some of the cash prices for many generic drugs, potentially costing the program and beneficiaries billions of dollars.

Other studies focused more on the amount and sources of variation in generic prices, such as pharmacy ownership, the dosage form or strength, and the patient's insurer. However, these studies relied on point-of-sale prices because post-sale discounts and fees are not publicly available.

Between 2015 and 2022, post-sale pharmacy fees grew much more quickly than gross spending on generic drugs, meaning the effect of such fees on net prices also grew.

The findings of these studies understandably may cause concern if the plans and beneficiaries are overpaying or face access challenges because of unnecessarily high prices or if cost-sharing changes along with the price variation.

However, there are two important facts to keep in mind when considering the potential impact of these findings. First, while it is true that beneficiary co-insurance is based on point-of-sale prices, most generic drugs used by Part D enrollees on formulary tiers are on formulary tiers with either no or low fixed-dollar copays. Thus, for these drugs, the point-of-sale price will only affect what a beneficiary pays if they fill the prescription outside of the initial coverage phase, such as in the deductible phase of the benefit.

Second, from a programmatic perspective, most of the benefit costs for generic drugs are covered by the capitated payments made to plans rather than cost-based subsidies, limiting the program's exposure to high and fluctuating prices.

Now we will discuss findings from our research. Given the concerns raised and limitations of the numerous studies conducted on this topic, we sought to examine net Part D prices to fill in some of the knowledge gaps and better understand price variation within the program.

For our analysis, we selected more than 100 generic drugs based on the highest total annual number of

fills and/or gross spending in Part D in 2021. Many of these drugs come in multiple dosage forms and strengths, known as pharmaceutically equivalent products, or PEPs. Across the 108 unique chemical molecules selected, there were 570 PEPs in total. Breaking down those products even further to the NDC level, which also identifies the labeler and package size of the drug, there were 5,900 unique NDCs included in this analysis. These selected drugs accounted for roughly 60 percent of total gross spending on generic drugs in 2021.

In our analysis, we found that the degree of variability depends on how both drug and price are defined. For instance, we generally found lower variation in prices when we defined a drug narrowly at the NDC level compared with when we defined a drug at the PEP level, a broader definition of drug.

When the definition of price included dispensing fees and even more so when it included pharmacy fees, variation widened relative to when the price reflected ingredient costs alone.

We also note that net price variation may be even higher, but because pharmacy fees reported to CMS are

aggregated across all claims for a given NDC, our analysis required an even distribution of fees across each claim, which may mask greater variation that occurs perhaps by month or across pharmacies.

The effects of including dispensing fees and pharmacy fees in the definition of price were larger for lower-priced drugs. This makes sense, particularly for dispensing fees, since dispensing fees are typically a small fixed-dollar amount that does not vary by, say, the ingredient costs of the drug and, thus, account for a larger share of a drug's price the lower it is.

Our analysis also revealed complex interactions between the various factors affecting price variability. Here we highlight some of the findings to provide a sense of the different types of patterns we observed as we examine data at a more granular level.

Lower-prices products tended to have higher variability, even when excluding dispensing and pharmacy fees. This is because even a small fluctuation in price can translate into a large percentage change for a drug that costs, say, a few pennies per tablet. However, this relationship was not linear.

Prices for some therapies varied more than others. For example, antineoplastics and multiple sclerosis therapies both had relatively high price points, but the interquartile range for the price of antineoplastics was four times the median price, compared with less than two times the median price for MS therapies.

We further studied a subset of drug products representing different price points in therapeutic classes, which revealed different patterns of price variation across products, such as differences by pharmacy ownership or type or by plan type, with standalone PDPs often paying higher prices than MA-PDs or SNPs.

Lastly, we found instances where prices varied more for a subgroup than the overall variation in a given category. For example, prices of some individual NDCs varied more than prices at the broader PEP level, and prices at chain pharmacies varied more than average prices across all pharmacy types.

So what did we learn from our analysis? First, point-of-sale prices do not accurately reflect the final prices paid by Part D plans. Pharmacy fees must be accounted for when comparing prices. There were no

consistent patterns to the price variation identified across therapies, products, or at the individual NDC level. Price variation across pharmacy types or individual plans may explain some, but not all, of the price variation for a given product.

After failing to find systematic patterns, we decided to turn to the experts to get a better understanding of the market and interviewed a number of pharmaceutical supply chain experts.

Pamina will now share key takeaways from those interviews.

MS. MEJIA: Thank you, Tara.

Commission staff conducted 14 one-hour interviews with individuals and organizations representing pharmacies, PBMs, plan sponsors, wholesalers, and other pharmaceutical supply chain intermediaries and experts. We used a semi-structured discussion to conduct the interviews. Interview questions were related to how prices of generic drugs are determined and the nature of interactions among supply chain participants, how Part D plans set their reimbursement rates for generic drugs, and other factors that affect generic price variation in Part D.

In the next few slides, we highlight major themes that emerged from the stakeholder interviews.

The first theme that emerged from the stakeholder interviews was that pharmacies often face different acquisition costs for the same generic drug. Interviewees generally agreed that most of the variation in pharmacies' acquisition costs resulted from different prices charged by wholesalers rather than prices set by or received by generic manufacturers. Pharmacy acquisition costs for generic drugs reflect the purchasing decisions of wholesalers; for example, the wholesaler's choice of a manufacturer when there are multiple generic manufacturers producing a given generic drug.

Some interviewees noted that differences in bargaining leverage likely contribute to variation in pharmacies' acquisition costs. For example, large chain pharmacies have greater bargaining leverage compared to independent pharmacies, allowing them to obtain lower acquisition costs.

The second theme was that wholesalers' prices for generic drugs may be tied to prices of brand-name drugs. Multiple interviewees described what are called "tying

arrangements," which are agreements between wholesalers and pharmacies that explicitly tie the size of the discounts on brand-name drugs to the volume and prices of generic drugs that a pharmacy purchases. Under such arrangements, wholesalers may charge higher prices for generic drugs in exchange for larger discounts or lower net prices on brand-name drugs.

As a result, some interviewees said that independent pharmacies often agree to these tying arrangements to avoid losing money on branded drugs, even if it means that they are paying more for generics.

As an alternative, we heard in interviews that some independent pharmacies have formed cooperative-style wholesale businesses that provide transparent pricing and the ability to have some control over pharmacy purchasing decisions.

The third theme was that Part D payments to pharmacies do not reflect pharmacy acquisition costs or prices set or received by generic manufacturers. We generally heard that the prices that Part D plans pay for generic drugs at the point of sale are typically based on a PBM's MAC price, unless the U&C price or discounted AWP

price is lower. MAC prices are updated periodically, sometimes as often as every week, and vary widely across PBMs and across pharmacies. Many voiced concerns about the lack of transparency in how PBMs set MAC prices.

We also heard about the PBMs' use of a target generic effective rate, or GER, as a factor contributing to generic price variation. PBMs may adjust their MAC prices and/or their post-sale pharmacy fees to ensure that they meet the GER target that is set across all or most of the generic prescriptions.

In recent years, some pharmacies have negotiated different reimbursement terms, moving away from MAC pricing to an AWP-based pricing; for example, AWP minus 80 percent, to better align them to their acquisition costs or to improve transparency and predictability of reimbursement amounts.

The fourth theme was that point-of-sale payments may not provide an accurate picture of prices paid by Part D plans. When asked if Part D plans are overpaying for generic drugs, some interviewees considered overpayments as a possibility, but that these overpayments would disappear once post-sale fees and dispensing fees were accounted for.

Several interviewees noted that GER makes it difficult for pharmacies to know the profitability on individual drugs, because GER is determined across a broad set of generic drugs dispensed.

Some interviewees emphasized that any meaningful Part D price comparisons would need to go beyond just looking at point-of-sale payments and would need to account for the totality of payments, including dispensing fees and post-sale pharmacy fees.

The fifth theme was that PSAOs typically do not negotiate reimbursement contract terms with PBMs. We consistently heard from interviewees that PSAOs have little effect on determining pharmacy reimbursement amounts. Some commented that reimbursement rates are generally not up for negotiation. One person noted that even when negotiations around price schedules have taken place, there have not been stellar results. Interviewees conveyed that PSAOs primarily serve as facilitators for pharmacies, existing largely to relieve independent pharmacies of contractual and administrative burdens.

The sixth theme was that pharmacy fees may continue to create financial uncertainties for independent

pharmacies. Interviewees generally agreed that post-sale fees make it difficult to know the true reimbursement amount for a specific drug. There was a general acknowledgment that differences in post-sale fees across pharmacies contributed to price variation. Interviewees also expressed dissatisfaction with the lack of transparency from PBMs in determining post-sale fees.

A few commented on the policy change to reflect pharmacy fees at the point of sale beginning in 2024. One interviewee said that this change will result in pharmacy fees being indistinguishable from ingredient costs, preventing pharmacies from appealing MAC prices. Another thought that the policy may allow for pharmacists to decide not to fill a prescription if they expect to incur a loss.

Lastly, we heard from nearly all interviewees that, in their views, Part D plans' payment rates are not likely to be the direct cause of ongoing drug shortages.

Several interviewees noted that large purchasers are contributing to race-to-the-bottom pricing, pushing prices down until they reach a level that is too low for some manufacturers to operate profitably and, therefore, leave or not enter the market.

Some added that higher reimbursements for generics would only contribute to pharmacy margins and would not reach others in the supply chain.

One interviewee, however, suggested that higher payments may flow through to the manufacturers and help address shortages caused by financial rather than other supply chain-related issues.

Now to summarize. In summary, we want to highlight two key takeaways. First, when analyzing Part D prices for generic drugs, it is important to understand some unique features in Part D, namely that, in most cases, generic point-of-sale prices only indirectly affect beneficiaries and the Medicare program. This is because both premiums and program costs are based on net prices accounting for post-sale pharmacy fees.

In addition, cost sharing for most generic prescriptions are subject to copays. So in most cases, beneficiaries are not affected by high point-of-sale prices or wide variation in prices.

Another key takeaway is that the amount paid by a Part D plan for a given generic prescription is likely different from what we typically mean by price in that it

reflects MAC prices set by PBMs and varies widely by plan and by pharmacy.

Further, rather than focusing on the payment for a given prescription, Part D plans and their PBMs may have a specific target price, such as AWP minus 80 percent, across all or most generic prescriptions, which is often achieved by periodically adjusting MAC prices or post-sale pharmacy fees.

We plan to continue to monitor prices and pharmacy fees as well as any beneficiary access challenges as changes take place both in Part D and across the pharmaceutical landscape over the next several years.

We welcome any questions or comments that Commissioners may have on this work. Thank you, and I'll now turn it over to Mike.

DR. CHERNEW: Pamina, thank you. That was great. It is amazing how complex we have built the market around a product that's supposed to be commoditized, and the ramifications are extensive.

