MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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GoToWebinar

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10:35 a.m.

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AGENDA PAGE

P R O C E E D I N G S

[10:35 a.m.]

DR. CHERNEW: Hello, everybody. Welcome to our January MedPAC meeting. As is the norm, this is the meeting where we vote on our update recommendations, and we have a full slate of update recommendations. Because many have been discussed before, the discussion is somewhat briefer than, for example, we had in December. But we do look forward to going through all this material.

I am not going to belabor those points. We are just going to start with Geoff. So we're going with physicians. Geoff.

MR. GERHARDT: Great. Good morning, everybody. In this session, I'll follow up on the December meeting by recapping the Commission's draft recommendation for updating payment rates for physician and other health professional services for 2025.

To those watching remotely, you can find a copy of these slides in the handouts section of the webinar's control panel on the righthand side of your screen.

In today's presentation, I'll go over some key facts and figures about the physician fee schedule. Then

I'll summarize our assessment of the Commission's payment adequacy indicators for this sector. And finally, I will present the draft recommendation you discussed in December.

I'll start with some quick background.

Medicare's physician fee schedule includes billing codes for about 8,000 professional services which are delivered in a wide variety of clinical settings. In 2022, fee-for-service Medicare and its beneficiaries, paid 1.3 million clinicians a total of $91.7 billion for fee schedule services. Compared to 2021, fee schedule spending was 1.2 percent lower in 2022. This decline was largely driven by a 3.9 percent reduction in the number of beneficiaries enrolled in fee-for-service Medicare, as enrollment in Medicare Advantage continued to grow.

In calendar year 2025, current law calls for a 0 percent update to fee schedule payment rates. In addition, a one-year-only increase of 1.25 percent that applied in 2024 will expire.

The physician fee schedule's payment rates are updated each year by changing the conversion factor, which is a fixed dollar amount used when converting a service's "relative value units" to a payment amount.

Annual changes in the conversion factor usually reflect two things: a percentage update specified in law, and a percentage calculated by CMS to maintain budget neutrality. The budget-neutrality adjustment ensures that any changes CMS is making to values for particular codes in the fee schedule do not, in and of themselves, increase or decrease total spending.

MACRA specified that clinicians' payment rates were to be updated by 0 percent from 2020 to 2025. But in 2021, CMS increased the payment rates for office and outpatient evaluation and management services, which required a minus 6.8 percent budget neutrality adjustment to offset the cost of these higher payments.

To avoid an immediate reduction to payment rates of this size, Congress passed subsequent laws that provided a series of one-year-only increases that decline in size from 2021 through 2024. These temporary increases have the effect of phasing in the 6.8 percent reduction to the conversion factor.

In the graph on the left of this slide, you can see the how the substantial increase in E&M rates that I mentioned affected the payment rate for a widely used E&M

service. The graph on the right shows the decline in the conversion factor over the 2021 to 2024 period, when a series of year-only legislated increases were in effect.

Turning to our annual assessment of the adequacy of physician fee schedule payment rates, we found that beneficiaries continue to have good access to clinician care. Our annual survey finds that beneficiaries report access that is comparable with, or better than, that of the privately insured.

Comparable shares of clinicians accept patients with Medicare and private insurance. The total number of clinicians billing Medicare is increasing, although the mix of clinicians is changing. And the number of clinician encounters per fee-for-service beneficiary increased in 2022.

Turning to quality, it's difficult to assess the quality of clinician care, but we note wide variation in rates of ambulatory care-sensitive hospitalizations and emergency department visits, and stable patient experience scores.

In terms of clinicians' revenues and costs, spending per Medicare fee-for-service beneficiary increased

in 2022; the ratio of private insurance payment rates to Medicare payment rates has increased slightly; clinician compensation grew rapidly in 2022; and MEI growth peaked in 2022 but is projected to slow to 2.6 percent in 2025.

Taking a step back, we note that, in totality, our payment adequacy indicators are similar to, or better than, last year.

We now turn to the update recommendation you discussed last month and that you'll be voting on today.

The recommendation you discussed last month has two parts. It would increase base payment rates in 2025 by 50 percent of the projected increase to the Medicare Economic Index. Since the MEI is currently projected to increase by 2.6 percent in 2025, this part of the recommendation would result in a 1.3 percent increase to payment rates, relative to current law.

In addition, the recommendation would direct Congress to enact the clinician safety net recommendation we included in our March 2023 report, which would increase the average clinician's fee schedule payments by an additional 1.7 percent.

The combined effect of these two policies would

be to increase average physician fee schedule payments by an estimated 3 percent, relative to current law.

As we say more about on the next slide, the size of the increase would vary by clinician specialty. Relative to current law, primary care clinicians would see an average increase of 5.7 percent, and all other clinicians would see an average increase of 2.5 percent.

As a refresher, last year MedPAC made a clinician safety net recommendation to institute add-on payments for all fee schedule services furnished to low-income, fee-for-service beneficiaries. We define low-income beneficiaries as fee-for-service Medicare beneficiaries who are also enrolled in Medicaid or are enrolled in the Part D low-income subsidy program. We targeted services provided to this population since they report worse access to care than other beneficiary populations.

In addition, clinicians do not always receive the full amount of Medicare cost sharing they are entitled to, due to Medicaid payment policies.

Under our safety net recommendation, when treating low-income beneficiaries primary care clinicians would receive a 15 percent add-on to their fee schedule

payment rates, and all other clinicians would receive a 5 percent add-on. Our recommendation specifies that the add-on payments would not result in increased beneficiary cost sharing and would not be paid for through offsetting payment cuts elsewhere.

We also called for safety net add-on payments to be excluded from Medicare Advantage benchmarks.

The draft recommendation reads as follows:

The Congress should, for calendar year 2025, update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the Medicare Economic Index; and enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.

In terms of implications, relative to current law our two-part recommendation would increase spending by 2 to 5 billion dollars during the first year and by 10 to 25 billion dollars over five years.

The draft recommendation is expected to maintain beneficiaries' access to care and improve access among low-

income beneficiaries.

In addition, the recommendation is expected to maintain the willingness and ability of clinicians to furnish care, and should improve their willingness and ability to treat low-income beneficiaries.

We're happy to answer any questions you might have, and I'll now turn things back to Mike.

DR. CHERNEW: Great. Thanks. So we are only going to have one round because these are somewhat abbreviated sessions. And we do have a queue, and I think Jonathan is first in it.

DR. JAFFERY: Thanks, Mike, and thanks. This is, as always, a great chapter. And to start off with, you know, I'm supportive of the recommendations. I feel like it is a great move in the right direction for trying to make sure that we're keeping up with costs for providers.

My comments are really about a couple language-related things. So you talked about, one of the slides said that beneficiaries have good access to care, and I think, if I think about where our health systems are and how they continue to struggle with access in so many places, and so many ways of getting that, and I think just

-- I'm confident that most, if not everybody, here can share personal anecdotes of struggles with access and getting appointments for all sorts of things.

I think that feels like a conclusion that isn't based on the data. It feels like we're making that comparison to the fact that maybe it's as good as in commercial insurance. I think that's explicitly what we say, or what the data show, but that doesn't mean that it's good access.

And so I think we should not draw that conclusion, which doesn't change our recommendation, I think, at this point, but I think it's something we should be truthful about and clear.

The other thing is -- and I appreciate you changed some of the language around this in response to, I think, some of my comments in December -- on page 13 there's a bold headline that, "Among beneficiaries looking for new clinicians, a higher share report problems finding a primary care provider than a specialist." And that still feels to me like it's pushing a bit of a narrative that primary care access, or the primary care shortage is the problem, and maybe not so subtly that specialist shortage

isn't the problem.

And again, I think they're both problems. I think the data suggests they're both problems. And, in fact, if we're being really transparent about it, the data that then is not bolded suggests that the specialist problem may, in fact, be greater -- 7 percent of beneficiaries experience problems finding a new PCP, and 11 percent report problems finding a new specialist. So I know that of those looking for a new one, more people might have trouble finding it, but if you think about the beneficiary population, the Medicare beneficiary population as a whole, it actually can be more challenging finding a specialist than a PCP.

And again, I don't think we need to choose about who -- they are both problems, but that does have other policy implications that ripple.

So again, thank you, and those are just my couple of concerns about how we frame things.

MS. KELLEY: Brian.

DR. MILLER: Thank you. I really enjoyed this chapter. I know that this is a very fraught topic so I appreciate your efforts.

I wanted to share a thought which I will give

credit to Larry as opposed to myself, that when we think about these recommendations we shouldn't think about them in isolation, but the recommendation of the update in conjunction with the safety net should be an "and." So not an either/or, but that those two updates we should strongly emphasize go together.

A few technical corrections. On pages 6 and 41, we noted about growth of physician salary. I think we should note that those grow due to employment. And then on page 40 we noted that the private insurance driving consolidation, I think we meant that a lack of site-neutral payment in Medicare is driving consolidation.

And I know that many have discussed concerns about access measures. I think that there's been a debate that says, oh, if so many percentage of physicians participate in Medicare we're doing well. Participation in Medicare is tied to employment, and something, depending upon your measure, 50 to 55 percent of docs are employed, so that's a requirement at your job that you participate in Medicare. Many people who are specialists often do procedures and have hospital privileges. To get hospital privileges there's often a requirement that you accept

Medicare. So functionally, the employment framings of most physicians is that they have to accept Medicare regardless of the payment rate.

I was curious about this so I dug around in the literature and I found this great article in JAMA Network Open, "Trends in participation in Medicare among psychiatrists and psychiatric mental health nurse practitioners," by a collection of authors from Harvard, and it noted that psychiatry Medicare participation is around 55 to 60 percent. I mention this not just to emphasize the importance of behavioral health, a neglected part of the Medicare program, but also because psychiatrists frequently are independent. They are not employed and I imagine do not have hospital privileges. And therefore, while this measure is not perfect, this may be more indicative of the deeper access problems that are present in the Medicare program.

I do support this recommendation.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. Good chapter, and I support the recommendations. Just a couple of small things.

I think Jonathan and others who have talked about access relative to commercial I think is an important piece, and might not be too hard to add.

I wanted to follow up on the issue of psychiatry that Brian just raised. And it might be too late for this report, but I was curious if that's stable, the 80 percent. I should have looked. I think it is. I think that might be an important thing to monitor and report, is that fewer psychiatrists accepting Medicare, or kind of the level it's at.

And I don't think we can easily do this, but it would be interesting to see psych mental health nurse practitioners and psychiatrists, because, in general, most programs actually give special preference to nurse practitioner enrollees who want to work with underserved populations. But I assume that once they are in practice that they may sort of amalgamate to the practice environment. So that would be an interesting piece of data in the future, if you can get it.

But I am very supportive. Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Yeah, I just want to go on record

thanking the staff for excellent work, and I am enthusiastically supporting the recommendation. I am particularly pleased in how we incorporated the safety net aspect into the recommendation. I think that makes it significantly better than just an across-the-board increase.

MS. KELLEY: Gina.

MS. UPCHURCH: I echo what Scott just said, and I'm just going to tell you why. I continue to support this recommendation, and thank you to the staff, really, for an excellent chapter. I am particularly supporting the safety net added payments.

I remember at our last meeting we talked about dual eligible, and I learned about lesser-of states, where somebody has Medicare and Medicaid, and the states can pay the lesser of the 80 percent of Medicare, or if Medicaid pays a little bit more, they may pay a little bit more, but it's often below the 100 percent of the allowed for Medicare. We don't want to disincentive for providers to see people who are dually eligible for Medicare and Medicaid.

So after learning more about lesser-of policy I

really support this measure to support safety net, because providers, if they are getting at least 80 percent, they know they don't have to focus on uncompensated care. That's one thing. The second thing is they know that their patients can follow prescription directions, because they have extra low-income subsidy, so they are patients you want to see because they can actually follow a plan to improve their care.

And lastly, Medicare shared savings programs also have some incentives, you know, in essence, for people, through the risk adjustments, to pay people that are dually eligible a little bit more. So I support all of that, so thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you. Well dome presentation. I definitely appreciate the updates from the last meeting that we had. I am very supportive of the recommendation.

I just want to briefly mention sort of a tangential issue, not so much an issue but as a curious observation, which is on page 41 of the chapter, which has to do with the fact that more and more physicians are being

employed by health plans. I think we're aware of the trend, including one particular health plan that was kind of called out for employing up to 130,000 physicians, so for either employed or aligned.

It may be something worthwhile looking into in a deeper way, perhaps at an upcoming meeting. I would certainly like to learn more about, you know, what are the impacts of this trend, you know, will we be seeing more physicians employed by health plans, what does it mean in terms of Medicare access. And then for those that are turning 65, how does it influence their choices? Are they going more into MA, or are they high acuity, low acuity patients? Do they tend to use Medigap to close out any type of coverage?

I think it's a trend that will probably continue, so trying to study any type of anticipatory effects might be worthwhile doing.

But thank you. Again, I'm very supportive of the recommendation.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks.

Thanks. I also wanted to echo support for the

high quality of the work and the recommendation.

I just thought, briefly, I would just quickly kind of agree with issues that Jonathan, Betty, Brian, and others have brought up regarding some of the access questions. I think it does seem to contrast a little bit with the lived experience, I think, of a lot of people, which kind of very generally speaking. So it might be good for us to examine where in the chapter we can maybe just make the language a little bit more balanced.

I like Betty's suggestion that the stability of the measures over time is really helpful actually, and I think -- so that's something that I think, at least to me, is quite helpful and influential, and the language as sort of stable might be a little bit more defensible to some extent, relative to good, given the concerns that people have raised.

I think the other point which might be hard for us to exactly say, but I think is consistent with what we're learning from the commercial -- the comparisons to commercial is this is an aggregated payment update, a chapter, and I think to the extent that we see that commercial rates are higher, I think we should feel

reassured that it's not like a higher payment update that would necessarily solve this, quote/unquote, "access issue," to the extent that there is one. And so there's a broader sort of structural issue, perhaps, that that's really implying.

So I think if we can -- if we can refine the language a little bit, I think that might help address some of the commercial concerns and improve the work. Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, very nice work. I feel like it's redundant for me to say that because the work is invariably really good.

If the recommendation were only for half of MEI as an update without the recommendation for the safety net payment, because I would have to vote no, I think. And why would I think it? MEI alone wouldn't be enough.

It's not that I think that given an extra point or two points or really almost any number of points would increase access for beneficiaries. I don't think the access problem is a minor payment issue. I think there are other reasons that we may want to look into that don't

have anything to do with payment updates.