With that, I think we're going to go to Round 1 questions, and if I have this right, Larry is first.

DR. CASALINO: Yeah. I found, as you're

speaking, I have a few questions. Very nice work with the interviews, by the way. It adds so much.

The first question I have is the point of service fees that, I guess, you said since beginning of this year are paid at the time, at the point of sale -- the pharmacy fees, I should say, are paid at the point of sale. Since those seem to be -- if I understood properly, those are determined by certain measures that the health -- the PBMs use of what pharmacists do over a year, I guess. How do they know what the pharmacy fees should be at the point of sale? Seems like you wouldn't know that until much later.

MS. SUZUKI: So the regulation is based on the lowest possible fee. So if they had a performance-based fee that could just subtract maybe 5 percent, up to 5 percent off of the total gross spending, then that would be the prices that would be reflected at the pharmacy counter. Later on, if they actually performed well on some metrics, they could get some of that payment back as a bonus payment.

DR. CASALINO: Okay. So it really isn't the final pharmacy fee necessarily.

MS. SUZUKI: Exactly.

DR. CHERNEW: All right. Thank you.

The second question is the -- so since the beginning of his year, the pharmacy fee data is available to you guys but not publicly, or it's not available to you or publicly?

MS. O'NEILL HAYES: There's always a lag in us getting the data from CMS, and so we won't have any of the data for this year until later in 2025 or possibly 2026.

DR. CASALINO: But you will be able to get it. And will researchers be able to get it, or is this special for MedPAC?

MS. SUZUKI: So this was part of the confidential DIR data. Some of the lowest price might show up at the pharmacy point-of-sale prices. It's not clear to me how much of the pharmacy fees are going to be distinguishable from the ingredient cost and dispensing fees that are in the claims. So what we might see is that the net adjustment at the end of the year.

DR. CASALINO: Okay. Now, next to last question. You didn't talk about it so much today, but in the written materials, there seems to be a fair amount of consolidation. I mean, I think a lot of us knew that

there's consolidation among PBMs and health insurers, but the wholesalers, a ton of consolidation. So in other sectors of the industry, I kind of understand how the concentration plays out. Can you talk a little bit about what kind of impacts you think consolidation has in generic drugs?

MS. SUZUKI: So one of the themes we heard is when you are smaller independent pharmacies, you are negotiating with essentially the three big wholesalers over generic pricing. Their leverage is not quite as big as it would be if you were one of the larger chain pharmacies. So your acquisition costs are likely to be higher than for chain pharmacies.

DR. CASALINO: Mm-hmm.

MS. SUZUKI: And in addition -- we touch on this a little bit in the paper -- the larger chain pharmacies have a joint venture with wholesalers, which is called "consortia," to negotiate better acquisition costs. So they have the leverage. They have this joint venture that provides them with lower costs.

DR. CASALINO: So consolidation, wholesalers versus pharmacies, is an important issue potentially.

But PBM consolidation vis-a-vis wholesalers is not really an issue because the PBMs are not interacting directly with the wholesalers? Do I understand that correctly, or am I wrong about that?

MS. SUZUKI: So some PBMs do own pharmacies.

DR. CASALINO: Right.

MS. SUZUKI: And actually, most of them own specialty pharmacies.

DR. CASALINO: Okay. All right. Last question. And this is personal, but I ask it because I think it will maybe help us understand things. So there's a generic drug, long-acting diltiazem. It's a very common important cardiovascular drug. I've been taking it for years. I recently got -- started to get emails from one of the largest PBMs in the country saying, "This drug is out of stock. Talk to your doctor about a substitute." Actually, there is no really good substitute for it. So I finally called, and after five minutes with AI and nine minutes on hold with no sounds of any kind, hung up, called back, five minutes with AI. I got someone who kind of knew what they were talking about. She said, you know, "No, we don't have it. We don't know when we'll have it. Would you like to

be put on a waiting list?" This is one of the biggest PBMs in the world, right? "Would you like to be put on a wait list?" I said, "Well, that isn't going to do me much good. I only have about six left, and you don't know if it's going to be a month or six months or what it's going to be." So she said, "Well, call around to the local pharmacies. Some of them may have it."

So how can it be that over a pretty long period of time, this huge PBM does not have a very common, important drug and yet local pharmacies do. The local pharmacies were part of a big pharmacy chain. They were chain pharmacies, but can you elucidate this at all?

MS. SUZUKI: So PBMs are not technically purchasing prescription drugs. Pharmacies are purchasing them. So when there's supply chain disruptions, that means the PBM is the payer. The payer has no control over what happens in the supply chain and if there's a shortage.

DR. CASALINO: But they serve as a mail order -- I should say they serve as the mail order pharmacy in this case. So they are directly providing it, buying and providing the drugs.

MS. SUZUKI: Right. And so when there's supply

chain disruptions, they're not even able to obtain.

DR. CASALINO: But how would one pharmacy chain be able to have the drug and this big PBM with its own mail order pharmacy not be able to have it, not just for a week or two, but over months?

MS. SUZUKI: So I don't know the specifics of the prescription, but a lot of times there are multiple manufacturers for cheap generic drugs. And each wholesaler may choose one out of multiple manufacturers, and the supply chain disruption could be related to that particular generic manufacturer.

DR. CASALINO: Okay.

MS. SUZUKI: So that might be one of the reasons.

DR. CASALINO: And this is my last comment. So unlikely to be the PBM and its pharmacy holding out for a lower price from the wholesaler. That's unlikely to be the cause?

MS. SUZUKI: Not a direct cause.

DR. CASALINO: Yeah, okay.

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

DR. NAVATHE: Yeah, I just had a quick question

about the consolidation part, and I may have missed this, Shinobu, so I apologize if I did. But when we talk about the consolidation of the wholesalers, there's the kind of "ill effects," let's call it, of the consolidation in the negotiation with independent pharmacies. But is there a benefit then in the concentration with negotiation with manufacturers?

MS. SUZUKI: So I think some of the themes that we heard is that wholesalers, the large wholesalers, have huge leverage with generic manufacturers, and that's where a lot of the downward prices may be happening because they're so powerful. They have 80, 90 percent of the market share.

But from the independent's perspective, they're working with GPOs that account for a much smaller market share than the chain pharmacies that have their own negotiating entities.

DR. NAVATHE: So just out of curiosity, I think, to some extent, asking the question that Larry probably intends to ask is, have there been studies that looked at -- all said and done, does that concentration play out better for beneficiaries and consumers? Does that

consolidation net out because it's kind of in the middle, or is it worse? Or do we not know?

MS. SUZUKI: So I don't think we have a clear view, and it may be different for different therapies.

If you only have one generic manufacturer, your leverage may not matter.

DR. NAVATHE: Thanks.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you for this excellent work.

One of my Round 1 questions is about the --

DR. CASALINO: Stacie, put the mic a little closer.

DR. DUSETZINA: Sorry. Struggling with the cold, too, so this is double whammy.

For the post-sale DIR, there's a comment about it returning to Medicare and taxpayers. One of the things I worry a little bit about in this space is how much of that gets soaked up in the supply chain, and do we have any insight into, like, those post-sale DIR fees and to what extent they actually do come back to Medicare? Are there some opportunities, I guess, for especially vertically

integrated groups to take advantage of those, like, callback payments?

MS. SUZUKI: So this is where it's hard to follow the money, and in the bids, they're expected to bid with the assumption of certain amount of DIR fees that they're going to earn. There's reconciliation at the end to make sure that your capitated payments are near what you bid at -- or your actual cost was. Sorry. But I think there could be some amounts that are not completely clawed back, but some plans do lose money, in which case, they're eating some of the losses as well.

DR. CHERNEW: Can I just say -- and maybe I'll ask this as a question. It's very hard to do this all in an accounting sense, because there's negotiations all along. So you might say I've got all this money and I'm using it for this, but it could change the other prices that are being negotiated. So it's very hard to assume that the money is fixed.

I just think all of these rules about when things have to happen affect the overall equilibrium, and that's really ultimately what's going to matter.

MS. KELLEY: Gina.

MS. UPCHURCH: First of all, thank you for taking a super complicated issue and pointing out that it's super complicated.

[Laughter.]

MS. UPCHURCH: That's what you did, and this is just payback for those of us who've had to learn about the physician fee schedule, by the way.

And full disclosure, I am a pharmacist, but I do not dispense and did for about a week and haven't done it in about 40 years.

Could you explain -- just four questions in Round 1. Can you explain what the generic effective rate is? Can you describe what it is, the GER?

MS. O'NEILL HAYES: I'll take a stab at it. So essentially, when a PBMs contract with pharmacies for their reimbursements, at the end of the day, what is paid for an individual drug is not necessarily as important as what is paid for all drugs overall, including with these post-sale pharmacy fees. And that generic effective rate is really getting at that point, and so they are looking at -- they have a formula that they are looking to have as an average across-the-board payment rate. So when you add up each

individual price, it all adds up to, for example, say, AWP minus 80 percent.

And so as they're going through the contract here, they've made a payment at this rate, at this rate, at this rate, at this rate, and then they say, "Oh. Well, we're getting away from our GER. It doesn't look like we're going to meet our target effective rate of AWP minus 80 percent." And so then they start adjusting, whether it's the MAC price -- we've heard from many people that MAC prices are adjusted regularly. We've heard as frequently as every week. And so that's for the drug itself.

But then also on top of that, they can adjust the post-sale fees, and so they have two different levers to make adjustments to try and keep them on target towards that effective rate for everything overall at the end of the year.

DR. CHERNEW: Gina, I think it's just an index. It's like a price index relative to AWP.

MS. UPCHURCH: Right.

DR. CHERNEW: Is that basically right?

MS. UPCHURCH: Yeah, yeah.

So at the bottom of page 13 in our chapter, it

says pharmacy fees accounted for 94 percent of DIR. Is the other 6 percent of the DIR, the GER?

MS. SUZUKI: So pharmacy fees are inclusive of whatever GER adjustment that PBMs are making at the end, and so we don't have a clear view of, like, how much of the pharmacy fees are based on GER versus other performance metrics.

MS. UPCHURCH: Right. Well, my experience talking to pharmacists is very little of the DIR has to do with how well they're doing in the pharmacy improving patient care. It's more of this price situation.

So on page 14 -- and this is getting at some of what Stacie was talking about -- it says under Part D's risk corridors, Medicare shares financial risk with plans by limiting each plan's overall losses or profits through risk corridors, excluding reinsurance. It's much higher or lower than plan sponsors anticipated than it's been. Do we know what's going on in terms of do plans often owe Medicare money at the end of the year, or does Medicare often owe plans money at the end of the year?

MS. SUZUKI: So this is something that changes every year. There's a total amount that we know, and we

can look at plan by plan to see which plans are paying CMS back for larger profit versus receiving money from CMS. And this is just all over the place.

MS. UPCHURCH: Okay. So it doesn't trend really one way or the other.

MS. SUZUKI: I think there are years when it's larger than other years. It's -- my recollection is it hasn't been particularly large in recent years --

MS. UPCHURCH: Okay.

MS. SUZUKI: -- meaning that plans are able to predict fairly well.

MS. UPCHURCH: Right. Okay, great.

And my last question -- and this might be a Stacie question too, but on page 17, it's talking about antipsychotics and antineoplastics. It says the therapies with widely different price points -- and then you give a range of $1.60 and $102 for a medicine -- have a relatively large variation. Is that because they are often used in specialty pharmacies, and many of them are vertically integrated or not vertically integrated? Do you know why there's incredible variation in those medications, in particular?

MS. SUZUKI: I don't think we have a very good insight on why these particular classes have large variations. Typically, what we have seen is lower-cost drugs tended to have larger variation because prices can go up by a dollar, and that's a huge change.

But this was a case where we were not sure. Antipsychotics seems like a very widely used, relatively low-priced drug.

MS. UPCHURCH: Mm-hmm.

MS. SUZUKI: So we have dug deeper into the drug-level data to see what's going on. It hasn't been clear to us what was driving the large variation.

MS. UPCHURCH: All right. Thank you so much.

MS. KELLEY: Brian.

DR. MILLER: Thank you for this chapter. I have to admit I read about it two or three times. I was like, "Wait. Hold on. There's something more in here I missed."

So one small thing and one question. I saw on page 37; we gendered the HHS Secretary. Generally, they're referred to as "the Secretary." So we should probably correct that.

My question was when we were talking about

stakeholders -- and I loved it that you guys did stakeholder interviews across the spectrum, which I don't think enough people do in this space -- two stakeholders that I was wondering, did we talk to generic drug manufacturers or contract pharmaceutical manufacturers?

MS. SUZUKI: So we tried within the couple months to reach out to different stakeholders. As we noted, it was fairly small stakeholder interviews and did not include the manufacturers themselves. We did talk to experts who have some knowledge of what's going on with the manufacturers.

DR. MILLER: So we didn't talk to -- just to clarify, we did not talk to a generic pharmaceutical manufacturer when looking at pricing in the generic drug space?

MS. SUZUKI: And I think part of this is our focus was on what Part D plans pay and whether or not it was related to, say, acquisition costs for the pharmacies or whether we could learn from wholesalers what they're paying to the generic manufacturers. And what we learned is generic manufacturers, particularly when there are multiple competitors, can set their AWP, but what they get

paid may not be related to that AWP.

DR. MILLER: Right. But we didn't hear that from the manufacturers themselves. I think it's really important in work like this, when we're looking at a marketplace, to actually talk to the organizations making the product, be it a generic pharmaceutical product manufacturer, a contract pharmaceutical product manufacturer, because many of them contract out their manufacturing -- or at least the trade association.

And then there's another key factor, I think, in determining price, which is FDA product regulation and manufacturing regulation. So as part of those stakeholder interviews, did we talk to the FDA Office of the Generic Drugs or the Office of Manufacturing and Pharmaceutical Quality?

MS. O'NEILL HAYES: No, we did not.

DR. MILLER: Okay. I think we should. Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you so much for, as Gina said, making this very complicated topic clear in terms of how complicated it is.

So I have a few questions, which will hopefully be relatively straightforward. The first question is, on page 6, you allude to Medicaid inflation rebates, the basics of the reading materials. And I was just curious how those work and how they work relative to the Inflation Reduction Act, inflation rebates.

MS. SUZUKI: So they track the average manufacturer price amp, and they compare that to CPIU and figure out how much is the excess inflation. And that's what the manufacturers get charged for excess price growth.

DR. NAVATHE: Great. Thank you.

Second question. So Larry asked a question about the January 2024 change, where the point of sale price has to reflect the lowest price, and he asked about it in the context of how the data would change. And I was just curious. Do we expect that any of the pharmacy fees themselves would be likely to change with this POS change?

MS. SUZUKI: So this just began. Some pharmacies have said that the payment rate that they've received is so low, because this should be -- this is supposed to be the lowest possible amount that a pharmacy could get paid under the system. But we don't have an actual data to know how

it compares to when it was post-sale.

DR. NAVATHE: I see. But then in response to Larry's question, you had noted that there may be a kind of later true-up, right? So I guess we don't know. It's possible that it could have some effect, but it's also possible that that could be netted out in a later point. Is that correct?

MS. SUZUKI: Yes.

DR. NAVATHE: Okay, great.

And then my next question is, later in the reading materials, you noted that cardiovascular medications are the ones where the average net price is actually greater than the gross price, and I was curious why for metoprolol or amlodipine is this likely to happen relative to other medications and other classes.

MS. SUZUKI: I don't think we have an insight into why. It probably depends on what the metrics are that PBMs are using to determine the amount of pharmacy fees. Pharmacy fees, in general, could be positive or negative.

DR. NAVATHE: Thank you.

Last question here. So you looked at the price variation and also noted the difference in levels by state,

and I was curious. Did we expect to see differences by state, and are there specific aspects of state policies, state regulation, or something else that would lead us to expect that?

MS. SUZUKI: So earlier in the Part D program, we looked at variation in prices, average prices across states, and it generally seemed like on average, prices are not variable across states. It's a national market. So this was a little bit surprising to see how much the pricing differed for the exact same drugs across states, and some states were more likely to be on the lower end versus the other. But we also looked at a very small number of drugs. So this may not be generalizable.

DR. NAVATHE: I see. So to say that in another way, there could -- so what we're observing could be true, could not be true if we look at the whole kind of whole kit and caboodle. At the same time, it doesn't seem that there's necessarily anything about the states per se, but there could be market differences in terms of presence of MAPD and other things that could also be related. In our analysis, we wouldn't be able to reveal, but we can just sort of see that there's a state-by-state variation.

MS. SUZUKI: The state-by-state variation may be related to the fact that PDPs typically serve at the state level, and so the extent to which some of the market shares are larger for certain PBMs or plan sponsors might be affecting the prices.

DR. NAVATHE: Okay, great. Thank you so much. That was very helpful.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much. I thought this was absolutely fascinating, and I often read things twice, but this one was thrice. And I still feel like a novice.

I mean, I particularly appreciated the stakeholder interviews and the magnitude that you were able to do in a very short time, and I have a question about tying arrangements. I understand that tying arrangements are not necessarily unlawful, but that antitrust concerns are raised with tying arrangements, to the extent that they maintain or augment the seller's existing market power or preexisting market power or impair market competition. And obviously, in this space, this is when we really need, you know, good market competition. So thoughts on that? Or hopefully, that's a Round 1, Michael, but that really

jumped out at me.

MS. SUZUKI: So again, this was based on a handful of people who we spoke with, but we did get a sense that this was a commonly used way that wholesalers would provide different ways of discounting prices.

And I think what was interesting is there were a couple people who mentioned that they now have these alternative arrangements with cooperative-style wholesaler arrangements. So they're not purchasing from the big three necessarily, and maybe their prices are slightly higher. But they are not tied to these arrangements.

DR. RAMBUR: I see. Thank you very much.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. Again, kudos on great work, particularly including the stakeholder interviews and making sense of a very challenging space.

So what I'm trying to get my head around is as we went into this work and net of the work we've done, what do we think the biggest problems we're trying to get to the root of or potentially solve? And as I thought about it, there's at least four. There may well be others.

So from the beneficiary perspective, there could

be the issue of somebody using their Part D benefit and paying more out of pocket than they would through a GoodRx or Mark Cuban. That's a potential problem.

From a key provider perspective, there's the issue of small independent pharmacies potentially being run out of business and the implications that has, which would be very significant in many parts of the country.

And then from the regulator and public policy perspective, I think there's at least two. One is whether the overall lack of transparency in this space precludes any meaningful oversight, and that would then have a lot of downstream implications potentially.

And lastly, whether the current behaviors in the industry, including consolidation and the various means of contracting, some of which may raise, as Betty and others point out, some antitrust issues, whether those behaviors are contributing to generic shortages.

So do we have a sense what -- you know, as we tee up further work, because obviously this is very preliminary, right, what are the biggest issues that we're trying to get to the root of?

MS. SUZUKI: I think our initial goal was pretty

narrow to understand what we're seeing the literature about higher prices or variation in prices, whether that's affecting the program itself. It was a narrow goal of understanding that situation. But in the process, we felt that we had to understand the supply chain negotiations that goes on.

I think it's -- I think for your discussion that you can talk about what are the things that we should focus on going forward.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks for such great work. Such an interesting read and kind of following sort of all the actors in this. It's like trying to sort out a maze.

So I want to echo Larry's comment about consolidation issues. You know, there just seems to be a lot of concentration at every step in this chain, which I think raises concerns.

But in terms of my two questions that I need clarification on, on page 33, there's reference to performance measures that are used to determine fees to pharmacies, that pharmacies pay. And I guess, can you provide any examples of what those performance metrics are?

Is that information that they shared with you?

MS. SUZUKI: So we did not get into the exact performance metrics that they think were used, but a lot of people said it was unclear how these were measured.

We've read in literature that sometimes they're based on generic dispensing rates. At the same time, if it's a statin and you're evaluating this at, say, long-term care pharmacy, there may not be a generic dispensing rate that's applicable to many patients who are getting drugs through the long-term care pharmacies.

DR. DAMBERG: Yeah, go ahead.

MS. UPCHURCH: That's a great question, and I do think it's pharmacists don't know, and each PBM can have different metrics. And you aren't talking to the PBM. You're going through your PSAO to get the information, and you get audited. And they can come back and snatch money and come into your pharmacy, or they're doing it virtually now after the fact, like a year or so after the fact.

But one of the things that we hear is the generic fill rate, and as I think I pointed out at one point, Annette DuBard and team came up with this heavy weighting and the star ratings that puts pressure on pharmacies and

the PBMs to have generic fill rates. So you can go into somebody's home, especially if they're dual eligible, and see massive amounts of medication, because it was just auto-sent to somebody because they have a wonderful generic fill rate, and we're wasting medication.

So the metric of generic fill rate can create a massive problem, and it's highly overrated.

DR. DAMBERG: Yeah. Thanks for saying that, and I've actually heard from some people that that is going on. So I think that's hugely problematic.

And then my other question -- so on page 8, there was a sentence, and I think it's related to the study done by Trish that says 90-day fills have higher prices than 30-day. And I found that counterintuitive because at least in the plan that I belong to, they're always trying to push 90-day fills and sort of promoting them as, like, you'll save money. So can you help me --

MR. POULSEN: Sorry. Just wanted to -- my recollection was it said higher variation among the 90 days, not higher prices, but I may have remembered that wrong.

DR. DAMBERG: Yeah. On page 8, it says higher

prices in part D were found to be much more common for 90-day prescription fills than 30-day.

MR. POULSEN: Okay.