I will echo other -- but I will say that what -- I think what one point, more or less, can make a difference in -- and I've said this before -- it's not access, but the small increase compared to inflation and the unpredictability of what the payment rates are going to be from year to year, I think really do affect physician morale and therefore quality, although I realize it's hard to prove that.

But I value of the safety net payment a lot more than -- I'm so glad you've recommended -- we recommend doing that rather than a 1.7 percent or whatever it is or increase generally. I think it's very, very valuable.

I want to emphasize to the public that safety net is a little bit misnomer. It's not like there are safety net clinicians and non-safety net clinicians and only the safety net clinicians are going to get the payment, if Congress goes along with this recommendation. Everyone will get it for every low-income patient they see. Some people see more low-income patients than others, but I think that's an important point.

I don't think half of MEI is enough, though. So

I would strongly encourage Congress to accept both recommendations. Just accepting the first would, I think, be perceived by physicians as unfair.

And just to conclude, in terms of access, I think the chapters generally take a pretty sunny idea of how good access is, and the data appears to show that, but we hear again and again from pretty much all the Commissioners, a pretty broad range of social networks, that access problems are severe and common. It's a conundrum. I don't think any of us quite know why there's that paradox, but we may want to look at -- try to look into that more in the future.

But I would be happy to see a chapter that made the point that access for patients is not really a matter of 1 or 2 percentage points, more or less, of a payment update. It's other factors that are important.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you for the great work on this chapter.

I just want to plus one on what Jonathan and Amol said about access and the workforce.

I very much support both recommendations, and one

thing that really stood out for me was a sentence on page 45 related to the growth of volume and intensity helping offset the gap between MEI growth and the annual updates, and this just really underscored for me sort of the need for the Commission to stay focused on that issue about volume and intensity and trying to unpack whether this is related to people being sicker or how much of this is being driven by things like consolidation.

MS. KELLEY: So I think that's the end of the queue, unless I've missed anyone.

Mike?

DR. CHERNEW: Okay. I'm going to make a few comments, and we're actually right on time. So then we will go to the vote, but let me say a few things.

First, it's very clear that we have to continue to think through the language around access and what we mean, and to emphasize some things that was said. The comparison to commercial is not to assume that commercial access is the gold standard. As someone with commercial coverage, I can say that it is not, but to say that the differential is not a payment differential.

We worry about this a lot in a range of workforce

issues. We struggle with exactly what to do because workforce has been a hard thing. Betty has really planned this out repeatedly, and I think she's right on this, not just the physicians, but also to other types of clinicians that play an increasingly important role in a wide spectrum of things that we do in the health care sector. So I think that's kind of a uniform view around the table, and I think that's been heard, and I think that's important.

I want to call out two other things. First, I want to pick out something that Robert said, which I think is particularly important, which is the role of employment amongst physicians. This is challenging for a whole myriad of reasons. The amount of patients that are seen by employed physicians isn't necessarily the same as the amount of patients seen by physicians otherwise, and that has access concerns.

I think there's a lot of things going on in the nature of practicing medicine, the role of portals, the demands on measurement and such, that make practicing as an independent physician or in a small group increasingly challenging for a variety of reasons.

And, of course, I would be remiss if I didn't

mention site neutral as incentives for employment. And understanding the ramifications of that on care is important, and I don't want anyone at home to prejudge whether we think the employment is inherently good or bad. On one hand, I think there's concern, certainly concern about pricing and integration. On the other hand, these larger systems do enable innovations, managing the portal, a bunch of others. There's value in that. And so I do think the point about understanding that matters.

The other thing that is sort of implicit in that is the inherent mismatch between the structure of the fee schedules and the structure of the way that medicine is practiced these days. It's just a general challenge, and it comes to fore when we do our update chapters. And that's why we spend time on things like site neutral and other related things, and I think that matters.

The last thing I'll say is there will be work later in the spring on broader changes to the physician fee schedule. The update work is an inherently narrow exercise. We understand this inherently narrow exercise. Thinking about the physician fee schedule's structure, things like the lack of an inflation update, for example,

is a bit beyond what we would do in the update chapter and a bit beyond what we will vote on in a moment, but it has not escaped us that a physician fee schedule with no inflation update leads to a progressively slow deterioration in inflation-adjusted fees. It could have ramifications moving forward, even if we have not seen them yet, in the analysis that we've done.

And so just -- the Commissioners know this, but for the folks at home, this is actually quite front of mind. I'm not sure where we will land on how to deal with that, but we will see that body of work. And I'm going to look to Paul, but I'm going for April.

MR. MASI: This spring, we will have that work. I think we're still doing some planning with respect to exactly where that work will land, but you are correct, it will --

DR. CHERNEW: Look at that smiling staff. Look, it is nice to have such wonderful staff.

But I guess the key point is I don't want people to take the update recommendation as sort of the be-all and end-all. I think this dovetails with our continued thinking about workforce and how we deal with that. It

updates -- it relates to our site-neutral work. It relates to other work we do on payment reform and work we will do sort of on bigger structural things in the physician fee schedule.

So that's sort of the summary of where we are. I do appreciate all the comments, and I think now, Dana, in lieu of -- sorry. I'm not checking. I may have missed something. But we are now ready for the vote.

MS. KELLEY: Okay. Is the vote up on screen? Yes.

Okay The draft recommendation reads: "The Congress should for calendar year 2025 update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the Medicare Economic Index and enact the Commission's March 2023 recommendation to establish safety net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries."

Voting yes or no. Lynn?

MS. BARR: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert?

DR. CHERRY: Yes.

MS. KELLEY: Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Jonathan?

DR. JAFFERY: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Greg, can you give us a visual? We got a thumbs-up from Greg.

Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Okay. Thank you.

DR. CHERNEW: So, again, I'll emphasize this could not be done, the amount of work that goes into this analysis -- the surveys, the focus groups, the claims data analysis, and the staff is really enormous, and so I will thank the staff.

We're going to take a quick break. We will be back at 11:15 to talk about -- I believe hospitals is next.

[Recess.]

DR. CHERNEW: All right, everybody. We're back. Thank you. We're going to, without further ado, move to our next update chapter, which is going to be the hospital inpatient and outpatient services. And I think, Betty,

you're kicking us off.

DR. FOUT: Thanks, Mike. Good morning. The audience can download a PDF version of these slides in the handout section of the control panel on the righthand side of the screen.

Before we start, we would like to thank Alison Binkowski who did much of this work, but who could not come to today's meeting.

In today's presentation, I will provide an overview of general acute care hospital use and spending under fee-for-service Medicare, review the four categories of payment adequacy indicators presented in December, and then present the draft recommendation and estimated impacts and implications.

As a reminder from December, to pay general acute care hospitals for the facility share of providing inpatient and outpatient services, fee-for-service Medicare generally sets prospective payment rates under the inpatient and outpatient prospective payment systems.

In 2022, over 3,000 hospitals were paid under these systems, and collectively IPPS and OPPS payments, including those for uncompensated care and separately

payable drugs, totaled about $180 billion.

More details on each of our fee-for-service Medicare payment adequacy indicators were presented in December and are in your mailing materials, so today I will briefly summarize the results from each of the four categories of indicators.

The first category is beneficiaries' access to hospital care, which we found to remain generally positive, though there was variation across hospitals. Specifically, the supply of general acute care hospital beds and locations was relatively steady, but, in fiscal year 2023, there was an uptick in the number of closures relative to the number of openings; hospitals maintained available capacity in aggregate and hospital employment increased, but some hospitals neared capacity and some reported staffing shortages; fee-for-service Medicare beneficiaries' use of certain hospital services continued to shift to other settings, including joint replacements shifting to ambulatory outpatient settings and some ED visits shifting to urgent care visits; and hospitals with available capacity continued to have a financial incentive to treat fee-for-service Medicare beneficiaries, as indicated by a 5

percent fee-for-service Medicare marginal profit on hospital inpatient and outpatient services.

Our second category of hospital payment adequacy indicators are those related to the quality of hospital care. In 2022, these hospital quality indicators were mixed

Specifically, after peaking during the pandemic, fee-for-service Medicare beneficiaries' risk-adjusted mortality rate decreased to 8.1 percent, the same level as in 2019; and fee-for-service Medicare beneficiaries' risk-adjusted readmission rate decreased to 14.7 percent, below the level in 2019. However, most patient experience results declined relative to 2019, including the share of patients rating the hospital a 9 or 10 out of 10 declining to 70 percent.

Our third category of hospital payment adequacy indicators are those related to hospitals' access to capital. These hospital quality indicators were generally negative, though demand for bonds remained strong.

In particular, hospitals' all-payer operating margin fell from a record high of 8.8 percent in 2021, to 2.7 percent in 2022, the lowest level since 2008; and preliminary data for 2023 from six large hospital systems

suggest that hospitals' all-payer operating margin remained below pre-pandemic levels in aggregate, though not for all systems.

However, demand for hospital bonds remained strong in 2022 and 2023, as evidenced by the declining risk premium above treasury bond yields.

Our fourth category of payment adequacy indicators is the relationship between fee-for-service Medicare payments and hospitals' costs. These indicators were negative in 2022, and are projected to remain low in 2024.

Specifically, as shown in the left-hand figure, in 2022, hospitals' overall fee-for-service Medicare margin across service lines declined to -11.6 percent, or -12.7 percent when excluding Medicare's share of federal coronavirus relief funds.

Furthermore, among a subset of hospitals that consistently had relatively low costs and relatively high quality -- a subset we refer to as "relatively efficient hospitals" -- the median fee-for-service Medicare margin was negative, at about -2 percent, or -3 percent excluding relief funds. And looking forward, hospitals are scheduled

to receive $9 billion in 340b remedy payments in 2024. However, absent these one-time payments, we project hospitals' Medicare margin to remain near the levels in 2022.

The Commission aims for a draft update recommendation for hospital inpatient and outpatient payments that balances several objectives.

Specifically the draft update recommendation aims to support hospitals with payments high enough to ensure beneficiaries' access to care; maintain payments close to hospitals' cost of providing high-quality care efficiently to ensure value for taxpayers; maintain fiscal pressure on hospitals to constrain costs; minimize differences in payment rates for similar services across sites of care; be cautious in how much emphasis is placed on a single year of data, especially in volatile periods; and avoid large, across-the-board payment rate increases to support a subset of hospitals with specific needs.

The draft recommendation is the same as was presented in December, but repeats details on the construction of the Medicare safety net Index from our prior year recommendation.

The draft recommendation reads:

For fiscal year 2025, the Congress should update the 2024 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1.5 percent.

In addition, the Congress should begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI); add $4 billion to the MSNI pool; scale fee-for-service MSNI payments in proportion to each hospital's MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.

The combined effect of two parts of the draft recommendation is about 2.8 percent above the current law update to IPPS and OPPS rates, which is currently projected to be 2.8 percent, and targets increases towards hospitals serving high shares of low-income Medicare beneficiaries.

On a dollar basis, the draft recommendation is

estimated to increase spending above current law by between $5 and $10 billion in year 1 and $25 to $50 billion over 5 years.

The draft recommendation will help ensure Medicare beneficiaries' access to care by increasing hospitals' willingness and ability to treat beneficiaries, especially those with low incomes.

Thank you, and I now turn it back to Mike.

DR. CHERNEW: Betty, thanks a lot. We do have a queue. Remember, this is just like we did for the physician, going to be a one-round set of comments and then a vote. And I think Kenny was the first person in the queue. So Kenny.

MR. KAN: Thank you for an excellent chapter. I acknowledge the criteria and analytical framework used to frame the recommendation, which contributes to process efficiency in a data-driven manner.

I do struggle, though, with the retrospective view of the data, which contributes to forecast errors. For future payment update recommendation I would encourage us to consider alterative prospective methods to evaluate hospital payment updates. For example, could we use

Kaufman Hall's hospital CFO margin survey, which suggests 10 months through October, year-to-date, hospital margins of 1,300 hospitals nationwide actually have improved to 1.2 percent. Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thank you. I recognize this is an extremely hard chapter.

My comments sort of are around three areas. One is the issue of precedent. I know that, as one of the new kids on the block, the preference is for MedPAC to respect precedent of prior decisions, if at all possible. I note that the Chair has emphasized this importance, and I went back and looked through our work and saw our site-neutral recommendations.

In that line, I note that this update is a general hospital update as opposed to a separate IPPS and OPPS update, and therefore we are not respecting our prior recommendations. So I do believe that we need separate IPPS and OPPS updates for the hospital payment section, as we do have separate payment updates for every other separate payment model in the fee-for-service Medicare program, and we should not treat this market differently.

I think there are two other challenges. One, my colleague, Lynn, has highlighted many of the challenges that rural hospitals face. I, myself, had the privilege of practicing in a rural hospital for a year during my training, with a village that had one stoplight and served a 10-county area, such that when it snowed, you could not actually access the hospital without a helicopter many times if weather was bad.

I think that rural hospitals have unique challenges and that they should have a specific payment update, knowing that this is a bipartisan concern in Congress, to ensure access to care.

I think the final challenge is the worker experience in health care, all the way from the phlebotomist and unit secretary up to the physician. The entire workforce is burned out, and I would say that labor advocates have rightfully pointed out that when there are payment updates that the workers who are actually delivering the care to patients do not benefit, and as a consequence the beneficiaries do not benefit and that payment updates frequently go into administration and management as opposed to supporting clinicians who support

beneficiaries.

So I think with these concerns, unfortunately, I cannot, due to precedent, a failure to support the clinical worker, and then a failure to differentiate between rural hospitals, I cannot support this update.

MS. KELLEY: Lynn.

MS. BARR: Thank you. Thank you, staff, for this tremendous amount of work you do and the quality of it.

I do support the recommendation and feel that the important part -- and this is really following on what Larry said about the physician update -- it has to also include the safety net index. And I urge Congress to add that piece and not ignore it and just take the 1.3 and say that we're done, like they did last year, because we're not done, and we really need to provide additional support.

So thank you for doing this work, and I do support the recommendation, as stated.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you. I also support the recommendation, and I want to double down on what Lynn just said about the safety net. I mean, we've seen a decline in payments to the safety net, and I definitely support, you

know, and think it's urgent that Congress act on implementing the safety net index, both for better targeting as well as increasing the amount of money in the pool. Because I think this is having potentially adverse consequences on certain subpopulations and certain facilities.