DR. DAMBERG: So I'm just kind of confused by that.

MR. POULSEN: Yeah.

MS. SUZUKI: So one possibility is that a lot of the Part D plans do own their own mail-order pharmacy. Their PBMs own their mail-order pharmacies, and what they're comparing is what's paid to those mail-order pharmacies before any post-sale reductions. And that might be one of the reasons why you're seeing a bigger difference there, potentially, because it's not the regular retail pharmacies that you're dealing with.

MS. KELLEY: So that's the end of Round 1. Shall we go to Round 2, Mike?

DR. CHERNEW: Yes, but I do want to say one thing --

MS. KELLEY: Okay.

DR. CHERNEW: -- related to this issue of consolidation. Consolidation is clearly important. The challenge in this market is there's horizontal

consolidation, there's vertical consolidation. In markets where there's consolidation on different sides of the market, it's very hard to know how the equilibrium is going to play out, and I think the economics of this particular market where it's not just horizontally consolidated people working with others, and then there's pricing arrangements where, like, you pick one unique generic manufacturer, so that ties you into something that creates other switching cost issues, it's just the economics of this are really, really, really challenging. And I think that's, in many ways, what I take from the chapter.

But it also means it's going to defy some sort of simple solution, because you're going to be pulling something somewhere. There's a whole other bunch of things can change.

So I think we're going to need to keep thinking through these aspects of consolidation, but it's not going to be some simple story in the end, in my view.

Anyway, sorry. That was a lengthy comment, and I think, if I'm right, Stacie is first.

DR. DUSETZINA: All right. Thank you.

So I agree completely this is not going to be one

simple set of solutions or a simple story. The chapter made that very clear. It's a complicated area.

So the first comment I wanted to make was really about -- so I've done a little bit of work here specifically around specialty generics for cancer drugs. And one of the things that I worried about in that work was around what looked to be just kind of extreme overpayments to pharmacies that were occurring. And again, knowing that you don't have public-use DIR, post-sale DIR, so knowing that's inflated, but also not knowing to what extent the amount that's being assessed is going to be different by vertically integrated set of organizations that own that pharmacy and especially when they're specialty pharmacies and ones that are not.

So maybe 00 I really liked Scott's comment about the framing of the different problems. One of the problems there to me is, you know, how much of those potential overpayments -- like, let's say a vertically integrated organization doesn't take as much back from their own pharmacies than they do from all of the other pharmacies they work with, which would be my suspicion. So then you wonder about like the sustainability of pharmacies that

aren't owned by that parent company, which I think is an important problem. I don't know what to do about that. That's a really hard thing to understand, and it might be that looking overall, you can't see that pattern. But it might show up more in the specialty pharmacy space. So I guess vertically integrated and specialty pharmacy feel like a place to potentially look a little bit closer if you continue work in that space.

Another thing I think is really important here is what problems are solved now under these new changes. So I think you did a nice job of highlighting that prior work didn't have this information, but, you know, what we're looking at in the future will really be closer to the actual prices that are paid. Maybe not. Maybe we are underestimating in that case more likely. But I think there's also an opportunity to talk about policy changes that kind of reduce our worry about beneficiaries being harmed.

And you do a nice job of kind of saying a lot of people pay co-pays. I think that's even going to be more likely under the redesigned benefit, so not switching into co-insurance depending on where your drug spending is at

certain points in the year.

And I also think you could potentially weave in the $2 drug list that CMMI is going to be piloting. That's going to cover a very large number of generic drugs. So for people who worry about this for, like, general beneficiary generic drug access and, like, how big of a pain is it to not overpay -- you know, are you going to have to go to multiple pharmacies and look up coupons? That might be another thing that kind of lessens our concern that this is harmful to beneficiaries.

And then I think the last thing I wanted to comment on was around the issues of things like drug shortages. Yeah, I actually think -- kind of counter to Brian's comment about interviewing the manufacturers, I think the wholesaler is the right group to be talking to for the scope of work you're looking at right now. But I think if we were orienting this around things like drug shortages and larger access issues, I worry a lot.

And you got this from one of the interviews, was, you know, that that money, if you started to pay more, it doesn't necessarily fix the issue of the generic manufacturer getting paid adequately. So it's possible

that money just gets taken up in the supply chain, and I'd say if we did want to work in that space or try to understand that dynamic, I think that's probably even more extreme in the clinician-administered drug space where the contracts -- you know, it's hard to believe they could be even more complicated and worse. My impression is that they are in that space.

So thank you for this really excellent work. Really appreciate it.

MS. KELLEY: Gina.

MS. UPCHURCH: Yeah. I'm sorry. I'm going to read this just so I don't miss anything here.

This chapter is about much more than generic drug prices. The word "idiosyncratic" was used several times and rightfully so, as you tried to find trends to describe how and why generic medications are more or less expensive than the same medicine at a different time or a different place. It's too complicated with all the different players. In fact, some players are missing from the diagram, which you call the "simplified," like switch companies that route claims between the pharmacy and the plan via facilitator, troop facilitator related to Part D.

FYI, Change Health is a big switch company. So it's been a real headache for pharmacists lately, and by the way, they're not paid to -- the pharmacies actually pay the switch company to adjudicate claims.

Pharmacies also have to spend time and resources when they're audited by all the different PBMs. The Part D benefit added lots of expenses to pharmacies, and the new payment plan that's coming in January will also put more unpaid responsibility on pharmacists -- pharmacies, pharmacists and their staff. There are now so many middle men and women in the prescription-dispensing world. The actual pharmacy slice is dangerous. The pharmacy slice is dangerously small, especially for independent pharmacies, as you pointed out.

We're allowing the system to squeeze out the actual health care professional who is trained to be the drug expert.

We note that we want to continue to monitor prices and access to Part D. I will add that we need to monitor access to the pharmacy of the Medicare beneficiary's choice. In order to do that, I want to continue following the money flows from the manufacturers

to the Medicare beneficiaries.

For older adults and adults with disabilities, beginning in 2006, June, they would no longer need to shop around, as one of the beauties of Part D was that the Part D card would mean you have a negotiated price at a pharmacy as long as it was in network. Now with irrational drug prices explained in your chapter, preferred aka "often vertically integrated pharmacies" and DIR fees mean that pharmacists actually may lose money, often significant sums, by dispensing medications, especially brand-name medications.

Medicare beneficiaries in the know have to strategize multiple means to access their meds. GoodRx over here, a mail order from Mark Cuban over there, patient assistance programs over there, and the many other methods -- and many of them bypass the local pharmacists, which, given errors in electronic health records and the lack of interoperability in electronic health records, can often be the last hope for catching drug interactions and other potential medication-related problems.

It's bad enough that the plans can dramatically change what medicines they cover and what costs from each

year with different utilization management tools, but then to have multiple sources of the least expensive drug is just too much for older adults and adults with disabilities who may struggle with transportation, technology, and who are barraged by sales tactics every year.

Pharmacies are being squeezed. On the purchasing side, you've got the GPO to negotiate with the wholesaler, and by the way, independents usually buy from a wholesaler distributor who is part of a GPO. But those pharmacies are offered better generic pricing but only if they pay more for the brand-name drugs.

On the reimbursement side, they contract with PSAO, which we've just learned is really not negotiating better prices for them with the PBM. They're just helping them with administrative burden and reporting. So pharmacies are being squeezed, some right out of business.

The pharmacy preferred by their vertically integrated brothers and sisters are overwhelmed and literally walking off the job as they feel their working environments endanger patient care. The independents are literally having to send people away as they cannot afford to fill some of their brand-name medications.

As you can imagine, in 2018, a federal law was passed that wouldn't allow PBMs to include gag clauses that prohibited pharmacists from telling patients that they could save money by not using their insurance card but by paying cash.

Now, as I understand it, there is a clause in PBM contracts that pharmacists or their PSAO, sign that says pharmacists cannot tell their customers that they are losing money by dispensing medications. So they simply say something like, "I couldn't get the medication" or "I can't get the medication," so people are having to shop around to get those expensive medications, like Eliquis, for example, at your regular pharmacy, not being able to get it.

The PBM's plan quality bonus payment was sold to pharmacists and pharmacies as a way to be a part of the health care team, that their engagement in medication safety via med reviews and work on adherence would not only benefit patients but mean that they could make money by providing interventions beyond being tied to dispensing a medication.

That's not what happened, and it really could be no further from the truth. In general, we know that

pharmacists are not considered providers and cannot directly bill Medicare, but we want them to be accessible to Medicare beneficiaries in meaningful ways, and we want them to use their years of medication education to improve patient care. The current reimbursement system needs to be examined. It will be critical as the redesign of the Part D benefit begins.

If access to medication improves, we'll want to make sure that there are boots on the ground to deal with polypharmacy.

In addition, the Part D plans will likely tighten their formularies and once again will rely on pharmacists to help navigate access to medication with no reimbursement for that service, the critical counseling that should be happening when people have questions about their prescription and over-the-counter meds.

Finally, if we want to access pharmacists and we want their expertise to improve access to medicines, ensure that medicines are doing more good than harm, we have to understand where the money is going and ensure that pharmacists are able to hire the help they need to adjudicate claims so they can focus on better patient care.

So I really want this chapter published and I want us to keep diving.

Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thank you.

So sort of three areas I was thinking about. One, I would say is variation versus price level. So we spent a lot of time in this chapter talking about variation because the idea is that generics are a commodity product. There are lots of other -- within health care, outside of health care, there are lots of other commodity products that also have a lot of price variation, gasoline, food, electronics, the candies that I enjoy munching on. So that I think that our focus on variation potentially puts us at risk of missing the big picture of the actual price level.

So when I read this chapter, I read it as a chapter about problems in price variation in generic drug markets as opposed to problems with pricing and, hence, access in generic drug markets. The reason I mention that is if we have a different lens, we can often end up in the wrong place.

Looking historically at other economies, in the

former Soviet bloc countries and the Soviets, they were very obsessed with price variation, and they believed in centralized administrative pricing, and that there was one unitary price for goods and services that had a lot of negative economic and innovation consequences. So I think we should be focused more on price level as opposed to price variation.

The sort of second thing I wanted to talk about was I think that we need a wider lens, and that's why I was asking those questions about the FDA. It wasn't to be annoying. It may have been annoying, but that was not my intent.

So I realized that our focus here is payment, but if our focus is on price levels and beneficiary access, there are a lot of factors that go into that. I agree that the purchasing supply chain is a mess -- that's my professional medical opinion; it's a mess -- and that you did a phenomenal job laying it out. And it would have probably taken me about two years to do this work. So hats off to you all.

The reason I was asking about things like the FDA, so thinking about the FDA and pharmaceutical product

regulations, so generics, there's a standard for entry. There's bioequivalence. Manufacturing is a big concern. The FDA set up, arguably appropriately so, a lot of manufacturing quality oversight in the last couple of years that took a lot of capacity offline for both generic manufacturers and also contract pharmaceutical manufacturers, which obviously in a batch-based production model affects supply, which then affects what the wholesalers and other components in the supply chain then face.

I realize that we can't go tell the FDA what to do, but it's, I think, actually highly possible that many of those factors related to the FDA -- or I also would mention the FTC, the way that they approach pharmaceutical product mergers, typically takes what we would call the "Skittles counting," so it's counting the colors of the Skittles of the products and then a divestiture model. They've used that for 30 years, which then ignores macroeconomic effects that you normally would look at in mergers, manufacturing capacity being one of them. A long way of saying, I wonder if some of these competition dynamics and competition policy issues, along with the FDA

product regulation issues, affect the generic markets even more than the messy diagram that we have laid out here.

As a consequence, even though the supply chain that we've laid out, which is highly dysfunctional, that those other factors matter even more. If we don't look at those other factors, then we might make recommendations about payment when it's really those other factors that could be driving a lot of this.

And I'm not saying that the PBM and the wholesalers and the DIR and all that stuff is not a problem, but that those other factors might be equal or more so, and so we should look at that, Because that way, if the answer is, yes, there are problems in payment, but by the way, there are 10 other things that are really outside of our scope that are much bigger factors, that's really important for us, because then we'll give better advice.

The third thing I was thinking about was shopping, and it's not because I need to go to the grocery store, which I do. But it's because shopping is a principle that sort of everyone has talked about and talked about challenges with things being confusing for consumers.

It's hard to figure out what the price is, the different prices, but really you want to know what the price is and what you as a consumer have to pay. We also want to know what the taxpayer has to pay.

So one thing I think that went unmentioned here is the real-time benefits tool under the Part D rule. Now, I don't kid myself. I don't think that the average beneficiary is going to go home and say, "Hold on. Let me log in online and look up my five heart failure drugs and my two diabetes drugs and my cholesterol drug and my rate control drug." That's just not realistic. That's not going to happen.

So then the question is -- that's a well-intentioned policy, but could price transparency and shopping help here? And the answer is probably. We have price transparency for the consumer at the point of service. When we go to CVS or our independent pharmacy, there's a real-time benefits adjudication, and you see what your price is as the consumer.

The problem is you don't have a prescriber there to change that if your drug -- if you show up and your drug is $300 and you can't afford that, you have to go back to

your doctor.

And so I think one of the things that's worth us exploring is could price transparency at the point of clinical service and taking that real-time benefits adjudication tool so that that pricing is available to patients and physicians or patients and nurse practitioners or patients and physician assistants at the point of service so they know how much the drugs cost, because then they could have those discussions.

And I'll say the AMA has actually updated sort of their professional guidelines and cost-effective practice and being a good steward of the patient dollars is considered part of the professional ethos. So being that we're hopefully in the business of solving problems, I would say that's an important solution that we should look at.

Thank you.

MS. O'NEILL HAYES: We appreciate your feedback and had to work within the scope of our project and the time constraints that we had, but yes, of course, all of those things are helpful.

DR. MILLER: Yeah. And so what I'm saying is

maybe we gave you the wrong scope.

MS. KELLEY: Kenny.

MR. KAN: Thanks very much for the fascinating analysis and shining light on a very complicated topic.

I echo many of my fellow Commissioners' concerns on consolidation, especially the impact on supply chain and beneficiary access.

I'm especially concerned about the impact on independent pharmacies, which Gina has articulated eloquently.

For future updates, can we look at possibly the impact not only of the -- you know, how the consolidation of PBMs and wholesalers has actually impacted generic drug makers and with respect to impact on price and to the extent that that consolidation from the customer could have contributed to them probably signing up more than what they could deliver, resulting in capacity issues and then possibly generic shortages? It's a conjecture. I have no way of proving it or disproving it, but I'd be very, very curious.

Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. So I was trying to think of the right analogy for this work, and I think some of it is you've illuminated this giant ball of yarn with all these threads. Maybe a "hairball" is a better term.

[Laughter.]

DR. SARRAN: So I think we may be at the point where the real question is, what threads do we pull on with the highest priority? And as I sort of listed those in my mind earlier, what I think I'm most struck by is the potential harm to the public if independent pharmacies are squeezed out, because they're not going to be easily replaced for a variety of reasons.

So I'm just going to make a suggestion that I think that is not necessarily is our top priority but should be among the top priorities for us to continue to understand better and whether there are potential things that Medicare can do that would alleviate that, because that is a -- you know, again, that is potentially, I think, an irreversible harm to beneficiaries. So I think we've got to prioritize that.

But I would perhaps -- if I had to rank them, rank second is the issue of Medicare -- what Medicare can

do differently to address the periodic generic shortages. And I know it's even more complicated on the Part B than the Part D side. But again, that's an area where there's potential immediate harm to beneficiaries.

So again, just making those suggestions that we continue to dive deeper into at least those two spaces from the perspective of what can we do to protect beneficiaries.

MS. KELLEY: Mike, that's all I have.

DR. CHERNEW: Thank you.

I don't have a ton of summary comments, except to say that it's really easy to think through the problems with this market and all the things that are going on, and it's very hard to figure out what the solution will be or how we will get to the solution in a range of ways.

And I think one thing that comes up -- some of this came out in Gina's comments -- there have been attempts to make reforms in a range of ways that we thought would then help the problem, and then there's a bunch of other things seem to happen around that because of the complexity here.

I do think it is particularly useful to note that this is the generic market. So some of the problems in the

branded market where there's monopoly innovation work out differently, but still, given all the different types of consolidation, I think a lot of money is going to efforts to both gain and then counter market power. And I'm not sure I have a good sense as to how to go about that, because there's usually some -- in those activities, there's usually some kernel of value, some reason why that's there.

And so I think we're going to continue now to at least shed light on what's going on. You guys did a terrific job, and we'll give some noodling to what we might do in terms of how to help this market, because I do think it's really not a good state of affairs when people have a hard time accessing the drugs from the providers that they want and have to shop in ways that I think are unreasonable to expect people to have to shop for the medications that they need.

So I think we'll give it some thought. My fellow Commissioners, if you actually have thoughts of things that you think could actually improve this situation, please let us know. This has defied, I think, a lot of people's easy one-time solutions, but it is certainly eye-opening to

read.

So again, thank you all.

We are now going to take a five-minute break, and ironically, we're going to come back, and we're going to talk about 340B. And this is just another example where we're trying to use drug markets to accomplish other particular aims, and so we will be able to voice our own level of frustrations around that in the next session.

But we're going to take a five-minute break and recharge. So see you soon.

[Recess.]

DR. CHERNEW: Okay. Welcome back for our last session of both the April meeting and this cycle, and we are -- as I said right before the break, we are going to jump into another complicated topic, 340B. And for that I'm turning it over to Nancy and Kim.

Nancy.

MS. RAY: Thank you, Mike.

The audience can download a copy of the slides on the right-hand side of the screen.

During today's session, Kim and I will present findings from our initial analysis that compares Part B

drug payments to 340B drug ceiling prices. We did this work because the Congress gave us access to confidential drug pricing data that permits us to update our prior 340B analysis. This material is informational only. It will not be included in our June 2024 report to the Congress, and we want to thank our colleague, Dan Zabinski, for his assistance with this analysis.

The 340B Drug Pricing Program requires drug manufacturers to sell outpatient drugs at discounted prices that is at or below the ceiling price to certain types of hospitals and other health care providers, called "covered entities," to be covered by Medicaid.

To be eligible for the 340B program, covered entities must meet various criteria, which may include treating a disproportionate number of low-income Medicare and Medicaid patients. This slide lists examples of hospitals and other providers who are able to participate in the 340B program. Covered outpatient drugs under the 340B program include prescribed drugs and biologics other than vaccines.

The Health Resources and Services Administration, HRSA, administers the program, and according to HRSA, the

340B program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients, and providing more comprehensive services.

Currently, Medicare pays all outpatient prospective payment system, OPPS, hospitals, whether the provider participates in 340B or not, the same payment rate for Part B drugs.

Prior studies by the OIG and MedPAC listed on this slide have found that 340B ceiling prices exceed the Medicare payment rate for Part B drugs.

In March 2016, the Commission recommended that the Congress direct the Secretary of Health and Human Services to reduce 340B hospitals' Medicare payment rates for separately payable Part B drugs by 10 percent of ASP and direct the savings from reducing Part B drug payment rates to beneficiaries and to the Medicare-funded uncompensated care pool.

Before 2018, all hospitals, irrespective of 340B participation, were paid at the same rate, average sales price, ASP, plus 6 percent. Let us know in Round 1 if you have any questions about what ASP represents.

Between calendar year 2018 through 2022, CMS via rulemaking established a policy of paying ASP minus 22.5 percent for most separately payable drugs that OPPS hospitals obtained through the 340B drug pricing program, except for new drugs for their first two to three years on the market.

In 2022, the Supreme Court ruled that the process used to change the OPPS payment rate was inconsistent with the statute. Because of the Court rulings, CMS reprocessed 2022 claims that had been paid the lower rate to bring the payments up to ASP plus 6 percent, and the agency implemented a separate remedy payment to adjust payments for the 2018-to-2021 period.

We calculated 340B ceiling prices, as shown by the formula on this slide, using 2022 confidential pricing data on the average manufacturer's price and best price. We then compared the estimated 340B ceiling price to Part B payments.

The Consolidated Appropriation Act of 2021, CAA, granted MedPAC access to the confidential pricing data for Medicare Part B and Medicaid drugs. MedPAC's use of the pricing data are subject to disclosure limitations defined

by the statute. The CAA prohibits disclosure in a form that would reveal the identity of a specific manufacturer or the prices they charged.

Our analysis used 2022 claims submitted by OPPS hospitals, the confidential drug pricing data, and published Part B drug ASP payment rates.

We included OPPS hospitals that billed fee-for-service Medicare Part B for drugs acquired under the 340B program as indicated by a modifier on the claim. The analysis does not include retail pharmacy drugs, including those furnished by 340B contract pharmacies.

To identify drugs to include in the analysis, we used 100 percent of the outpatient claims data and began with all Part B drug billing codes with OPPS spending on 340B drugs greater than $2 million in 2022. We excluded products exempt from the 340B program, vaccines, products without AMP data, products not paid under the ASP system, and billing codes that include generic products.

We excluded generic products because they account for a small share of OPPS spending for separately payable drugs. Generics that are separately paid represent less than 3 percent of OPPS 340B spending. Low-cost drugs,

including many drugs with generic equivalents, are often packaged into payment for other services under the OPPS rather than separately paid.

Based on these criteria, we identified 189 Part B drug billing codes for single-source drugs, originator biologics, and biosimilars, which account for 97 percent of OPPS spending on separately paid 340B-acquired drugs.

Now Kim will review our results.