The other comment I just wanted to make, and this has nothing to do with the payment update per se, but on page 23, where the discussion is comparing the margins between for-profit and nonprofit hospitals. And the discussion notes that for-profit entities were able to help constrain cost growth through reducing the number of employees to below their 2018 levels, as well as constraining the growth in salaries.

One thing that I would wonder, and if staff could be looking at this over a longer period of time, is what are the implications on quality of care related to those types of reductions.

MS. KELLEY: Jonathan.

DR. JAFFERY: Yes. Thanks, Dana, and thanks, Betty. This is a great, clear presentation, and I thank the whole staff for the chapter.

I'm supportive of the recommendation. You know, like the physician chapter I think it's moving in the right direction. It's a struggle to think about 1.5 percent on top of current law when the aggregate negative margins, you know, are negative 13 percent and keep dropping.

And I think related to that is -- and I recognize that that's in the context of the analysis around relatively efficient hospitals, but I think related is my overarching concern, ongoing concern, about that definition. You know, I get the concept. Quality is defined fairly narrowly in terms of mortality and readmission. You know, sort of building on Cheryl's comments about what we see and how the for-profits become more profitable through decreasing staff and things like that, and how that impacts things that, you know, may impact things like readmissions, but they go beyond that.

And I think, in particular, even on the cost side, I know it's risk adjusted, but since we're not really at a place where we're capturing fully and adequately social determinants, that's not included. And I think that violates some of our principles about adjusting costs for social needs and not outcomes.

So basically the patient population has increased social determinant of health needs, and a provider has to spend more time to prevent bad outcomes, here defined as death or readmissions, and could be other things. You know, that's expensive to do.

And so, again, I'm not saying that we should use that to adjust how we assess quality outcomes, but they will be described as relatively inefficient if they're spending more to care for that more complex patient population, complex being from a social needs aspect.

So again, directionally I'm supportive, but I do think we should be thinking about this notion of relatively efficient and what really goes into it. Thank you.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, I'm supportive of the recommendation as well. I think the framework, I like that it balances across the board with more targeted sort of directed support as well.

I also like the transition to incorporating the safety net. I think that's really important. You all have heard me comment before about the importance of mix, and there's payer mix, service mix, programmatic mix, and I

think that complicates the assessment of access for hospitals. Hospitals can stay open, but when programs die, I think that's a very different access outlook.

And I think the safety net aspect is a big one that plays into that dynamic. We know that there are needs and challenges that are greater in certain populations and certainly communities, and it takes more resources to accommodate and address those needs and caring for those patients.

So I think for all those reasons I like the MSNI aspect of this, and I think, all in all, the rationale that you have incorporated since the December draft, I appreciated that as well. So I'm supportive.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I am supportive as well. Just a few comments. I fully support the comments that have been made about the safety net index that were made by Lynn, Cheryl, Jaewon, and others.

I wanted to respond to Brian's comment, and I have also been concerned that if we give more money that it doesn't necessarily go to the people who are doing the work. And there was literature, pre-COVID, that really

demonstrated that. I haven't seen as much post-COVID.

But it's actually complicated. I mean, I was initially really in favor of wage passthroughs and those kinds of things, but it's really complicated. And there is just simply more demand for higher salaries by the people doing the work, and I don't think that's going to go away.

And so I also, between Cheryl and Jonathan, the issue of relatively efficient hospitals and how we define it I think is really important. And we have more explanation in here than we did when I first came on the Commission, just around relatively efficient.

But I hope we continue to look at many more nuanced measures of quality, and nursing quality, I think, in particular, because there are nursing-specific indicators, and the best way to get your cost down is to slash your staff. So I think that's really something important.

We often hear the analogy that physicians are the pilots of the health care system. I would just say nurses are the air traffic controllers, and none of us want to be flying blind. So I think future iterations, if we can think how do we really get at the metrics so that we really

know that efficient hospital is really high quality, on multiple dimensions, and more cost effective. Thank you.

MS. KELLEY: Scott.

DR. SARRAN: I just want to go on record by thanking the staff again for very excellent work, and I am very enthusiastically positive about the recommendation. I am particularly proud of how we have incorporated, to a significant extent, the safety net index. I think that makes the work and the recommendations and the impact much stronger than if it were simply an across-the-board recommendation.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. Very good report, and I appreciate that this is really a heavy lift. Nicely done.

Just a couple of brief comments. One, the idea that we incorporate at least a statement that the rating agencies' outlook is a bit mixed with hospitals I think is very helpful, and I appreciate that update since the last time that we met.

There are some facilitates that are struggling financially. Not every hospital is homogenous. And the

fact that the rating agencies do see that is helpful because for those that are struggling, many of them are actually in vulnerable communities. And I think this is where the safety net index can actually be quite helpful.

The other thing, and these are statements that I have made for a while, is that it would be great, at some point in time, if we could get to two-part recommendations that kind of link the update payments that we are legally and regulatorily required to recommend, with performance metrics, at some point in time.

And, you know, I found it interesting that the HCAP scores are inversely proportionate to mortality rates as well as readmission rates. You know, I'm not sure all of us will necessarily agree on what the metric is, but I think concepts like that, that are intuitive, simple, reasonably actionable for many facilities to take up are things that we should consider in the future when we start talking about payment updates across a wide variety of industries within health care.

So again, I want to thank you for the work. I am very much supportive of the draft recommendation.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, I support the recommendation and just wanted to double down on the other comments. First of all, I do hope Congress will pay attention to the safety net index recommendations. This is an opportunity that shouldn't be missed, right, to direct money to where it's really needed, and I'm very glad for the work that the staff has done on that.

The second point, workforce. I'll just say that to be a floor nurse right now -- a nurse that does not work in the ICU or the ER but on the floor -- it's a terrible job. The only reason to be a nurse in that setting is because you like to talk to patients and take care of them and help them.

And, you know, "efficiency," quote/unquote, demands cutting down on your number of nurses and increasing the number of patients that each nurse sees. It's very noticeable, the difference. Nurses probably can't talk to patients at all right now, in my experience in the hospital.

So I don't know what can be done about that, but it's really an issue if we want to have a decent nursing workforce. I think it is a quality issue as well. How to

get at it is tougher. Patients satisfaction measures might help.

And then the last thing, on Brian's point about the fact that we recommended a uniform update for IPPS and OPPS to be lost. It's not something that we're really discussed much, to my knowledge. But I would like to see more discussion of that and thought about that in the future, whether the recommendations can be separated and just more on that issue.

MS. KELLEY: I have a comment from Greg, and it is the hospital update is challenging for all of the reasons mentioned. He strongly disagrees with Brian's conclusion that the hospital workers are not supported by this recommendation. As he looks at the salary increases to hospital staff over the last couple of years, the increases are sharply higher than general CPI and much higher than this recommendation.

With that said, he thinks this recommendation is appropriate for sustaining future access.

DR. CASALINO: Dana can read my comments in the future. They're so much more convincing.

[Laughter.]

MS. KELLEY: I have come to the end of my list, but in preparing to read Greg's comments, I may have missed someone. So if I did, please raise your hand now.

DR. MILLER: May I make an additional comment?

DR. CHERNEW: Absolutely.

DR. MILLER: I think my concern is not from an aversion to raising rates. It's from a lack of specificity, and I tried to communicate this may not -- it may be that IPPS rates hypothetically need to go up a lot, because they're inadequate, and then they may need to go up even more in a rural setting, and that OPPS rates need to be cut in order to result and respect our site control payment, and because we don't have any specificity in our rec -- it's just a broad rec for the entire industry -- we unfairly reward and penalize players and parts of the marketplace, not necessarily in accordance with their need or their performance, which is not fair or equitable to the industry.

DR. CHERNEW: On this point, or do you want -- okay, go ahead.

DR. CHERRY: Yeah. So the reason I think, Brian, why many of us strongly supportive of this is because

there's a lot of work done around the SNI to create equity within the health care system.

And to Mike's point earlier, one of the things that we're trying to accomplish here is to decrease the noise, the signal ratio with the legislators. There's a very important message that we're trying to communicate here, which is that there are vulnerable communities that hospitals are operating in that desperately need some assistance. And I think that our full support for that high-level message is critically important, because I think some of the details that you're talking about will get lost in the other noise.

DR. CHERNEW: Okay. I have no one to say, but can I talk now? So go ahead, Larry.

DR. CASALINO: No, very briefly. I think, again, on the safety net index point, I think Congress should understand that general updates will result in the rich hospitals getting richer and the poor hospitals getting poorer without the safety net index. That's been happening pretty dramatically, and it will continue to happen if we don't do some kind of safety net index work. And that does not serve just about anybody well. It does not -- there's

a lot of patients who get hurt when the rich hospitals get richer and the poor hospitals get poorer, and that would be the result of not adopting some version of the safety net recommendation.

DR. CHERNEW: Yes, Lynn. No, it's all right.

MS. BARR: But I do want to stress that the safety net index did a tremendous amount to make rural hospitals whole. So if we do adopt the SNI, the rural hospitals are going to get taken care of. So let's not forget that.

DR. CHERNEW: I want to make a comment about process a little bit more than substance. First -- and Jeff, who was here when I came in 2008 and apparently is still here, I think --

[Laughter.]

DR. CHERNEW: -- and is a --

DR. CHERRY: Thank goodness for that.

DR. CHERNEW: -- national treasure, he may know more about what I'm about to say. But this is my understanding, and I think it dates back as far as Glenn Hackbarth, and so again, I might be wrong about this.

When we do the updates, we have data-driven

updates. When we have data-driven updates, we have a bunch of criteria. When we do those criteria, they include things like margins and a bunch of other things that you know, and it became -- and this was not a me issue; this was a Glenn Hackbarth issue. It became very, very challenging to run through a separate update on margins and access and access to capital for hospital outpatient care, which is very hard to do. And so for a range of reasons, it was decided we would keep the update the same.

To Brian's point -- and he is correct -- the relative pricing -- everything Brian said, I think is basically right. You might think inpatient services need to be higher and outpatients need to be less. How that fits in with site neutral is a problem. I really truly understand that because, particularly as the world becomes more outpatient, it is more challenging because some of those outpatient services are now competing with, say, freestanding services in a range of ways, and that's a problem.

It is a problem we're worried about, and again, as Brian pointed out, I think correctly, we have tried to deal with that through aspects of our site-neutral work.

Frankly, our site-neutral work has tended to take the view, if you can provide a cheaper outpatient, send an outpatient, and just pay the hospital outpatient what you could get for the service otherwise. But it has been a different strategy because there's a set of services there. It's not a collective update thing, and you might imagine trying to get the update right. That is a, I think, very reasonable intellectual point. It's just something that we would have to take on outside of our normal update work, because it is quite complicated to figure out, for example, if we were going to change the criteria or apply the criteria, how would we do it? So that's my understanding on that particular issue of the history.

So before I go on, Jeff will now correct me how much of that I got right or wrong.

DR. STENSLAND: I think that's generally right. We've generally said this exercise today is to say, is there enough money in the system as a whole? And then there's other exercises, like we'll talk in March and April. Should we redistribute that money differently? Should there be a different increase to rural? Should we have a site-neutral policy where we extract some money from

some services and give them to others? So I think those are two different questions.

And just because we're having a recommendation today that might pass on overall how much money should be in the pot, that doesn't mean our site-neutral recommendation goes away. That's still sitting there as a standing recommendation.

DR. CHERNEW: Right.

DR. MILLER: On this point, which I've been waiting to make, this is that, yes, this is about a pot of money, but that that pot of money could be bigger or smaller depending upon the implementation of our precedent, which is site-neutral payment, which MedPAC has historically strongly supported. So this update, this broader update may be too big. It may be too small. We actually don't really have enough information to make that decision because we didn't integrate the site-neutral analysis.

And the IPPS and OPPS are separate payment systems, separate care delivery, and so lumping them together then potentially washes away our site-neutral recommendation and gives an unclear signal to Congress

whether we are trying to say we need more money to support inpatient care or more money to support outpatient care. So it's very -- and it also doesn't fit with our recommendations on the physician fee schedule, because we would think that OPPS, ambulatory surgery, if you want to go there, physician fee schedules, that we should be looking to bring these payment systems closer together as opposed to farther apart, and so our recommendation will push them farther apart.

We all know that the lack of site-neutral payment drives consolidation, and so then we would be making a recommendation that potentially worsens consolidation in the health care delivery system.

DR. CHERNEW: Go ahead. Paul wants to say something, then I will continue.

MR. MASI: Sure. And thanks for this conversation.

Brian, I just had a narrow clarifying question. If the text is more direct and clear that the Commission's site-neutral recommendations, which I think were made just this past June, if it were made clear that those recommendations still stand, standing recommendations to

the Congress, would that affect your support for this? I just want to understand where you are.

DR. MILLER: I think that is the requirement, but also that we should have a specificity and have a separate IPPS and OPPS recommendation. It seems unclear to be merging payment systems and making a broad recommendation. It would be like making a recommendation about home health, SNFs, and IRFs as a broad payment update rather than separate markets.

DR. CHERNEW: So two things. There's complications for doing that. I understand what they are. I hope it was clear from my last comment.

The discussion about changing the broad processes about what we would do -- and I would include to this issue of rural, which I'm quite aware of, as Lynn knows, how we target things has been a big, big -- we will never target them right. We will try and target them better. Usually, the target things, just for workload and process reasons, come in our June report as we try to build things out in the targeting point.

So if the issue is we should change the fundamental structure of the work and the updating things

that we do, that is a reasonable thing to raise, a reasonable thing to be considered, but it's not going to address the core problem that I think we're trying to signal with this recommendation here. And again, you can tell me if I'm misinterpreting.

So to build off of what Jeff said, this recommendation basically says the hospitals -- for inpatient hospitals probably more money than current law, that's the first point, and that money should be targeted in a particular way, and the targeting that we've chosen relates to the safety net index. These other issues, we will have a discussion on rural, and rural is dealt with there. There's a whole range of other type of targeting things one could do, which we will try and figure out how we could better target. And again, in the rural case, it's complicated, because we're actually not making any -- about two- thirds of hospitals, I think rural hospitals are critical access hospitals -- we're not thinking through the balancing of how the critical access hospitals, low-volume hospitals, Medicare- dependent hospitals all flow into rural IPPS hospitals. There's just a lot there. That doesn't mean it's unimportant. It's just it's more than the

-- and at least I'll take blame for this. It's more than I believe we can deal with, and I think it's more, frankly, than Congress is asking us to deal with. And the update recommendations historically were just give us a number. That's what they want.