MS. NEUMAN: Thanks, Nancy.

Next, I'll summarize the steps in our analysis method and the results.

As Nancy talked about, we used the Medicaid Drug Rebate Program data on average manufacturer price and best price to estimate the 340B ceiling prices.

We first calculated the ceiling price at the individual national drug Code, NDC, level. Then we estimated the 340B ceiling price at the Part B drug billing code level. For Part B drug billing codes with multiple NDCs, we calculated the volume-weighted average ceiling price for the NDCs associated with the billing code.

Because the data used to calculate 340B ceiling prices is typically reported in different units, often

milliliters, than the Part B drug billing codes, often milligrams, we converted the ceiling prices into comparable units to the Part B drug billing codes.

So here are the results of the analysis. For the 189 single-source products, OPPS payments, including program payments and beneficiary cost sharing for 340B-acquired drugs, was $11.9 billion in 2022. Note these payments reflect the ASP plus 6 percent rates, not ASP minus 22.5.

We estimated the cost of these products at 340B ceiling prices to be $8.1 billion. Expressed in terms of ASP, 340B ceiling price costs equated to approximately ASP minus 29 percent, an aggregate for the group of 189 products.

Overall, we estimated Medicare payments and beneficiary cost sharing together exceeded 340B ceiling prices by 48 percent, or $3.9 billion in 2022.

As one way to explore whether the difference between Medicare payments and 340B ceiling prices differed by type of product, we identified two broad groups of products, antineoplastic products that treat cancer and other products. We found that in aggregate, Medicare

payments exceeded 340B ceiling prices by 42 percent for the group of cancer products and 57 percent for the group of other products. The results we presented were for 189 products in aggregate.

The next slide provides a sense of the distribution across products.

For each of the 189 product billing codes, we calculated the ratio of the published Medicare payment rate, generally ASP plus 6, to the estimated 340B ceiling price. Across 189 products, the median product had a 340B ceiling price by 38 percent.

For half of the products, the Medicare payment rate exceeded the 340B ceiling price by between 38 percent and 60 percent, and you can see that by looking at the 25th percentile and 75th percentile in the chart.

The 10 percent of products with the largest 340B discounts had a Medicare payment rate exceeding the 340B ceiling price by 145 percent or more. For a few products, beneficiary cost sharing exceeded the 340B ceiling price.

There are several caveats to keep in mind with this analysis. First, our estimates do not incorporate any 340B subceiling discounts that manufacturers may offer for

some products. Data on subceiling discounts are proprietary, and the extent to which they occur and their magnitude for the group of drugs in our analysis is unknown. This means that 340B prices could be lower than we estimated, and therefore, the amount that Medicare payments exceed 340B prices could be larger than we estimated.

Second, our analysis excludes drugs with generic competition and is not generalizable to that set of drugs. The statutory formula for the 340B ceiling price requires a smaller percentage discount for generic drugs than brand products. Part B drug billing codes that include generic drugs comprise less than 3 percent of OPPS spending on separately payable 340B-acquired drugs in 2022.

Third, our analysis focused on 340B OPPS hospitals and does not include Part B drugs acquired by other types of 340B covered entities such as critical access hospitals or hemophilia clinics.

So this brings us to the end of the presentation. To summarize, in aggregate we estimate Medicare fee-for-service payments, including beneficiary cost sharing, exceeded 340B ceiling prices by about 48 percent for 189

single-source drugs, biologics, and biosimilars in 2022. We plan to update the analysis as data become available in the future. We would like your feedback on additional research ideas. As Nancy mentioned, there are confidentiality limits on how the data can be reported and presented, but we would very much like to hear your ideas. And we can bring through going forward what is feasible with that in mind.

We would also be happy to answer any questions. So with that, we turn it back to Mike.

DR. CHERNEW: Great. Thank you. This is just another amazing aspect of the system we have.

I think we're going to jump right into Round 1, and I believe this is going to be Stacie -- no.

MS. KELLEY: Scott.

DR. CHERNEW: Scott.

DR. SARRAN: So again, great, great work and really, you know, I think a very tightly written section explaining things quite well.

So the question I have, the Round 1 question is, is there another mechanism that CMS could take if they so desired to reduce reimbursements to hospitals who acquired

drugs under the 340B, meaning was it the specific process they took to execute that action that was deemed incorrect, or is it the entire pathway, if you will, towards changing reimbursement permanently closed off, other than if there is legislative solution?

MS. RAY: It was the process.

DR. SARRAN: Just to be clear, they could pursue some of that same action via different processes?

MS. RAY: So I'm looking -- I'm always looking at Kim, of course, but the statute states that CMS has to conduct a survey first and then can lower -- and then can change drug prices. And so the Supreme Court decision focused on the process that CMS -- at least my interpretation of the Supreme Court decision.

DR. SARRAN: Are we aware of whether CMS is pursuing the same action via different route?

MS. NEUMAN: I don't think we can speak to what their future plans are. They did a survey.

[Pause.]

MS. KELLEY: So it sounds like we're not aware of what their plans are for the future, Scott. Did you have another question?

[No response.]

DR. CHERNEW: Okay. Greg, did you have a Round 1 question?

MR. POULSEN: I did, but Scott asked it, so it was basically the same question.

MS. KELLEY: Okay. Should we move to Round 2, Mike? Oh, I'm sorry. Cheryl, go right ahead.

DR. DAMBERG: Yeah, thanks.

This is great work, and I look forward to seeing more updates in the coming months, year.

I think this is touching on where Scott was going which is, while this is informational now, is there some interest on MedPAC's part about formulating possible solutions, or is this really just kind of highlighting the continued differential?

MR. MASI: I see Nancy looking at me, and Mike should certainly weigh in here too.

I think this first step was just, as the presentation describes, initial findings. Congress gave us access to these more granular data, and so we wanted to report out what we learned from them.

But to the extent, as always, if Commissioners

want to pursue policy here, that's up to your discussion.

DR. CHERNEW: So I'll just say, again, to echo what Paul said, this, as I think the last session as well -- right now we're reporting data on things that we have. It does lend to a lot of concerns about things that are going on, and that, of course, generates a lot of interest to figure out, "Oh, my gosh." But the answer to what should happen is unclear, and we would have to both hear from all of you, have discussions of that in public. We're far away from getting to that point.

In this particular case, this is a 340B program and how you might structure it, but it's part of a bigger issue about how you would support the entities that the 340B program supports. And there's a lot of things you might do that would be quite broad of how you do that.

Right now, we're not at that place, so one guy's answer.

MS. KELLEY: Okay. So moving to Round 2, I have Stacie first.

DR. DUSETZINA: Thank you for this really important work.

I think maybe this is more kind of a big picture

question about how to advance this work or think about future analysis. And unfortunately, this is one of those areas where I think our segmentation by, like, the Part B versus other parts of the benefit is tricky, because I think when you say we aren't looking at retail drugs and we know that the increase in the number of contract pharmacy relationships are increasing, I think to me that brings up a lot of questions about the broader issues around 340B and sort of where those payments are flowing.

And now with more contract pharmacy relationships, are we seeing a greater proportion of that coming through the retail side in addition to what we see in Part B? And I realize that's different than our normal work streams where we kind of focus on one part of the benefit.

But I guess what I would encourage is that should we continue to move this forward, trying to really dig into the contract pharmacy relationships and how those have grown over time and then what proportion are retail drugs versus Part B drugs, just to have a fuller sense of the spending implications for this amount of overpayment, because that is a lot, 48 percent above the ceiling price.

That's a lot of payment.

So I think this is really important work to be doing, but I think, broadly, it would help to have the fuller context if we could get there.

MS. KELLEY: Brian.

DR. MILLER: Thank you.

A couple things that I was thinking about as I look at this. One is, in contrast to Stacie, I think we should be a little careful about 340B because 340B is, to some degree, out of our jurisdictional issue and our jurisdictional area -- pardon -- and is a MAC -- more of a MACPAC issue as opposed to a MedPAC issue.

The question here seems to be looking at setting up a narrative to reform Part B by tying it to 340B prices. That's a very narrow policy narrative, and I don't think that that is a good model for Part B reform. I think we need to think holistically about Part B physician-administered drugs, if that's what the goal is.

If we are looking only at the 340B to Part B ASB plus 6 comparison, this again sort of goes down the centralized administrative pricing as the only tool for drug pricing, and it supports the idea that only a single

central authority can set prices and solve what dynamic markets have solved in every other industry in the economy. I do not subscribe to the idea that centralized administrative pricing is the only option. It's one of multiple policy options. So I think if we're going to look at Part B physician-administered drugs, we need to look at all the models, not just compare to 340B.

Some of those models could be changing the ASB plus 6 formula, a flat fee, making Part B drugs more like Part D, moving Part B drugs into Part D. There's a whole long range of policy options that we should explore if we're going to look at physician-administered drug pricing. Only comparing it to 340B, I think, is a highly limited narrative, and as I said, it supports a frame of policy thinking that doesn't support the diversity of approaches to drug pricing.

I think on top of that, it also perpetuates stacked administrative interventions and drug pricing. The more legislative and policy interventions we have in a marketplace, the more administrative and technical complexity there is, which creates loopholes and opportunities for exploitation that then require further

legislative and policy intervention.

So again, I think that the idea of looking at centralized administrative pricing as the only option is a huge strategic error for MedPAC, and I think that a lot of this work related to 340B is more of a MACPAC issue.

Thank you.

MS. KELLEY: Jonathan.

DR. JAFFERY: Yeah. Thanks, Dana.

So first off, Nancy and Kim, thanks. This was very clear, and just to be clear, I didn't hear any particular narrative come out of this other than you're updating the approach to how the analysis is based on having new access to data under the current law.

You know, this is my last session as a Commissioner, and so I have a few sort of summative thoughts after six years of having lots of conversations on a whole host of things. And it's sort of less about this particular analysis, but this is a really good example of some of this thinking.

And so my summative thought is that health care financing in the United States is a total mess. So thanks, everybody. Have a good day. No.

[Laughter.]

DR. JAFFERY: Make sure. I got a plane to catch. Right? So yes, I failed.

Well, but the mess is really that, you know, we've got this distorted amalgam of payments, which then lead to some piecemeal policy fixes, and each of which doesn't really end up fully achieving its full intent because they're so complex, but they end up creating more distortions, and then providers across sectors have to patch together enough revenue to cover expenses year after year.

And so the basic distortion is that some services are paid really well, have robust margins, and others are paid well below costs and have fairly negative margins and huge losses. And in fact, if everything at a modest margin, of all services and procedures and programs that providers provided were paid at a modest margin, then a lot of things we're talking about as fixes go away.

And even on -- I think it's on slide 3, where you, you know, quote HRSA as talking about this, the 340B program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible

patients and providing more comprehensive services. And a big part of the need to do that is, in fact, what I was just describing is that some things don't pay.

And so to mitigate all that negative reality, that's what these --where we, over decades, have created the system where we've got these targeted programs, 340B, but also DSH, IME, hospital outpatient department payments, and all these things. And they're helping support providers so that they can stay in business, care for their spectrum of patients, you know, fulfill their missions, and other functions that we deem valuable, like research, education, clinical innovation, community support.

But the fact of the matter is that providers can't really tie -- they can't at all tie every single dollar that comes for one service -- from one program to just that service or program, and that if they did, it wouldn't leave anything to care for the, the plethora of services and programs that don't bring in enough money, like mental health or many of the complex chronic disease management services or a big chunk of pediatric care.

And we know, in fact, that, you know, it's absolutely true. Forty-eight percent in isolation sounds

like a huge amount of excess. But we also know, at the same time, hospitals are at a Medicare margin of negative 13 percent. And we just released a report last month worrying about that.

So I think, you know, this is really inefficient to the system. Providers didn't create it. It's really the policies over half a century that did. So I think it seems rational to us to always want to try and remove or reduce or redirect payments that aren't necessarily meeting their intended goals, but I think we have to think about it in the totality of the payment system.

If we only focus, which we tend to -- and I'm not just talking about we like the Commission or the staff. I'm talking about policymakers, in general, and the public conversation. We focus on these, you know, the quote/unquote, "overpayments" without addressing underpayments, that the whole thing will fall apart.

And so I appreciate MedPAC, you know, can't fix all these structural problems, but I just want to, because I won't be here, say, you know, be careful. Thanks.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. So, Jonathan, thanks for

framing things in an appropriately broad context, and thanks, Brian, for reminding us of various levers that can and should pursued, like the whole idea that there should be lots of tools in the toolbox kind of thing.

That all said, I think it at least calls for a continued highlighting of the relatively high profit margins in this space, and that then leads to -- I think can lead to the appropriate dialogue, Jonathan, to your point about, okay, is that the right thing? Are those profit margins occurring in a way that enables providers who lack profit margins in other Medicare service areas to execute on behalf of beneficiaries?

So I think at least highlighting the issue in terms of it can be the relevant comparators of what profit margins exist in other service lines, perhaps. I don't know if I could have said it better than that.

MS. KELLEY: Greg.

MR. POULSEN: Thank you.

I'd like to pile on to what Jonathan said. In fact, he went down the path I was going to go to, starting with the HRSA statement. You know, this was created for a reason. It may not be the ideal way to fund hospital

shortfalls in other areas. It may not be the ideal way to figure out mechanisms to support organizations that take a disproportionate share of the disadvantaged in our communities, but it is the mechanism that was created -- or one of the mechanisms that was created. And to look at it in isolation and potentially contemplate disadvantaging it in isolation, I think would be a big mistake.

Now, with that said, I'm grateful for the information. I think the work was well done. It was what we were asked to look at, but I really, really would also pile on. Let's be very cautious here, because we could do a lot of damage, that the program was intentionally oriented to do what it's doing. It wasn't a mistake that there's a margin there. It was created specifically to do that, and so to do something that takes that intent away, I think would be very much what, at least I read, the Supreme Court ruling was saying shouldn't be done, that in fact, it was that the program was created for a purpose. And to eviscerate that purpose without congressional participation was viewed, in my view, as being incorrect.

Jonathan talked about the Medicare margins that are currently negative. We all know that. We reviewed

that. I would remind us that even the -- what do we call them? -- efficient hospitals were essentially break even, at best. So we don't really anticipate, when everything's said and done, that hospitals can make money on Medicare.

So to find another way to take from those exact institutions -- and even those institutions that I would argue are probably among the most stressed because of the populations they serve and put an additional burden on by taking 340B out of the mix -- would be a mistake, unless we step back --and I'm not at all opposed to this. I just know it would be a huge lift if we want to step back and look at another mechanism to fund the institutions that are taking care of the most vulnerable. Then great, let's do that.

But I think to do this, to discuss this as a funding mechanism in the absence of that, would be something that we would all look back on with regret.

DR. CHERNEW: Yeah. And Paul may correct me if I get this wrong, so a few things. The most important thing is I understand when we see descriptive data how tempting it is to figure out why we're showing this descriptive data and assume we're going to then do something and then react

to what you think we're going to do because you've seen the data. That's not what's going on here, just so you know.

MR. POULSEN: No, I appreciate that.

DR. CHERNEW: Right now we are just presenting data.

MR. POULSEN: I think a number of us are just on the point of recognizing that if we decided to go down that path --

DR. CHERNEW: Yes.

MR. POULSEN: -- it could be a very big lift.

DR. CHERNEW: Understood, and yes. And so I'm just -- I don't want people to get the impression that we're about to go down that path. That's the main point.

The second thing I would say is we have the rec on the safety net index in general, and I don't know -- Paul can correct me. So there was a rec that MedPAC made on 340B prior to my time as chair. You may be familiar with it, but I do think there was this notion of how to then compensate for lost revenue to organizations that had it.

Again, I was not involved in that. Paul can say more.

MR. MASI: Yeah, that's exactly right. I also was not involved in that.

In the one, maybe salient policy detail from that 2016 recommendation, for purposes of this conversation, is that it was budget neutral, and so it was to reduce Medicare's payments by 10 points of ASP and then funnel those monies through the uncompensated care pool, and so it was structured to be budget neutral. Again, that's what the recommendation was in 2016.

DR. CHERNEW: And just I would add the three -- as you said, and I think spot on, the 340B was developed for a purpose. Whether you think it was the most efficient mechanism to accomplish that purpose, we could have a separate debate, but it was developed for a purpose, which we're quite aware of.

A lot of that purpose was to support hospitals that needed support in a range of ways. That is a topic that has been central to a whole bunch of other stuff we've done and will be central to a whole bunch of other stuff we've done.

The role that 340B plays in that ecosystem is -- or how we address the role that 340B plays in that

ecosystem is unclear, but certainly, 340B is a very important part of that ecosystem.

So to the extent that we are interested in supporting hospitals and targeting payments in efficient ways to hospitals to support care, which is something that we have been very concerned about and will continue to be concerned about, I think it's important to at least understand what's happening in 340B.

Where we go from that is -- you know, I don't want to discourage people from thinking about policy solutions to problems that might arise when they read this material. That would, I think, not be true. I do think that's right. But I also don't want people to jump to a sense that we are now contemplating X, Y, or Z. We have not had discussions about X, Y, or Z. It would take us -- as you know, our process is a slow arc of activity, and so we will potentially --

MR. POULSEN: No, I really do understand that. I guess I just -- when we put a document out that shows numbers in billions of money that appears to be overpayment, there would be the assumption on some people's part that we're trying to find a way to recoup that. And I

get that we're not, and I'm truly not a conspiracy theorist on this by any means. It just seems to me that we need to call out that there would be consequences that we need to think about carefully before we go down that path.

DR. CHERNEW: And just so we wrap this up and go on to the next is I'm glad you did, and I hope for folks listening at home, it is now clear.

Dana wants to say something.

MS. KELLEY: Yeah, I just wanted to add one thing about the recommendation from 2016, and I'm going to ask Kim and Nancy to jump in and make sure I get this right.

I think the concerns back in 2016 were twofold; first, there were some concerns that the 340B monies were not being distributed necessarily to the neediest hospitals. So that although there was certainly a desire in creating the 340B program to help those hospitals, that maybe it wasn't being done as efficiently as it could be.

And I think the other issue to remember is that there's cost sharing for beneficiaries attached to spending for outpatient drugs, and so that was, I think, the recommendation, to reduce payments for 340B drugs but not have that money be taken out of the system, but rather that

it be distributed through the uncompensated care pool instead.

Did I get that about right?

MS. NEUMAN: Yes, that's right.

DR. CHERNEW: Okay. I think we've belabored this point enough. Are you done, Greg?

[No response.]

DR. CHERNEW: Okay. So then the next person -- now I've lost it on my spreadsheet. The next person is Cheryl?

MS. KELLEY: I am still keeping the queue, and it is Cheryl.

DR. CHERNEW: Yes.

DR. DAMBERG: Okay, thanks.

I just think this is a really interesting topic, so kudos for pulling it together for us. And I want to acknowledge Jonathan's comment and Greg's comment.

You know, there's a lot to unpack here and a lot to understand, and that this functions in a larger ecosystem. But I would like to see MedPAC continue to explore this space, and to the extent that, you know, through that exploration, we identify issues that need to

be addressed, explore some policy options.

I guess, you know, I've tried to adhere to, you know, the MedPAC approach of trying to target resources in a very directed way, and this sort of feels like it's not necessarily as specifically targeted as we'd like it to be, to ensure that hospitals are appropriately supported, particularly in caring for those people who are disadvantaged and have high resource needs.

So again, I think if we, as we move down this path, could frame this and consider it in that larger context, I think that would be helpful.

MS. KELLEY: Gina.

DR. DAMBERG: Thanks so much for this information.

Just Jonathan and Greg's comments, it does feel like a little bit of whack-a-mole. We've built a health system that feels like whack-a-mole. You're underpaying over here, you're overpaying over here, and it somehow all, year after year, fits together mostly. So it's a little concerning in that way.

But I remember back in the day, we were setting up the program that I run now. We were looking at 340B

pricing through our FQHC, and I thought, well, why don't we just tap that? And they're like, oh, if your patients are being seen at that site, they can't access this program. Robinson-Patman was, I guess, antitrust that kept people from using the 340B program that weren't eligible for it.

So my question is -- and this probably was around one question. Sorry -- is this is meant for safety net providers to be able to get medications at discounted prices so that it can go to consumers who struggle financially. Do we know if that's -- do we have our head around if that's really happening? And does it mean less cost sharing for that individual because you did get it at a discount, or is it just a flat copay fee? Are consumers seeing the benefits of this better pricing?

MS. NEUMAN: So on the Part B side, speaking about the physician side, the beneficiary's cost sharing is calculated off of the Medicare payment amount. As I think many of you know, there are situations where a hospital can waive cost sharing under certain circumstances. We don't have a window on whether and when that would be occurring.

MS. UPCHURCH: Thanks.

DR. CHERNEW: Can I ask -- I had an

understanding, and it might be wrong, that a lot of the motivation was to actually support their providers and to have the money just enable the providers. So having the providers keep that money was actually -- this is a question -- I think some of the goal. It was not intended to have all of that money pass through the consumers. It was intended to support the providers that were serving certain populations. Again, I don't know, and I don't want to ascribe intent to anybody, if it's too hard to ascribe intent, but that was my understanding of the role that it played.

MS. NEUMAN: I think what you're saying sort of articulates the HRSA statement of stretching scarce resources. So in that sense, sort of supporting other activities to help the providers care for uninsured patients and so forth.