So that's just an explanation of where we are. The question for you is if the -- there's three ways to read your recommendation. One is it's too much money, which I don't think you think. One is it's too little money, which I don't think you think. And the other one is just the structure of the work isn't right, and so you just don't know.

DR. MILLER: Yeah. The answer is I don't know what the answer is because we're making a recommendation about inpatient and outpatient services. Whereas every other market, we're making a recommendation about a specific service market. We're merging two payment chasses together and sort of running the blender and saying here's what we think. And so we don't actually have -- we're potentially not allocating payment recommendations clearly for Congress.

DR. CHERNEW: Right. So I understand that, and

again, we can continue this discussion. In a moment, we're just going to go for a vote, but let me just say one other thing.

There's other dimensions of where that happens in a whole range of ways. The one that has me most concerned about is the physician fee schedule blends practice expense with work, which are fundamentally different constructs, but historically, they've been blended together. And, in fact, that becomes the crux of where we get to site-neutral problems, and I think that's an unfortunate aspect of the way that works. It becomes problematic when you have big health systems that own across all of these things. We're giving an update, but they're moving money between the different fee schedules.

So the reason why they're together, actually -- and again, we can have a conversation. You may have ideas on this -- is actually to think now, okay, what data would we need to look at to figure out, oh, the OPPS is overpaid and the IPPS is underpaid? That is hard. What we -- because we don't -- a lot of our criteria are hard to apply that way. But we -- you're site-neutral stuff, I could not agree more. I hope it's really clear for some of you. So

I spent a lot of time on the phone with talking about site neutral and why it's important, understand that we are very clear on that.

We've gone at the site neutral on a service-specific way. We had a whole separate body of work that was more service specific than update specific, but I do acknowledge that there are going to be places where inevitably the fees are going to fall through the cracks, because we just don't have that level of granularity. So that's why we haven't come up with separate updates, and if we thought that there was a relative mismatch and say the OPPS and the IPPS updates, one should be more versus the other said, say we thought that was true, we would have to think through a whole new set of criteria to how to tell that out. And that would be something that would be, say, cycle for 2025. That's not a 2024 cycle issues, not that it's unreasonable. It's just really hard analytically to get there.

So we put them together and do what Jeff said, which is basically efficient hospital margins under current law are negative. We believe that we should put more money in the system to support hospitals, and that that money

should be targeted. So that's it.

So that the vote, just to be clear, because we're about to vote a vote, a vote yes is hospitals need more money. That money should be targeted. A vote no, I guess, by contrast -- and I guess you can get to interpret your public record, what you believe a vote no is, but the way that I interpret a vote no is that -- actually, I'm not sure. So I'll stop.

What I was going to say -- and I might be wrong -- is a vote no was hospitals don't need more money, and it shouldn't be targeted. I don't think that's what you think. So I don't think that's how your vote should be interpreted. It might be just I don't like this process, so I'm going to vote no because I don't know.

I'm just trying to figure out how to interpret it, but you -- I guess I'll give you one last comment, and then we'll go around to vote.

MR. MASI: I'm just trying to jump in real quick. It looked like we were getting close to voting. I wanted to make sure any other Commissioners had a chance to speak or not speak, but then just with an eye towards the clock, I wanted to make sure we had a chance to move into the

vote.

DR. MILLER: I'll just say I don't have enough information and specificity to make a decision.

DR. CHERNEW: All right. Dana?

MS. KELLEY: Okay. Voting on the recommendation for fiscal year 2025, the Congress should update the 2024 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1.5 percent. In addition, Congress should begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety Net Index, or MSNI, add $4 billion to the MSNI pool, scale fee-for-service MSNI payments in proportion to each hospital's MSNI, and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems and pay commensurate MSNI amounts for services furnished to Medicare Advantage enrollees directly to hospitals and exclude them from MA benchmarks.

Voting yes or no. Lynn?

MS. BARR: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes. And I'll just add, I hope

that when time allows, we will think more about the IPPS versus OPPS issue. It's complicated, I think.

MS. KELLEY: Robert?

DR. CHERRY: Yes. I can't get the --

MS. KELLEY: Try again. There you go.

DR. CHERRY: Yes.

MS. KELLEY: Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Jonathan?

DR. JAFFERY: Yes.

MS. KELLEY: Kenny?

MR. KAN: Abstain.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Brian?

DR. MILLER: Abstain.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Greg? Looking for the thumbs-up from Greg. Okay. Thank you.

Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Thank you.

DR. CHERNEW: Okay. So we're adjourned, and we will be back after lunch. I think we're adjourned. Yeah. We'll be back after lunch, and we're going to go through a whole bunch of the other sectors, dialysis, some of the post-acute ones.

So, again, to the public, we do want to hear your comments. So you can send comments at -- I think it's MeetingComments@medpac.gov, or you can otherwise reach out. and we will listen to all that you have to say. Thank you

for joining us.

Again, tune in again. We are coming back at 1:15. We're adjourned.

[Whereupon, at 12:00 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION

[1:19 p.m.]

DR. CHERNEW: All right. Thank you, everybody. We are back for our afternoon session and our update recommendation work for January in this cycle. And we're going to jump right in. We're going to go through a lot very quickly, so to get us along with that task we're going to start with Nancy, talking, I think, about dialysis.

MS. RAY: Good afternoon. The audience can download a copy of today's presentation on the upper righthand side of the screen.

During this session, we are going to run through the payment adequacy assessments for outpatient dialysis services, hospice services, skilled nursing facility services, and home health care services. For each of these sectors, we discussed the adequacy of Medicare's payments during the December 2023 meeting, and there was a strong consensus around the draft recommendation for each sector. Today's session for each sector is an abbreviated version of what was discussed in December. Commissioners can find additional detail in each sector's briefing papers.

And now we will start with assessing the payment adequacy of outpatient dialysis services.

In 2022, there were roughly 290,000 Medicare fee-for-service dialysis beneficiaries, treated at 7,865 facilities. Total Medicare fee-for-service spending was about $8.8 billion for dialysis services.

The indicators assessing adequacy are generally positive, and you have seen all of this material in December.

Between 2021 and 2022, growth of in-center treatment stations was relatively steady, while the number of all beneficiaries on dialysis, that is, those enrolled in either fee-for-service or MA, declined.

Looking at volume changes, the decline in the number of dialysis fee-for-service beneficiaries and treatments between 2021 and 2022, is largely attributable to the change in the statute that permits, as of January 2021, ESRD beneficiaries to enroll in MA plans, as detailed in your paper. We do not see this as a negative indicator of access. The 18 percent marginal profit suggests that providers have a financial incentive to continue to serve Medicare beneficiaries.

Moving to quality, between 2021 and 2022, ED visits, hospital admissions and readmissions, and mortality

remained steady for fee-for-service beneficiaries on dialysis, and the percent of dialysis beneficiaries using home dialysis has continued to increase.

Regarding access to capital, indicators suggest it is positive. Overall growth trends among dialysis providers indicate that the dialysis industry remains attractive to for-profit facilities and investors. The large dialysis organizations have reported positive financial performance related to their dialysis business for 2023.

In 2022, the aggregate Medicare margin is -1.1 percent, and the 2024 projected aggregate Medicare margin is 0 percent.

Based on our findings that suggest that outpatient dialysis payments are adequate, the draft recommendation reads:

For calendar year 2025, the Congress should update the 2024 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law.

This draft recommendation will have no impact relative to the statutory update.

We expect beneficiaries to continue to have good access to outpatient dialysis care and continued provider willingness and ability to care for Medicare beneficiaries.

And now I turn it back to the Chair.

DR. CHERNEW: Nancy, thank you tons. We've had a broad discussion of this. I think Brian wants to make a brief comment on this. We are going to move expeditiously to the vote. I may not have gotten this right, but Brian, I think you wanted to say something?

DR. MILLER: A brief comment. I was looking at the MA and fee-for-service penetration, and it showed that it rose from 0 to 35 percent in two years, after the 21st Century CURES change, and it's now at 47 percent. I'm unaware of a healthy end-stage renal disease beneficiary, so this is actually an important market indicator of a lack of~~black~~ favorable selection, at least in this particular population, with respect to MA.

DR. CHERNEW: All right. I think it looks like we're ready for a vote. Oh, Robert, I'm sorry.

DR. CHERRY: Yeah, no problem. Thank you. Just a brief comment, very similar to my remarks this morning. It would be great if we could find opportunities for

secondary recommendations in the future.

I found it interesting that among dialysis patients it was mentioned in the detail of the report that the admissions rates are 14 percent, not annually but per month, with a readmissions rate of 21 percent, and ED visits are 12 percent per month.

So I think it's just something to think about. I'm not saying these are the metrics, necessarily, but I think if we can tie performance to these updates in future meetings that would be great. And it would also be great if we could merge some of the MA data with the fee-for-service data as well, because that's a limitation in terms of making really good decisions here. Otherwise, supportive of the recommendation. Thank you.

DR. DAMBERG: All right. Super quick. One of the things that was new to me was on page 20, about the guaranteed issue rights and what proportion of the end-stage renal disease folks fall below age 65. And I wasn't sure. It's not related specifically to the payment update, but one of these kind of parking lot issue, has the Commission discussed, you know, thoughts about changing the guaranteed issue such that when people first qualify under

Medicare, say for disability.

DR. CHERNEW: That was a -- okay. We're going to do a little bit of this discussion and then we are going to save, because this is really now all about us getting to the vote on the rec, not about broader sets of things on dialysis. So let's have a broader conversation about that issue.

We are very worried about issues of guaranteed issue, and we're very worried about issues about community rating and a bunch of other things about how people move between sectors. Those issues are a bit outside of our update criteria issues.

MS. UPCHURCH: I was just going to say, Medigap policies are about state. And so the Medicare supplement, guarantee issue rights means to supplement, or Medigap policies. That's a state decision, as far as I know.

DR. CHERNEW: Right. But it is an issue that we're quite worried about because we're worried about the movement of people between MA, and not just on the dialysis issue, to be clear. That's a broad MA issue about people being in a plan, and can they get back, and what if they can't do what they want, or what are the rules around that.

And Cheryl asked, I think, how we thought about it, and the answer is we have thought about it. It's a quite complicated one, for a bunch of reasons, but it is on the radar.

Okay. Now looking around again because I got my who's in the queue and --

I think we're ready for a vote.

MS. KELLEY: Okay. Voting on the recommendation for outpatient dialysis. For calendar year 2025, the Congress should update the calendar year 2024 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law.

Voting yes or no. Lynn?

MS. BARR: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert?

DR. CHERRY: Yes.

MS. KELLEY: Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Jonathan?

DR. JAFFERY: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Greg? Oh, got to look for Greg's thumbs up. He did? He got it? Good.

Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: All right then. Thank you.

DR. CHERNEW: And our next topic we're going to move to is hospice services.

MS. NEUMAN: Next we are going to review the indicators of payment adequacy for hospice. There is more detail in your papers. The paper has been updated to reflect Commissioners' discussion and question at the December meeting.

For example, we included additional information about hospice use by beneficiaries in Medicare Advantage. We also included information about the Hospice Special Focus Program that will involve additional oversight for hospices that are the poorest performers on selected quality measures.

So here's a snapshot of hospice in 2022. Over 1.7 million Medicare beneficiaries, including nearly half of decedents received hospice care in 2022. These beneficiaries received an average of 3.9 visits per week from hospice staff. Length of stay was 18 days at median, and 95 days at average. About 5,900 hospice providers

furnished care to beneficiaries, and Medicare paid them $23.7 billion.

To summarize, indicators of hospice payment adequacy are favorable. The supply of providers increased 10 percent in 2022. The share of decedent using hospice, the number of hospice users, and total days of care increased. Length of stay also increased. In-person visits per week increased slightly. Marginal profit was 17 percent.

While quality is difficult to assess, the most recent CAHPS data were generally stable. Visits at the end of life were stable in 2022, but remain below the 2019 pre-pandemic level.

Access to capital appears adequate. We continue to see substantial provider entry, almost entirely by for-profits providers, and financial reports indicate the sector is viewed favorably by investors. Provider-based hospices have access to capital through their parent provider.

In terms of margins, different from other sectors, we have an estimated 2021 margin because data on the hospice aggregate cap lags. The 2021 aggregate

Medicare margin was 13.3 percent. The 2024 projected margin is 9 percent.

So this brings us to the draft recommendation. It reads:

For fiscal year 2025, the Congress should eliminate the update to the 2024 Medicare hospice base payment rates.

In terms of implications, the recommendation would decrease spending relative to current law by between $250 million and $750 million over one year, and between $1 billion and $5 billion over five years.

In terms of beneficiaries and providers, we expect that beneficiaries would continue to have good access to hospice care, and that providers would continue to be willing and able to provide appropriate care to Medicare beneficiaries.

That concludes the presentation.

So that concludes the presentation, and I turn it back to Mike.

DR. CHERNEW: Great. And as we did with dialysis we will have just a few brief comments, and I think Brian, you are also up.

DR. MILLER: This was a great chapter. I appreciated the section noting that California had a moratorium on new hospital licenses. I hope that we continue to crack state action in that space and take that into account.

One thing I wanted to note about policy, the policy options discussion about non-hospice services, I don't think that bundling here or a payment penalty for non-hospice services is a good policy option because it has the unintentional consequence at the end of life for the beneficiary as positioning the hospice agency as the police, for utilization, and breaking that sacred relationship. I think we all would agree that non-hospice service use is potentially not always but sometimes to the benefit of the beneficiary, but we should be cautious about over-regulatory action in that space because we want to encourage hospice use when the beneficiary feels it is appropriate, and allow them to still occasionally have access when they change their mind.

MS. KELLEY: Amol.

DR. NAVATHE: I had two brief points. One, kind of building off of Brian's point, I think, I'm very

supportive, broadly speaking, of our work in exploring this non-hospice spending piece further, and importantly wanting to differentiate where the potentially kind of like billing practices or the way that that benefit is managed by hospice providers and on hospice providers versus what is truly kind of non-hospice care per se, that's separate, that's not overlapping in any way. I think, in part, overlapping with what Brian said.

And the second point it I think that the chapter very nicely makes a point around need for more work in the future on the quality side. I think it's very, very apparent. I think the chapter does a nice job of making it apparent that it's kind of dizzying right now what's happening in the hospice space, and so I think I would support the chapter's assertion that we need to do more work in that space. Thanks.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Not to sound like a broken record, but again, you know, trying to link some of the update recommendations to performance metrics would be great. I like the idea that, you know, the chapter highlighted the Hospice Special Focus Program and defined

that a little bit more. Though it's only starting in 2024, it looks promising because it's based on selected quality indicators, condition level deficiencies, substantiated patient complaints, as well as outlier performance and CAHPS surveys.

So it's a nice index and algorithm to utilize. It's only being implemented in 2024, so it may be a couple of years before we have really good data around it. But I think it's things like this that are embedded in our report that the staff is working on in a very diligent fashion that I think we can utilize in the future. So thank you.

DR. CHERNEW: Okay. I think we are ready for a vote.

MS. KELLEY: Okay. Voting on the draft recommendation for hospice, which is, for fiscal year 2025, the Congress should eliminate the update to the 2024 Medicare hospice base payment rates.

Voting yes or no. Lynn?

MS. BARR: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert?

DR. CHERRY: Yes.

MS. KELLEY: Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Jonathan?

DR. JAFFERY: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Greg? I have a thumbs up from Greg. Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Thank you.

DR. CHERNEW: And so now we're going to move on to skilled nursing facilities. And is this Kathryn starting?

Okay. Kathryn.

MS. LINEHAN: Okay. Good afternoon. I will recap the payment adequacy indicators for skilled nursing facilities that you saw in December, and then I will present the draft recommendation for your vote.

More detailed information is in the paper, which has been updated since December to reflect your comments. Specifically, we added more detail about the average occupancy rates to the access section. In addition, the quality section of the paper now includes more detail about exclusions from calculating the discharge to community measure, more information about the change in function

measure, discussion of the limitations of staffing as a measure of quality for our Medicare beneficiaries in a Part A-covered stay, a text box that highlights the Commission's June 2021 recommendation that CMS finalize and report patient experience measures.

This slide provides an overview of the SNF sector in 2022. That year, there were about 14,700 SNFs, most of which also provide long-term care that makes up the bulk of the services that this sector provides.

For the average SNF, Medicare makes up about 10 percent of total facility days. This contrasts with other PAC settings, where fee-for-service Medicare makes up about half of providers' volume.

In 2022, there were 1.8 million fee-for-service Medicare-covered stays for SNF services, and the program paid $29 billion for care in SNFs and SNF care provided in swing beds. And you can see more detail about that breakdown in your paper.

In summary, our access indicators show a slight decrease in the supply of facilities. In 2022, SNF use per fee-for-service beneficiary increased, as did facility occupancy rates, after a decline in 2020 and 2021. While

these increases indicate capacity, employment in the sector remains below pre-pandemic levels and could constrain access in some places. Nevertheless, the high fee-for-service Medicare marginal profit indicates providers had a strong incentive to treat fee-for-service Medicare beneficiaries.

Our measures of quality show that the risk-adjusted facility rate of discharge to the community declined slightly compared to the pre-pandemic period, as did total nurse and RN staffing ratios. Notably, data on patient experience and function are lacking in this sector.

SNFs have adequate access to capital, and the sector remains attractive to investors. The total margin fell compared to 2021, but this is not a function of fee-for-service Medicare's payments.

As for fee-for-service Medicare payments and SNF costs, in continuation of a decades-long trend, the average Medicare margin in 2022 was high, 18.4 percent. Factoring in expected changes to payments and costs, the projected margin for 2024 is 16 percent.

This brings us to the draft recommendation for updating payments to SNFs. It reads: "For fiscal year

2025, the Congress should reduce the 2024 Medicare base payment rates for skilled nursing facilities by 3 percent. Relative to current law, this recommendation would decrease spending by between $2 billion and $5 billion over one year and between $10 billion and $25 billion over five years.

Given the high level of Medicare's payments, we do not expect adverse impacts on beneficiaries. Providers should continue to be willing and able to treat fee-for-service Medicare beneficiaries.

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

DR. CHERNEW: Kathryn, thank you. We have a few brief comments, and I think, if I'm right, Tamara is first.

DR. KONETZKA: First, Kathryn, I just wanted to thank you for being able to incorporate so much of what came out of our discussion last time in time for this meeting. Really appreciate that.

And I especially appreciated the analysis of occupancy rates and hospital length of stay as sort of starting to get at some of those access measures we've talked a lot about, the bluntness of the measures we use.

So I just want to put in a plug for the future

that we really need to focus more on MA in the sector like we have to in many sectors, but when we talk about length of stay in nursing homes, for example, in SNF stays, it's increasingly not just that there are more and more MA residents, but there are huge spillovers to the way SNFs practice. And length of stay is decreasing because of that, even though they're paid per diem. So just a plug to really to sort of focus on that in the future.

Other than that, I really support the draft recommendation. I think it's really a good weighting of the concerns about high margins versus the sort of really large uncertainty we see in this sector right now.

Thank you.

MS. KELLEY: Brian.

DR. MILLER: Quick question and a comment.

The question is, did our analysis take into account the September 1st, 2023, rule about SNF staffing requirements from CMS?

MS. LINEHAN: Did our recommendation --

DR. MILLER: Did our -- yeah, recommendation.

MS. LINEHAN: Yeah, that's in the chapter. It does not because it's not current law. So our

recommendations are -- or our projections are based on what's the current law.

DR. MILLER: The current proposed -- what the current proposed rule is.

And so I guess --and that's why I thought. Thank you for confirming.

MS. LINEHAN: No, it's not. It's not based on --

DR. MILLER: Yeah, not taking into account the current proposed rule. That's why I just wanted to confirm that before my comment.

I guess my question is knowing that there's that proposed rule, which would significantly affect the SNF margin, because it would totally change their operations, should we have two estimated recommendations, one based upon the current statute and regulatory framework and another based upon if this rule were implemented next year? Because this would massively change the industry, and I obviously support -- am generally supportive of the current recommendation, but again, I wonder if we lack the specificity, given that we expect this enormous change in how SNFs do business.

This is an analytical question, independent of

how any of us and our diverse views are on this proposed role.

DR. CHERNEW: So I'm going to weigh in quickly on that, but I'm going to defer to Paul.

I think the general view has been that we make our recommendations under current law because there's too many potential things that various people are proposing, and I think there's been uneasiness in trying to forecast the likelihood of whether or not things be implemented.

But your point, which is broader than just the SNF point, is the world changes in ways that some of us may anticipate going forward. It may make the recommendations that we vote on no longer seem like the things we would have voted on. And I think it is probably the case that if they did implement that rule and there was a change in margins, we would have a different recommendation.

So the way that we deal with that -- and this isn't the only case where that's true -- is if that rule gets finalized as we engage with the Hill or do other things, we would acknowledge that our recommendation was based under the current law at the time we made the recommendation. And when we engage with the Hill, we

would, I think, discuss with them implications of what our recommendation may or may not mean given the changes that are afoot. Again, that's not a particular SNF comment. It's really just very hard to do our work when there's shifting sands in a lot of ways. So that's the process that we've used.

Paul.

MR. MASI: And then, Brian, I know you want to get back in here.

I had one just clarifying fact that I wanted to -- I'm looking at Kathryn here, so she should correct me. I think at this time, there is not a set time table by which the rule would be either finalized or not. I think the proposed rule did not have a clear timeline, and so that's just a point of information to add to the conversation.

We completely agree that this is obviously a really important proposed rule, and that's why we're monitoring it, and we'll continue to do so.

MS. LINEHAN: Can I just -- sorry, Brian.

That's correct. And also, in the proposed rule, the rule wouldn't go into effect in 2025. So that's maybe another relevant factor here.

DR. MILLER: So a couple thoughts. One is it will take time for -- if the rule were finalized, it would take a significant amount of time for the businesses to actually implement the rule, and part of that work will start before the deadline of whatever the regulatory guidance is, which would, of course, change how their business operates.

I, of course, have no expectation that we respond to every single market condition that changes. We could sneeze, and like some rule or regulation can change, I realize, across the government, and probably several has changed while we have been having this meeting.

That aside, though, this rule is so significant. I feel like we'd be a better advisor to the Hill and Congress if we had some sort of estimate of what the impact would be on SNF margins, and our recommendation may still be -- end up being somewhat on point, and this is not to critique the work but rather to say, again, I think us having more information about this -- still recognize its proposed rule, but it's life changing for the industry and for the beneficiaries -- would be very helpful.

DR. CHERNEW: I think, Betty, you had a very

brief comment.

DR. RAMBUR: A very brief comment. I just wanted to comment on page 20, it says the nursing facility staff ratios and turnover are difficult to interpret because they apply to the entire facility, not just the Medicare covered. And I understand that. I should have brought this up last time, but if there is a reason to think that that population is dramatically different somehow, we should say that because it seems to me, it would be relatively consistent across the organization.

And I say that because I think that those criteria are so important because not only does it impact the people who are patients in a SNF, it also impacts the overall workforce, because the more people that leave and the more turnover there is, the more an organization starts to capitalize itself. So not to make any changes to this, but I think perhaps there are some interpretations that we can make.

And I may just come on Brian -- Brian, I hear what you say. It doesn't seem unreasonable to me, though, that we go with the law that's here, and if there's a big, erratic change at that point, we say, well, you know, and

something new goes forward. So that's why I would see that.

MS. KELLEY: Scott?

DR. SARRAN: Thanks again for the great staff work.

I support the recommendation, given that when we look at this area through the lens, as we must, of community-living beneficiaries experiencing a temporary skilled stay, the conclusion is certainly borne by the facts. I just want to put it in public record and remind us that there's two other populations that we are explicitly not really examining in terms of impact, either currently or what we should be doing for them, that are excluded from this. And that's MA members who are experiencing a skilled stay because the dynamics of how those stays are managed, both in terms of length of stay and dollars per day are much different and not well -- and not terribly transparent nor well understood in the policy community as well as beneficiaries living long term in a nursing facility. And so it's just reminded us of the importance of engaging in those bodies of work.

DR. CHERNEW: That was the nod that we go to a

vote.

MS. KELLEY: Okay. Thank you.

Voting on the recommendation for skilled nursing, the draft recommendation for skilled nursing facilities, which reads: "For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rates for skilled nursing facilities by 3 percent."

Voting yes or no. Lynn?

MS. BARR: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert?

DR. CHERRY: Yes.

MS. KELLEY: Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Jonathan?

DR. DAMBERG: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Brian?

DR. MILLER: Abstain.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Greg, a thumbs up or down? A thumbs-up from Greg.

Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Okay. Thank you.

DR. CHERNEW: Okay. Evan?

MR. CHRISTMAN: Next, I will recap the payment

adequacy indicators for home health, and then I will present the draft recommendation. More detailed information on our indicators is in the paper you received, which has been updated to reflect your comments. Specifically, we added more information about the current trends in the utilization of home health aides, the ownership of home health agencies and other PAC providers by health systems, and we noted the types of patients included in our quality measures.

Before returning to our payment adequacy indicators, here's a brief overview of home health care and Medicare fee-for-service.

In 2022, there were about 11,300 agencies participating in the program. Those agencies served 2.8 million fee-for-service beneficiaries and delivered 8.6 million 30-day periods of home health care, and total fee-for-service payments in 2022 equaled 16.1 billion.

Turning to our indicators, our indicators for home health were largely positive. Beginning with beneficiary access to care, 98 percent lived in a zip code with two or more home health agencies. Total volume decreased. The share of discharges to home health care

from the hospital was comparable to prior years, and in 2022, home health agencies had a fee-for-service Medicare marginal profit of 23 percent.

For quality of care, fee-for-service Medicare beneficiaries discharged a community rate decline but remained high, and the patient experience measures remained high and were stable.

For access to capital, the overall all-payer margin for home health agencies was 7.9 percent in 2022, and we note that home health agencies have been the focus of acquisition efforts by large insurance companies and private equity in recent years.

For Medicare payments and costs, we find that the Medicare margin in 2022 is 22.2 percent, and the projected margin for 2024 was 18 percent.

This brings us to the draft recommendation: For calendar year 2025, the Congress should reduce the 2024 Medicare base payment rate for home health agencies by 7 percent. For spending implications relative to current law, spending would decrease by between $750 million to $2 billion in one year and between $5 billion to $10 billion over five years.

We do not expect adverse impacts on beneficiary access to care, and that providers should continue to be willing and able to treat beneficiaries.

This completes my presentation, and now I turn it back to Mike.

DR. CHERNEW: Great.

I think Tamara had a comment. Is that --

DR. KONETZKA: Yes, a very brief comment.

So, similarly, Evan, thank you so much for adding so much to the chapter based on our discussion last time in a short period of time, especially the clarifications about community- initiated stays being included in most of these analyses, which was very helpful, and also adding the all-cause hospital readmissions.

Just really one brief comment, and that is that although I agree with the payment recommendation, I was a little concerned about the decline in the number of visits generally and especially the decline in home health aide visits. So just as future work, I would just encourage us to sort of really continue to monitor the quality. Efficient care is one thing, but I think the quality and whether beneficiaries are getting what they need out of

these home health episodes is really critical to continue monitoring.

Thanks.

DR. CHERNEW: Okay.

MS. KELLEY: Okay. Turning to the vote for the draft recommendation on home health care services, which reads: For calendar year 2025, the Congress should reduce the 2024 Medicare based payment rates for home health agencies by 7 percent.

Voting yes or no. Lynn?

MS. BARR: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert?

DR. CHERRY: Yes.

MS. KELLEY: Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Jonathan?

DR. DAMBERG: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Greg, can we get a thumbs up or down? A thumbs-up from Greg.

Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

MS. KELLEY: All right. Thank you.

DR. CHERNEW: So that brings us to the end of this session.

We are running about 10 minutes behind, so I think we should plow right through to the IRF session, and so it's going to take a second. I think it's Betty and Jamila.

Take your time, but if we let everybody get up, getting them back is always a challenge.

[Laughter.]

[Recess.]

DR. CHERNEW: So I understand. Everybody stretch.

Betty, by your body language are you starting? Oh, Jamila. By Betty's body language, are you starting? Okay. Just take your time, but whenever.

DR. TORAIN: Good afternoon. We continue with the update to Medicare's payments to inpatient rehabilitation facilities. The audience can download a PDF version of these slides in the handout section of the control panel on the righthand side of the screen.

We will review the indicators for IRF using the same framework you saw in the other sectors. The

Commissioners expressed a consensus supporting the draft recommendation presented in December. This presentation summarizes information that was presented in more detail in December, and there is more detail and information presented in your mailing materials. Those materials were updated to reflect Commissioners' discussion and questions at the December meeting.