MS. UPCHURCH: And just as a follow-up to that, I mean, I do see at our local FQHC that people have access to medications that would be really super expensive for that FQHC to purchase if they couldn't get it through 340B for Medicare beneficiaries. So I do see that it benefits the beneficiaries, but yeah. Thanks.

MS. KELLEY: Jaewon.

DR. RYU: Yeah. A little bit of piling on, but I also want to address Gina's question.

I've always thought of it as -- I think your example of the FQHC is a good one, but it's also programmatic. So the benefit to the beneficiary, I would argue, is that certain programs that are unlikely to be at safety net facilities are able to be there. They're able to exist because of this program. So whether it's cancer treatments or rheumatologic treatments, those programs would not be sustainable in environments like these covered entities. I think that's the real benefit. It's an access benefit to the beneficiaries, how I would think about it.

I want to double down on Jonathan and Greg's comments. I think it's the inherent nature of averages is that there are some pluses and there are some minuses, and that's what gives you the average. It's easy to cherry-pick the pluses and say there's overpayment or suggest there's overpayment, even though I know that's not the intent of what we're going after here.

But I think the larger issue is, well, let's take a look at the overall averages. And we know -- Jonathan

quoted the payment adequacy data that we review every year, and hospitals still substantially negative margins. Yes, this is one of those areas that are on the plus side of that average, but in the absence of it, it would be even more negative than it is. So I think that's one thing worth incorporating into how we talk about this or present this.

Now, that being said, I think the program is imperfect, and we all know that. And I think there's probably other more targeted ways to direct those kinds of subsidies, kind of Greg's point. But in the absence of those programs -- and I don't think we have them all developed out -- I think this becomes a really critical program for the sustainability of many places.

I think to Dana's comment about the recommendation from 2016, you know, I think if the Commission wanted to look at revisiting how these funds are distributed or is the formula not quite working, is the eligibility criteria something we need to look at, I think that's all fair to further refine. But I think the program itself, you know, I think the framing is important, because there's a risk that, you know, people hone in on the

overpayment aspect of this and not the bigger picture.

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

DR. DUSETZINA: Yeah. It was going back to Gina's question about who benefits, and probably more to this broader conversation is the point made about average is super important. Also, like, who qualifies for 340B and how that's changed since the original intent is super important here, because I think, initially, it really was, you know, really this group of organizations serving very low-income people who wouldn't have money to have services available, and probably pass those low costs on to people who are being served.

But 340B participation has really grown very substantially and a lot more diversity in who's participating, including a lot of places that maybe we wouldn't think of if you looked at who they serve as serving disproportionately low- income people and largely benefitting from more of a privately insured group of folks visiting and getting services there.

So I think part of the challenge here is that the heterogeneity and who qualifies and is benefitting from

340B and whether that is kind of trickling down to helping the people it was initially intending to help -- and places it was initially intending to help.

So I think it is a really nuanced issue. I think we saw this also with the other Part B drug work, where a lot of places that did mostly infusions, they said, "You know, well, that's how we stay in business, and so if our other payment doesn't come up to compensate, you cut this, and then we're out of business. And we're an efficient sort of place for people to go." So I think it is really important that we can both recognize that there is this substantial amount of money going, flowing through this program.

Not everybody is eligible. So that's the other thing, too, is if you think about all the hospitals. Not all hospitals are going to be eligible. So do we really want this to be the way that we compensate them or allow them to offer other services, or should we be thinking more holistically about how we pay for services?

That was Round 3. I apologize.

DR. CHERNEW: I think we're actually in Round 3, if I have followed what's going on.

Brian, I think, is going to have a comment. I've lost track of the Round 3 queue.

DR. MILLER: Thank you.

So a couple of things. One, I personally think that 340B reform is an interesting topic, but again, I caution that I think it is -- no matter how interested I personally am in that topic, I think it is very outside of the MedPAC jurisdiction, and I think that most of the 340B discussions do not really belong in MedPAC, and they belong in MACPAC from a jurisdictional perspective.

I think, again, going back to this particular scope of work, I think the broader question that we should be answering here is how do we pay for -- if we choose to continue is how do we pay for drugs in Part B, and what are the policy options thereof? Instead, we have a presentation on one very specific, narrowed policy option, which, understandably, is making a lot of my fellow Commissioners have lots of questions and concerns. And so that's why I think going back, if we're continuing this work, if we're going to continue the work, we need to look at Part B physician-administered drugs.

Now, I know we also have just spent a lot of

time, though it sounds like last couple cycles before I was here, on drug pricing related to Part D, obviously, and I had thought that we weren't going to be doing drug pricing going forward. So that's a bit confusing to me, but if we are going to be picking up drug pricing as an issue, I think it's a broader issue than this specific, narrow slide deck. And again, I would caution us about talking about other programs that our sibling commission has primary jurisdiction over.

DR. CHERNEW: We will take the jurisdictional comment to heart.

Again, prior to my time as chair, it was felt that MedPAC could engage on 340B, and we will -- you know, we will -- and there are limits -- there's also HRSA and other things, but anyway, I don't want to have -- we can deal with the jurisdiction. We don't need to have the jurisdictional discussion now. I think the broader point that whatever we were to do, it really gets wrapped into a series of other areas and payment, both for drug payment but also for how we support hospitals in a range of ways. I think that that is 100 percent true, and if we gave the impression otherwise, we did not intend to. This is

largely meant to be informational.

DR. MILLER: As is --

DR. CHERNEW: Right.

MS. KELLEY: Betty?

DR. MILLER: Just to respond --

MS. KELLEY: Oh, I'm sorry.

DR. MILLER: On-point response, if that's all right.

So I agree, and as I said, I think 340B, to me personally, is very interesting. I just think that's more of a MACPAC issue, and so I think the thing that we can pull out of here is what are physician-administered drugs in terms of pricing models, and how do we pay for them, and what are the options, and I think that that would be a way to continue this work that's within our scope and would allow a wide range of viewpoints from the wide range of Commissioners that we have here.

Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: I know we're out of time, but I just was going to -- given this discussion, I have found this very, very helpful and have felt it as part of a

responsibility that we need to think about.

And I do know these funds end up being fungible in many ways, and that is certainly a concern. But until there's better ways to support the things we think we need to support, I do think it's really important that we continue keeping our attention on it, and I really am very grateful for the work you've done and for the comments.

Thanks.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. So thanks, Jonathan, Jaewon, Greg, and others for pointing out -- and I always think about visual analogies that we have to be careful about somebody thinking the right move is to reflexively pull out a brick from a foundation of support for hospitals when the foundation is not as robust as we all might want it to be, right?

And so I think perhaps the best way to think about that is in context with the other work we continue to do around support for hospitals as a provider, and particularly for safety net hospitals.

I will comment, though, that by having a high-profit margin in one space and an insufficient support or

negative margins in other spaces does create distortions that can influence programmatic decisions.

As a small and potential example, as most people are aware, we now have at least one newly approved infusion drug for Alzheimer's disease. It's pretty good consensus that the drug and the ones that are likely to immediately follow that are a very limited benefit, really marginal benefit. But what it's doing to some extent is it's changing the profit, loss -- or the sustainability of programs for dementia care at hospitals because now there's an infusion profit opportunity. And that's not the way we want decisions made about support for dementia care. Dementia care is a huge issue for this country. It's going to get bigger and bigger with the aging population, et cetera. And so we don't want people sort of backing into supporting dementia care because there's a profit margin on the infusion drug, which is the least -- probably the least helpful mechanism for addressing patients with Alzheimer's.

So I think let's try to link the discussions, but I think we do want to be aware that creating very strong margins in one area does potentially lead to downstream programmatic distortions.

DR. JAFFERY: Yeah, 100 percent, Scott. And I think that was, in essence, a lot of my underlying point. I liked your brick analogy, but that's exactly it.

We already have this. We have distortion upon distortion upon distortion, and we try to fix things or do things that create more distortions. And we can't -- you can't just -- you can't just take away the good distortions and leave the bad ones.

DR. CHERNEW: So I'm just going to jump in. I'm not sure if there's anyone else in the queue, but I will say this. The tone of this conversation may actually mask the stunning agreement --

[Laughter.]

DR. CHERNEW: -- that I hear amongst everybody and I think we would share.

Price -- I think it's important to say, and I'll just say this is. Sometimes I wish I was the Commissioner and not the chair, because then I could make longer statements, but now I guess I will since we have a few minutes.

We often think that behavior is what behavior is, and then we're just moving money around with how we set the

prices. But of course, in the economics of it, you're setting a whole bunch of incentives, and so you have to think about what the relative prices are, where the profits are. So that's a very broad, general, theoretical point of view, and one thing you hear from the people that are actually on the ground is "Yeah, I understand what you're saying, but the way the policy process is going to work, it's not going to work the way you want it to work." And I think I understand that, and we're quite sensitive to what that issue is.

So the questions that I think we will grapple with -- and again, I need to emphasize we did not intend to grapple with them here, and I think that we're in agreement that people are aware of that. But how do we create the incentives and the targeting of the programs we have to get the things that we want? And I think there's broad, widespread agreement on that. So how do we efficiently target?

I think the general principle, independent of this discussion -- the general principle of efficient targeting has come up in our hospital recs. It's come up in physician recs. It comes up in a lot of recs. It is

more complicated in the post-acute space because then we really do have these very complicated issues about Medicare and Medicaid in a whole range of ways.

But in any case, all of these issues, I think, are very much -- they resonate, I think, with me. I think they resonate with the staff. It sounds like they resonate a lot with you.

I will close just by pointing out -- because a lot of the discussions seem to gravitate towards how challenged, for example, hospitals would be and what the problem would be if we got rid of 340B. So I just want to say this for the public in general. Our hospital update recommendation intentionally, I think, acknowledged that there were a lot of hospitals that were struggling. We needed to think about putting money into the hospital sector, and we needed that money to be targeted. And we worked through a particular way to do that targeting. Is it the perfect way to do the targeting? Is it the exact right amount of money? We will, it turns out, have that discussion again almost surely in March when -- actually for the March report. We'll have the discussion in December and January. But these are issues that are really

top of mind.

And as this session, I think, pointed out -- and, Nancy and Kim, I think you did a great job -- the 340B program is actually an important part of the hospital ecosystem, and speaking for Lynn, a really important part of the hospital ecosystem. And we are quite aware of that, and we aren't going to do anything without being aware of that. So that's my sort of closure on this.

I will again thank Nancy and Kim. I want to thank the staff broadly for their other presentations this cycle, both yesterday and earlier this morning.

For people at home, please do reach out to us and weigh in on what you think about this. You can reach us at meetingcomments@medpac.gov, or you could otherwise reach out on the website or contact us. We do want to hear what you have to say.

I will say again, as April comes to an end, a particular thank you to Jonathan and Jaewon. You will be really, really missed.

We will be back again in September. So thank you all for what I think was a very successful MedPAC cycle.

[Whereupon, at 11:29 a.m., the meeting was

adjourned.]