For example, we added a new section describing factors that contribute to lower margins in hospital-based IRF providers.

In today's presentation we will provide a quick overview of IRF use and spending under fee-for-service Medicare, review the payment adequacy indicators, review the draft recommendation and its implications, and then the Commission will vote. In the second part of this presentation, Betty will continue with a presentation on improving the accuracy of IRF payments.

This slide provides an overview of the IRF sector in 2022. There were 1,181 IRFs, and about 383,000 stays. Medicare spent about $8.8 billion on IRF care provided to fee-for-service beneficiaries. Medicare accounted for about 51 percent of IRFs' discharges.

In summary, our four categories of payment adequacy indicators for IRFs are positive.

First, in terms of fee-for-service Medicare beneficiaries' access to care, IRFs continue to have capacity that appears to be adequate to meet demand.

Second, in 2022, we are now reporting claims-based measures developed by CMS. We looked at the rate of successful discharge to the community and the rate of potentially preventable readmissions. The median facility risk-adjusted rate of successful discharge to the community increased to 67.3 percent during the fiscal year 2021 and fiscal year 2022 period, which, as a reminder, is an improvement.

Third, as I noted in your paper, almost three-quarters of IRFs are hospital-based units. These IRFs access capital through their parent institutions. The all-payer margin for freestanding IRFs was 9 percent in 2022. Freestanding IRFs maintain good access to capital markets.

Fourth, Medicare payments and IRFs costs indicators were positive. In 2022, the aggregate Medicare margin was 13.7 percent. We project a margin of 14.0 percent in 2024.

And so that brings us to the draft recommendation.

The draft recommendation reads:

For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

To review the implications, on spending, relative to current law, spending would decrease by between $750 million to $2 billion over one year, and by between $5 billion to $10 billion over five years. Current law would give an update of 2.9 percent.

On beneficiaries and providers, we don't expect any adverse effect on access to care. Providers should be willing and able to treat fee-for-service beneficiaries, though financial pressure on some providers may increase.

With that I will close. I am happy to take any questions. Thank you.

DR. CHERNEW: So, Brian, I think you have a comment.

DR. MILLER: Thank you. Question and comment. So when we talk about coding differentials and coding intensity, have we considered, as we should in, I think,

all of our analysis where we see a coding differential, the three components of coding differentials, one of which is outright fraud, the second is upcoding, and third is clinically appropriate coding intensity differences.

DR. TORAIN: When you say consider, what do you mean?

DR. MILLER: Have we evaluated those three components of coding differentials?

DR. TORAIN: Oh yes. In our next presentation we have more work in that area.

DR. MILLER: Okay. And then -- but I'm saying did we integrate that into our recommendation about --

DR. TORAIN: Oh coding --

DR. MILLER: -- the different types of, yeah, the different types of IRFs, the different components of coding intensity.

DR. TORAIN: No, that's not in that recommendation.

DR. MILLER: Okay. And then the second question, I saw on page 19 we have concerns about functional status. I share concerns about functional status measures. At the same time, I'd be hesitant about moving away from a

functional status measure because functional status is something that matters to the beneficiary. They're going to the IRF specifically in order to regain function and alleviate an impairment and be able to go home, and that is part of the transition from volume to value, which we have been working on all the way from Don Berwick to Alex Azar.

But I think that if we have more language about functional status, we should add that it is important to keep an outcome-based measure.

MS. KELLEY: So I just wanted to say that I do think we tried to do that in the chapter, but we'll certainly take another look at it and make sure that it does. I think the Commission has been pretty clear over the last several years that our concerns about functional status are real and present, but that functional status is obviously one of the primary outcomes that beneficiaries are concerned about, and therefore that policymakers should be concerned about as well. So we'll definitely make sure that the chapter reflects that.

DR. MILLER: Thank you.

DR. CHERNEW: I think we're ready for the vote.

MS. KELLEY: Okay. Voting on the draft

recommendation, which reads: For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

Voting yes or no. Lynn?

MS. BARR: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert?

DR. CHERRY: Yes.

MS. KELLEY: Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Jonathan?

DR. JAFFERY: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Greg? We're looking for his signal. He gives a thumbs up.

Betty?

DR. RAMBUR: Yes.

MS. KELLEY: Wayne?

DR. RILEY: Yes.

MS. KELLEY: Jaewon?

DR. RYU: Yes.

MS. KELLEY: Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Thank you. That's the end of our voting.

DR. CHERNEW: We're sticking with IRFs and we're moving to a broader set of issues, and I think that's Betty.

DR. FOUT: Thanks. I will now present work we have done to improve the accuracy of payments in the IRF

prospective payment system. I would like to thank my co-authors Carol Carter and Jamila Torain as well as Doug Wissoker and Bo Garrett from the Urban Institute.

Thus far, Jamila has discussed the level of IRF PPS payments. We now turn to the accuracy of payments across different types of IRF cases.

Last year, we reported findings of differential profitability across IRF case types. We said this was a concern because it may create financial incentives to admit certain types of patients over others, affecting access to care for less profitable patients. The Commission decided to conduct further analysis into drivers of these patterns.

We identified a change in the IRF payment weight method that would result in more uniform profitability across case types. This payment weight method is used in other Medicare fee-for-service payment systems.

We'll now review some of our findings on differential profitability across IRF cases. This chart shows profitability by the IRF condition in which inpatient rehabilitation was needed. Profitability is measured by payment-to-cost ratios, which were calculated by summing payments and dividing them by summed costs for stays in

each condition category.

The blue bar shows that across all stays, the payment-to-cost ratio was 1.16, meaning payments exceeded costs by 16 percent. Profitability differed substantially depending on the IRF condition. Stays grouped in the neurological category were the most profitable, with a payment-to-cost ratio of 1.26. In contrast, on the low end, stays grouped into the nontraumatic spinal cord injury category had a payment-to-cost ratio of 1.10.

Ideally, profitability would be closer to uniform across conditions so that clinical, and not financial, factors drive admissions and classification decisions. Such large differences in profitability could result in financial incentives to select one type of patient over others, affecting access for patients with conditions that tend to be less profitable.

Next, we show that profitability also differs by the case-mix groups that compose each of the IRF conditions, using stroke cases as an example.

The bars on this chart represent the 10 case-mix groups composing stroke stays. The case-mix groups increase in severity from left to right. Stays falling in

case-mix group 10 have the greatest severity, and stays in case mix group 1 are least severe. We expect costs to increase with severity from left to right, as would payments, but payments appeared to increase more than costs. That is, profitability, or payment-to-cost ratios, increased with severity. Profitability steadily increased as severity worsened for all stroke case-mix groups except for one. We found similar inverse relationships between payment-to-cost ratios and severity among the case-mix groups of other IRF conditions.

These large differences in profitability could create financial incentives to select some cases over others as well as code patients as more functionally impaired.

To better understand the relationship between IRFs' payments and costs, we compared IRFs' case-mix index, or CMI, with their average cost per stay. The CMI is an average of the payment weights across an IRF's stays and is a measure of the severity of the IRF's cases. Generally, IRFs with a higher CMI serve patients requiring greater resource intensity and, on average, would have higher costs.

Each dot on this figure represents the change in costs associated with a change in CMI. A value of 1 would mean that a 1 percent increase in CMI was associated with a proportional 1 percent increase in IRFs' average cost per stay.

In 2007, the relationship was approximately proportional, with a 1 percent change in CMI associated with slightly greater than 1 percent change in average cost per stay.

But by 2021, a change in CMI was associated with a less than proportional change in costs, about 0.6 percent. That is, the relationship between IRFs' CMI and average costs has changed over time, and in recent years IRFs with higher CMIs tend to have lower average costs per stay. IRFs' costs are no longer proportional to their CMI, meaning that payment weights are no longer tracking overall cost per stay as well as they have in the past. This could be explained by lower-cost IRFs tending to treat patients in case-mix groups that have higher payment weights.

In fact, we do observe growth in lower-cost IRFs over the same time period.

This chart shows the number of IRF beds by

ownership and type of IRF from 1997 to 2022. The IRF landscape has changed substantially since the implementation of the IRF payment system. The number of beds at freestanding for-profit IRFs has grown substantially, while beds at hospital-based nonprofit IRFs have decreased.

Freestanding for-profit IRFs tend to be large and have lower costs per stay compared to other IRFs. The average cost per stay in for-profit freestanding IRFs was about 30 percent less than the average cost per stay in hospital-based IRFs in 2022. Given these lower costs per stay, the types of cases admitted to these IRFs will be more profitable.

And we find that IRFs vary in the types of stays they admit. This figure shows that more than 20 percent of stays at freestanding for-profit IRFs were for neurological conditions while the share was between 7 and 10 percent for other types of IRFs. In fact, over 70 percent of all neurological condition stays were treated at freestanding for-profit IRFs, number is not shown on the graph. On a previous slide I showed that stays for neurological conditions were the most profitable. Lower-cost

freestanding for-profit IRFs tending to concentrate on these types of stays contributes to that pattern.

The Commission has also previously reported evidence suggestive of differential coding contributing to IRF profitability. Payment for IRF services depends, in part, on how functionally impaired patients are upon admission to the IRF. Patients who are coded as more functionally impaired would be categorized in a higher-severity case-mix group even though they would tend to have lower, case-mix adjusted. costs per stay.

We explored an alternative payment weight strategy that would reduce profitability differences across IRF case types. As shown in the left box, currently, the IRF payment system sets payment weights for case-mix groups using a hospital-specific relative value, or HSRV, method. This method sets payments to be proportional to within-IRF relative costs per stay. This means that weights reflect the relationship between cost per stay at an IRF compared to the overall average costs of that same IRF, and these ratios are averaged across IRFs to set weights. Under the HSRV method, generally, when weights are recalculated each year, they will change only if relative costs within IRFs

change.

In the right box, we show that another method for calculating case-mix group payment weights sets them to be proportional to average costs per stay across IRFs. That is, the average of all IRFs' stays in a case-mix group is compared to an overall cost per stay, and payment weights are set according to those comparisons. Under this method, if low-cost facilities were to concentrate on a particular type of case, the average cost of those cases would decrease, relative to other cases, and the payment weights would decrease accordingly. This method is currently used in the inpatient and SNF payment systems.

Both of these methods are valid approaches to setting payment weights to reflect costs, but the substantial differences in profitability across cases and decreasing relationship between CMI's and the average costs per stay may justify consideration of the average-cost method.

We simulated payments using an average-cost approach and compared payment-to-cost ratios, or profitability, between the two methods. The left, orange bars display profitability by IRF condition using HSRV

weights. The right blue bars show profitability by IRF condition using average-cost weights.

The average-cost method yielded payment-to-cost ratios that are more uniform than under HSRV weights. Across the IRF conditions, the payment-to-cost ratios based on average-cost weights differed by 3 percentage points, 1.15 to 1.18, compared to 21 percentage points using the HSRV method, 1.07 to 1.28.

Compared with HSRV weights, average-cost weights resulted in lower payment-to-cost ratios for some conditions and higher payment-to-cost ratios for other conditions. The payment-to-cost ratio for neurological conditions, shown in the top bars, decreased from 1.28 using HSRV weights to 1.18 using average-cost weights. In contrast, for nontraumatic spinal cord injuries, the bottom bars, the payment-to-cost increased from 1.07 with HSRV weights to 1.15 with average-cost weights.

We estimated the payment impacts of using average-cost weights in place of the current HSRV weights. We assumed budget neutrality in that the total payments remained the same. However, the direction and extent of impacts on individual IRFs depended on the types of cases

that were treated. Payments to hospital-based nonprofit IRFs would increase by 2 percent. Small IRFs, which tended to be hospital-based, would receive a 2.5 percent increase in payments. Freestanding for-profit IRFs would see a 1.5 percent reduction in payments. Large IRFs, which tend to be freestanding, would have payments reduced by 1 percent. Impacts on other groups of IRFs are shown in your meeting materials.

Actual impacts could be smaller or larger depending on the types of cases IRFs treat and whether they altered their admitting and coding practices.

Lastly, changing to average-cost weights affects the accuracy of payments across stays but not the overall level of payments that Jamila discussed earlier in the presentation.

CMS has the regulatory authority to replace the current HSRV payment weights used in the IRF payment system with average-cost weights without making any statutory changes. There would be no administrative burden on providers.

Average-cost weights may help in reducing in providers' incentives to admit certain patients, and avoid

others, and to code patients as more functionally impaired.

However, this change would not eliminate financial incentives to select profitable patients or differentially code patients, and it will be necessary to continue to monitor utilization of IRF services and audit the accuracy of the provider-reported assessment data.

As next steps, we will answer your questions. We will incorporate any feedback from today's meeting and include these analyses in the March 2024 report to the Congress on the IRF payment update.

Thank you, and I now turn it back to Mike.

DR. CHERNEW: Thank you. This is a really interesting analysis, and I'm glad you're on it.

My computer has frozen a tad, so I'm not seeing all of the queue requests. I see a hand from Lynn, but I'm going to let Dana manage the queue.

MS. BARR: [Speaking off microphone.]

DR. CHERNEW: We can do a Round 1 and Round 2, but it's a shorter time than usual. So I would encourage everybody to have Round 1 be really clarifying. I'd like to get on to Round 2 as quickly as possible, and if you can incorporate into Round 2, that works fine.

But again, I'm not seeing the chat quite well enough, so I don't --

MS. KELLEY: I'm sorry. I can't tell. I have Brian in the queue, but I can't tell if he was from -- if that was from the last --

DR. CHERNEW: I think that was from the first -- I think Brian was in the queue. That was when mine stopped.

MS. KELLEY: Okay.

DR. CHERNEW: Unless he went back again, I think Brian was in the queue for his questions that he asked.

MS. KELLEY: Okay. So then I have Tamara first.

DR. CHERNEW: Okay.

DR. KONETZKA: So it's a very Round 1 question, which is Betty or -- first of all, great detective work. I love this kind of analysis. I think it's very illuminating.

For you or for anybody else who knows the history here, I'm wondering what was the motivation for doing the HSRV in the first place? It seems almost a no-brainer to do the average method as opposed to the hospital-specific one. And so how did that come about? Was there a strong

motivation? Are there opposing reasons here that I'm not aware of?

DR. FOUT: That is a great question. We've thought about this a lot, and if anyone else wants to chime in from staff, they sure can.

I will say when the IRF PPS started, they really studied HSRV versus average cost method, and they were very similar. They yielded pretty similar results. HSRV performed a little bit better, and at the time, HSRV was considered because hospital charges were being used to set DRG weights.

When charges are used, some facilities charge differently than other facilities, and HSRV can be more accurately reflecting costs.

And I'll let Jeff add more.

DR. STENSLAND: Yeah. Originally, it was based on charges. Around 2008, we said this is not very good, because people's charges are all over the place.

Also, markups were high on some stuff and low on other stuff. We said let's revise the whole DRG system, which we did.

DR. KONETZKA: [Speaking off microphone.]

DR. STENSLAND: Hospitals, yeah. So this is how this --

DR. KONETZKA: We're talking about HSRV for --

DR. STENSLAND: The general history of HSRV. Okay, yes.

So then we had said, well, in addition to basing costs, we also wanted to look at the relative profitability within each facility. And the general idea behind HSRV is, well, if one hospital's costs are twice another hospital's costs on average, we shouldn't make the things at the expense of hospital look -- have a higher DRG weight. The relative weight should be what's the relative weight within each hospital, and that was the idea. And when they originally looked at it for IRF, it looked like that seemed reasonable with the original analysis that was done. But since that time, which is kind of unique to the IRF sector, there is some disparate profitability amongst different IRFs, in particular, the for-profit, nonprofit differences in terms of how their patients are coded, whether that's a difference in what their actual patients are like, and their relative costs.

And I think that's raised the concern, which has

brought this up. Maybe that's more --

DR. CHERNEW: I'm going to ask another clarifying question, which is a little embarrassing. I should have asked it earlier, so I apologize to everyone. Bear with me.

In the HSRV approach, there still is one set of weights that are ultimately used. It's just averaged across all the hospital-specific weights, and that the base is different when you use the average cost method. But it is not that every hospital gets its own set of weights. It really has to do, if I have this right, when they're doing the averaging.

DR. FOUT: That's correct, and think about it as HSRV is averaging ratios, whereas average cost is averaging costs.

DR. CHERNEW: Right, exactly. Yeah.

So I think it's easy to go through this and think that now every hospital gets its own weight. That's actually not what's happening. It's when they're doing the divisions and when they're doing the averaging. So it's a little bit -- I think -- I'm not sure this is an answer. I think there was a sense that that math might not have

mattered in the beginning. It might not have mattered, but now it seems that it does matter per the slide on the different profitability. And that's where the -- we can have debate about weighting, averaging, but that's maybe not the best debate to have now. But that's, I think, the issue that's being raised.

MS. KELLEY: Lynn, did you have a clarifying question?

MS. BARR: No.

MS. KELLEY: Oh, you're Round 2. All right, then.

I have Amol.

MS. UPCHURCH: Sorry. Just the HSRV weighting that currently exists and the profitability of 1.26 and it says neurological, what is that? Is that like ALS, Parkinson's? What are the conditions there?

DR. FOUT: Those would be included in that condition. It's a rehabilitation impairment condition. So it's based on your diagnosis codes when you're admitted into the IRF.

So Parkinson's disease, multiple sclerosis, cerebral palsy, and neuromuscular disorders are some of the

common ones in there.

MS. UPCHURCH: Thanks.

MS. KELLEY: Amol?

DR. NAVATHE: Thanks.

Super, super interesting, and thanks for all the technical work here.

I have a question which is coming back to the origins a little bit. When we're looking at the payment-to-cost ratio, to some extent, it seems like we're saying there are differences across hospitals, and those differences matter now in a more substantive way than they previously did.

So I was curious. How much of that variation between payment and costs as you go up different case mix intensities -- how much of that is within hospital variation, and how much of that is between hospital variation? Do you have a sense of that? It seems like that's what we're trying to solve, so that's why I'm curious.

DR. FOUT: I'd say there's a lot of variation across hospitals on the types of cases they take, and that is the driver. I can provide you more data or specific

answers.

DR. NAVATHE: Okay. So, qualitatively, the point is that there's a lot of cross-hospital variation. Okay, thanks.

MS. KELLEY: That's all I had for Round 1, unless someone wants to jump in here.

DR. CHERNEW: I'm going to go with Lynn.

MS. KELLEY: So Lynn will be Round 2?

DR. CHERNEW: Yeah.

MS. KELLEY: Okay.

DR. CHERNEW: Lynn, you'll kick it off Round 2.

MS. BARR: Thank you.

First of all, I'm wildly enthusiastic about this work, and the reason why is I don't feel that the 7 percent cut is really good for hospitals, right? And I'm very disturbed by that. I realize that we have to look at the big picture, but I'm not comfortable, honestly, with the recommendation without some sort of separation of the two.

And this -- I think this is the -- obviously, there's cherry-picking going on, and that recommendation is addressing that problem as opposed to the real problem.

So this work would, I think, solve the problem

for hospitals. There are a lot of the small facilities. They're rural. This is an important part of their business, and I'm very -- I'm actually very nervous about that 7 percent cut. So I would be really happy if we could back that up with a change of the methodology.

Thank you very much for this important work.

MS. KELLEY: Scott?

DR. SARRAN: Yeah. I just wanted to reinforce a kudos to staff. Really excellent work. This feels very directionally important, and I think it's just a reminder that when -- without impugning anyone, any players' adherence to regulations and laws, the for-profit sector will align around profit opportunities. And here, I think those of us that have worked in this space understand there's all sorts of ways that IRFs can influence their case types all sorts of ways

So this is, I think, extremely important that we continue to go down this road.

MS. KELLEY: I have Betty next, but before you go, Betty, I just wanted to clarify that the recommendation that you just voted on for IRFs was for a 5 percent cut, not a 7 percent cut. So I just wanted to clarify that.

That's okay. Thank you. Go ahead, Betty.

DR. CHERNEW: And this just -- we're not going to vote on what to do right now. We are trying to figure out how we go forward to deal with this. I think, in general, we're broadly in agreement.

And just to reiterate something, we have to come up with an IRF update. The earth update, you know, it's hard for us to do all the targeting, correct all the other things. So basically what happens, if you get the level of profitability that you typically see in the sector, we generally give a recommendation for a cut. Then we acknowledge there are unique issues in every sector. This is one of those unique issues.

Then we follow a cycle of how can we do a better job in doing what that is. This is the beginning of that portion which is -- although this is our update -- we've done a lot of update voting -- this is sort of how we're going to try to get ahead of something that now we might be not quite there yet. So that's just for everyone to understand where we are in this space.

DR. RAMBUR: Thank you. I just wanted to chime in with my support for this excellent work and voice my

support for Lynn's excellent comment. Amol's important point about the within and between variability, this was really pretty jarring and surprising to me, the disparate profitabilities and the chart on page 13, 9.4, in particular, I thought was pretty dramatic in terms of the shift.

So I just want to say really appreciate the work. I'm looking forward to what comes next.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks for the great work. I really enjoyed reading this, and similar to Betty, this was really illuminating. I was not aware this was going on, and it's clear that there are distortions being created by the current payment weights. And I think it behooves us to try to come up with some alternatives that CMS could consider to address the problem.

I think the approach that was tested in this chapter. I thought it had really good design properties, so appreciated you laying out that alternative.

DR. CHERNEW: I think Amol is going to be next. I think that's right, but I want to say one thing first.

This issue illustrates another bigger issue about

the things that we do, which is to some level what's happening with payment rates is they're moving money across services. They're moving money across institutions, and we'd like to get that basically right and that's totally agree.

But the way in which we do that creates incentives in a whole range of ways per what Scott said, and so you might think things are exactly right. We said it; it works fine. Then, all of a sudden, people respond to the incentives, and you come back later, say today, and you realize, oh, my gosh, the world has changed as people respond to all these centers. And what was true when we started isn't true now.

And so, again, as an economist, I tend to think as these prices as the underlying incentives and what would go on, as opposed to just trying to match some level of cost or profitability at a point in time, it just turns out that understanding the incentives, their strength, and how quickly people respond is easier to save than to do. But that's I think how we think about these things.

The same is true in all case mix-adjusted things. They're both an acknowledgment of the cost required to

treat certain people, so you're moving money to the organizations you think of sicker people, in some ways, but it also creates incentives for a whole bunch of other things. And we struggle with that. That's a difficult balance to get right.

So I'm sorry. Amol.

DR. NAVATHE: Thanks.

I'm also a big fan of the work. I think it's excellent. I think that analysis is very clear that suggested direction would be an improvement for all the reasons others have said.

I would actually probably love to just touch base offline because I feel like there -- the framing, in some sense, seems like it's somewhat hospital motivated, but I feel like the analysis that you've done that's just looking at profitability across the CMGs, like that itself is -- that seems like the best place to start, in a sense, because that -- and then the hospital responses and who's doing that or whatever kind of comes subsequent from that.

And the other piece that I'm -- this maybe could have been a Round 1 question, but it seems like sometimes we're referencing low-cost facilities, but it seems to me

that that is a relative term. It's not an absolute cost thing. It's a low-cost payment kind of thing, which is a -- I think the point of your work here is that that's partly a feature of the payment system itself, and we want to try to remove that circularity in a sense.

Anyways, I'm happy to share some comments offline. Thanks.

DR. CHERNEW: Now, my computer is a little frozen. So there may be someone else.

Robert.

MS. KELLEY: Robert.

DR. CHERRY: So this is really nice work. Not only that, but there's an interesting trifecta here where the presentation is overwhelmingly positive, the reports are very positive, and so are the comments from the other Commissioners. And that's refreshing and a little bit unusual.

[Laughter.]

DR. CHERRY: So I just wanted to ask you really kind of a straightforward question which is, is there any downside that you see this? You've been working with the analysis and the data. What sort of keeps you up at night,

if you will, about this proposal?

DR. FOUT: I wrote that down as a question that someone might ask me. What am I going to say? I think there is very little downside, but HSRV weights, their goal is to equalize profitability across IRFs or across hospitals. So I think there is a tradeoff. If you use average cost weights, your relative profitabilities might seem less equalized, if you showed that chart.

But that said, even on our profitability chart, the lowest profitability was like 1.10. I don't think that IRFs will be disincentivized from taking patients, whether or not we change around these weights a little. So I don't think there's a downside, but I do think we should continue to monitor, because this is the kind of thing that is sort of under the rug a little and up to people interested to examine.

DR. CHERNEW: Yeah. We're nothing if not willing to go under the rug.

[Laughter.]

UNIDENTIFIED SPEAKER: [Speaking off microphone.]

DR. CHERNEW: No, actually. I don't even know why that would be a SNF pun.

But in any case, the let me give another -- I'm going to -- I want to say one thing in response to Robert, and then I want to make one other comment, and then I'll see if this -- but anyway. When we do this, when we think of bigger-picture things like this, there's just a process by which we have to go through to get there, and part of the process is to kind of address that question.

I think one of the key things that we've done some on -- but I know we just got to get there -- is to make sure that the winners and losers, we aren't -- when you reach -- when you change the weights, you could be moving across different groups, and we aren't 100 percent sure who the groups are and that kind of stuff. So I think we just have to understand. You could say, well, how come you don't do a recommendation now? Look, you got everyone on board. It's just the process by how it takes us to get to there as terms of what we do, and some of that is a little bit just deliberativeness.

The other question, which I actually wish I knew -- it's a broader one -- is how the scale of organizations are weighted. So if there's an organization that's very big and an organization that's very small and they had

different ratios, are they weighted essentially equally, or are they -- and is that different across the methods? So the average cost weights them more by scale and the one weights them --

DR. FOUT: The scale will still matter. So if you have more volume, you're going to get a greater weight. You also weighted more with your CMI, so hospitals -- so the higher CMI get a higher weight. So this was a little glossed over in the presentation, but in the meeting materials.

DR. CHERNEW: Right. So yeah. So that I think this is a particularly mathematical thing about how it plays out. I think my reaction was it is disturbing when you see vastly different profitabilities by different case mixtures. That's just a general red flag, right? And so as a general rule, if we can avoid incentives across groups, that would probably be a good thing.

I'm not sure what the optimal profitability is, and I think in this sector overall, the sector's pretty profitable. So that gets at least some of Betty's earlier answer.

But we have a bit more to do just to get to where

we want to think through if we want to do something different in this setting, but that's kind of where we are about this.

There's not a vote now. I know that's a little jarring. We've had a vote at the end of everything now. I'm a little unsure about myself, but I think, Dana -- I'm just going to look around in case this isn't going quick enough.

MS. KELLEY: I don't have anyone else in the queue.

DR. CHERNEW: So we will get a slightly longer break to compensate for the one that we missed, and we're going to come back again with what I'm -- and please do come back on time because I know there is going to be interest in this. We're going to come back, and we're going to pick up with the Part D status chapter. So let's take a quick break and back in a minute.

[Recess.]

DR. CHERNEW: All right. So we had the set of votes that we are going to have this month, and now we're going to go through a number of status updates, and we're going to start with Part D, and I think, Tara, you're up.

MS. O'NEILL HAYES: Yes, thank you. Good afternoon. Shinobu and I are here to present the annual status report on Part D, Medicare's outpatient drug benefit. This material will be a chapter in the Commission's upcoming March report. As a reminder to the audience, a PDF of these slides is available at the righthand side of your screen.

Today we will start by providing some background information on the Part D program, including highlighting upcoming changes. Then we will discuss enrollment trends through 2023, and plan offerings for 2024, followed by a review of program costs through 2022. Lastly, we will discuss issues pertaining to beneficiary access and program quality.

First, let me highlight a few points on the program's purpose and how it operates. Part D provides Medicare beneficiaries with access to prescription drug coverage by using private plans that compete to deliver pharmacy benefits. These plans may be standalone prescription drug plans, referred to as PDPs, available to beneficiaries using fee-for-service Medicare, or part of a Medicare Advantage plan, known as an MA-PD. Plan sponsors

and their PBMs take part in a couple of sets of negotiations. One is with pharmacies, to set up networks and agree on payment rates for prescriptions and post-sale fees. The other negotiation is with manufacturers of brand-name drugs over formulary placement and post-sale rebates.

Enrollees pay a monthly premium, based on the plan's expected costs. Medicare subsidizes premiums for basic benefits for all enrollees, plus additional subsidies for low-income enrollees. The program was intended to have plan sponsors bear financial risk for enrollee spending so sponsors would have incentives to manage benefits, but in order to ensure a robust market, Medicare shares in that risk by providing reinsurance, risk adjustment, and risk corridors to limit plan losses and profits.

A few quick program stats.

Next year, there will be hundreds of PDPs and thousands of MA-PDs.

There were more than 51 million enrollees in 2023, or 78 percent of all Medicare beneficiaries.

In 2022, program spending surpassed $101 billion.

Beneficiaries collectively paid more than $15

billion in premiums and $18 billion out-of-pocket.

And a few additional highlights before we dig in to the details on the following slides.

Each year, more Medicare beneficiaries enroll in a Part D plan, and with more enrollees choosing Medicare Advantage over fee-for-service, more are in MA-PDs than stand-alone PDPs. Enrollee premiums have been hovering around $30 per month for the past several years.

There continues to be a large number of plans, though the types of plans available have changed somewhat, with more MA-PDs, and particularly SNPs, or special needs plans.

Program costs increased 7.5 percent from 2021 to 2022, and more beneficiaries reached the catastrophic phase, further increasing cost-based payments.

Overall, program satisfaction remains high, though some beneficiaries struggle to afford their medications.

Now for a little more detail. As mentioned, in 2023, Part D's enrollment continued growing as a share of all Medicare beneficiaries, and reached more than 51 million. From 2019 to 2023, enrollment in MA-PDs grew 10

percent per year, on average, and as of last year more than 56 percent of all enrollees were in MA-PDs, rather than PDPs which have seen enrollment decline by 3 percent per year since 2019. This is a dramatic shift from the start of the program. This movement is also true for low-income subsidy enrollees, who used to be predominantly in fee-for-service Medicare, but have increasingly moved into MA-PDs as plan sponsors offer more generous drug coverage and introduce special needs plans geared toward dually eligible beneficiaries.

Most beneficiaries are choosing to enroll in enhanced plans. Enhanced plans typically offer reduced or zero-dollar deductibles, additional coverage in what was previously a coverage gap, and may have broader formularies or lower premiums. MA-PD enrollees, in particular, are almost exclusively in enhanced plans where beneficiaries enjoy lower premiums as a result of plan sponsors' ability to dedicate some of their Part C rebate dollars to "buy-down" their members' Part D premium.

One categorical exception to the shift toward enhanced plans is LIS enrollees. Many low-income beneficiaries are choosing special needs plans exclusively

available for beneficiaries dually eligible for Medicare and Medicaid. Such plans are referred to as D-SNPs. Because LIS enrollees are only liable for limited copayments, the financial incentives commonly offered by enhanced plans, are less valuable to LIS enrollees. Further, the low-income subsidy only covers the cost of a basic premium, not supplemental premiums. These like contribute to them being less likely to enroll in an enhanced plan.

For 2024, plan sponsors are offering more than 3,500 MA-PDs and 1,300 SNPs, which are the fasting growing plan type, and now account for more than one-fourth of all MA-PDs. The number of PDPs declined again, though each region still has an average of 21 plans. The number of benchmark plans also fell, but each region has at least two this year.

Last year, more than 90 percent of PDP enrollees were in plans marketed nationally. If those enrollees stayed in those plans this year, on average, they experienced an $8 per month increase in premiums.

Today, the structure of Part D's benefit has plan sponsors bearing relatively little financial risk in

certain phases of the benefit. Part D now has two standard benefits, one for enrollees without low-income subsidies, on the left, and another for those with the LIS, on the right.

Focus, if you will, on the deep blue parts to the right. Those are the portions where plan sponsors bear financial risk for enrollee benefits. You can see that for either case, plans do not bear much risk in the coverage gap or in the catastrophic phase above the out-of-pocket threshold, where Medicare pays 80 percent of costs. Relatively low plan liability for benefits has undermined plans' incentives to manage spending.

One notable change effective this year is the elimination of beneficiary cost sharing above the catastrophic threshold. Enrollees used to pay 5 percent in the catastrophic phase, but that share is now being paid by plan sponsors. Additional changes will take effect next year, and we will discuss those later.

Between 2018 and 2022, program spending grew by 5.2 percent per year. However, as I mentioned earlier, Part D has seen capitated payments decline, while cost-based payments have risen.

Capitated direct subsidy payments declined by nearly 23 percent per year from 2018 through 2022, while cost-based reinsurance and low-income subsidies grew by 8.8 percent and 8.6 percent per year, respectively. In 2022, capitated direct subsidies, to cover costs for which plans bear insurance risk, totaled $4.8 billion, out of the $101.9 billion Medicare spent on Part D.

Reinsurance and the low-income subsidy are both largely driven by prices at the pharmacy. In the case of the low-income subsidy, which provides extra help with premiums and cost sharing for enrollees with low income and assets, nearly 90 percent is spent on subsidizing enrollees' cost-sharing liability. LIS enrollees tend to take more medications and have higher spending. That means, as you saw earlier, Medicare pays for nearly all of the costs when enrollees enter the coverage gap. LIS enrollees also account for the majority of individuals who reach the catastrophic phase of the benefit, where Medicare's reinsurance pays for 80 percent of the costs.

Another way in which the prices at the pharmacy directly contribute to the increase in reinsurance costs is that there are more drugs with prices for which a single

prescription is sufficiently expensive to meet the out-of-pocket threshold. In 2022, over 482,000 enrollees filled at least one such prescription, up from just 33,000 in 2010.

The trend we've witnessed recently, where cost-based payments account for most of the program's spending, led Congress to pass reforms intended to restore plans' incentives to manage enrollee spending. In 2025, the standard benefit will undergo significant changes. The redesign will provide beneficiaries with a $2,000 annual out-of-pocket cap; increase insurer liability, particularly in the catastrophic phase, by reducing the program's reinsurance coverage; eliminate the coverage gap; and extend the manufacturer liability into the catastrophic phase. This new benefit design will apply to all beneficiaries, including those with the LIS.

Shinobu will now discuss other recent and upcoming changes.

MS. SUZUKI: Besides the benefit redesign, there are several other upcoming changes aimed at increasing the affordability for prescription drugs.

Beginning in 2023, Medicare has required

manufacturers to pay a rebate if the price of their drugs sold through the program rise faster than inflation. In addition, Part D benefit has provided a more generous coverage of insulin products and vaccines recommended by an independent advisory group.

Beginning this year, cost sharing in Part D's catastrophic phase has been eliminated, and growth in the base national average premium was limited to 6 percent.

Eligibility for the full low-income subsidy benefits was expanded to those with incomes between 135 percent and 150 percent of the federal poverty level when they meet the asset test.

In 2026, prices negotiated by the Secretary of Health and Human Services for 10 Part D drugs will take effect, with additional drugs added in future years.

Going forward, legislative and regulatory changes will increase plans' share of insurance risk. In 2024, Part D plan bids show a decrease in cost-based payments and an increase in the capitated direct subsidy, from $2 per member, per month last year to $30 per member, per month, reversing the trend towards cost-based payments.

Several changes have likely contributed to this

change. For example, as we just discussed, Part D-related provisions in the Budget Reconciliation Act increase plan liability by requiring more generous coverage of insulins and vaccines and by eliminating cost sharing in the catastrophic phase of the benefit.

Going forward, annual growth in base beneficiary premium will be capped at 6 percent. When this cap is binding, as was the case for this year, Medicare's overall subsidy rate is increased to a rate above the 74.5 percent originally prescribed in law.

In 2025, the benefit redesign under the BRA will further increase plan liability.

Another factor is a regulatory change that requires all possible pharmacy price concessions to be applied at the point of sale, which we will talk about next.

Both lower cost sharing and lower point-of-sale prices will tend to increase plan liability and slow beneficiaries' progression towards the catastrophic phase.

Turning to the regulatory change made effective this year, the definition of negotiated price under Part D is the price negotiated between plans or their PBMs and

pharmacies in the plans' network. Before this year, the definition of negotiated price did not reflect any post-sale price concessions.

Post-sale pharmacy price concessions have grown rapidly, from less than $500 million in 2014, to over $17 billion in 2022. The large magnitude raises a concern that enrollee cost sharing have become increasingly disconnected from the price net of all pharmacy price concessions.

In addition, CMS has noted that when plans receive larger-than-expected price concessions that primarily contribute to plan profits.

In its May 2022 final rule, CMS redefined the "negotiated price" in Part D to be the lowest possible reimbursement that a network pharmacy may receive, effectively requiring point-of-sale prices to reflect the post-sale pharmacy price concessions.

At the aggregate level, CMS expects the change will reduce enrollee out-of-pocket costs, increase plan liability, increase Medicare's program spending for Part D, and provide more predictable revenues for pharmacies. However, the experiences of individual beneficiaries, plans and pharmacies are expected to vary.

The previous discussion highlights the importance of point-of-sale prices in affecting the distribution of costs across beneficiaries, plans, and Medicare. We have been tracking point-of-sale prices since the start of the program. The chart on the left shows overall Part D price index with and without accounting for generic substitution in blue, and price index for biologics, other than insulins, in orange.

Between 2006 and 2022, overall Part D prices more than doubled while it grew by just 20 percent after accounting for generic substitution.

During the same period, prices of biologics grew by more than 300 percent, which is shown by the index value of 4.06.

Unlike other drugs, biologics do not have generic versions that could help lower prices in Part D. With the shift in the pharmaceutical pipeline towards biologics and expensive specialty medications, the share of biologics, not including insulins, has risen from just 3 percent in 2006 to 15 percent in 2022.

Several top-selling products are now facing or are expected to face biosimilar competition in the next few

years. However, in order for Medicare and Part D enrollees to benefit from that competitive pressure, we need to ensure that biosimilars are successfully launched and adopted in Part D.

Humira is one of the top-selling biological products used to treat a wide range of autoimmune conditions, such as rheumatoid arthritis. It is an expensive therapy. Recent data suggest that annual therapy costs at list price can exceed $80,000.

Now that there are several biosimilars on the market, the hope is that the price competition will result in lower prices. However, because Humira comes in multiple forms, dosages, strength, and injection devices, there is a concern that that may complicate the decisions regarding substitution with a biosimilar product.

In 2023, nearly all Part D plans covered most or all versions of Humira, and over 80 percent of Part D sales are for the newer, high-concentration, formulation. In contrast, of the nine Humira biosimilar products that were launched in 2023, only three are available in high-concentration formulation.

Two products have the interchangeable

designation, which allows pharmacists to substitute the biosimilar product for the reference product without obtaining a new prescription.

Some products launched with list prices that are 5 percent below Humira's list price, while others have steeper discounts ranging from 55 percent to over 80 percent. Because Humira is an expensive medication, the steep discounts could provide substantial savings to patients who take them.

Humira biosimilars' success in gaining acceptance among Medicare patients and their prescribers crucially depends on their inclusion on plan formularies. To get a sense of how Part D plans are treating Humira biosimilars, we examined the formularies plans submitted for 2024. At a high-level, we found that most plans are continuing to cover most or all Humira products. At the same time, nearly 60 percent of all Part D enrollees are in plans that also include at least one Humira biosimilar product on their formularies.

About half of these enrollees are in plans that cover just one biosimilar product. About two-thirds are in MA-PDs, including SNPs. And most plans place biosimilar

product(s) on the same cost-sharing tier as Humira.

We also found that an interchangeable biosimilar product was most likely to be included on plan formularies, followed by a high-concentration formulation product that is available in multiple dosage forms and package sizes.

Having a low list price did not appear to give the biosimilar product an advantage in formulary placement over other biosimilar products with higher list prices. Manufacturer rebates play an important role in plans' formulary coverage decisions. As a result, plans may opt to cover a biosimilar product or reference product with higher list price when rebates make such decision more financially advantageous. This financial incentive is expected to lessen beginning in 2025 when the benefit redesign is implemented.

For years, the Commission has had concerns about the effectiveness of medication therapy management programs, particularly among stand-alone PDPs.

Over the 5-year period from 2017 to 2021, CMS tested an Enhanced MTM model to see if new payment incentives and regulatory flexibilities would spur standalone PDPs to improve their MTM programs and reduce

Medicare spending. Under the demonstration, 40 percent of more than 1 million enrollees eligible for enhanced MTM program received MTM services.

However, final evaluation found that the enhanced MTM model did not improve health outcomes as measured by reductions in drug-therapy problems and in downstream medial expenditures, and there was no statistically significant effects on Medicare's spending for Parts A and B services.

Finally, on access and quality, overall satisfaction with Part D remains high and a majority describe their plan as a good value and convenient to use. Most beneficiaries report that they have good access to medications. However, despite high satisfaction with Part D costs, coinsurance on high-priced drugs and biologics may make them unaffordable for some beneficiaries.

In our focus groups convened for the Commission, physicians and beneficiaries were acutely aware of high drug costs and reported having discussions about ways to lower costs. In the most recent Medicare Current Beneficiary Survey, nearly a quarter of enrollees reported an affordability issue. The extent to which beneficiaries

faced affordability issues did not differ between PDPs and MA-PDs or by low-income subsidy status.

As we noted earlier, however, the recent legislative changes to restructure the Part D benefit will cap beneficiary out-of-pocket costs and is expected to improve affordability of drugs and biologics with high prices.

We are interested in your feedback regarding the mailing materials and would be happy to answer any questions you have.

With that we'll turn it back over to Mike.

DR. CHERNEW: All right. So there's a lot there in both what we have to deal with, what we've done, what we're doing, where we're going. It's always hard to do a status chapter when there's big changes coming down the road, but we do status chapters.

So we are going to go through our queues. We're going to start with Round 1, and if I'm right, Brian is first.

DR. MILLER: Most of my comments are Round 2, but I really love this chapter, enjoyed reading it. I feel like I nerded out on enjoying it.

Just a phraseology. When we note the IRA and the Secretary's authority for negotiation, I think we should include a caveat that it is functionally a form of administrative pricing as negotiation when you're functionally not able to participate in the program. If you don't accept a price, it's not really a negotiation. So our language should reflect that somehow.

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

DR. DUSETZINA: I just wanted to ask about Slide 15 where you show the index of the prices. Is that post -- is that including the rebates to the net price, or that's gross prices?

MS. SUZUKI: Those are point-of-sale list prices.

DR. DUSETZINA: Okay. Okay, thanks.

MS. KELLEY: Lynn?

MS. BARR: Thank you.

I'm curious about the MTM study. It seems like such a no brainer when you look at pharmacy data, that you've got a bunch of people that are on a bunch of the wrong drugs, and they're not taking them well. And, you know, I mean, Stacie could go on and on.

So was the study poorly designed? Was the intervention poorly designed? So you hear these things: "Well, we studied MTM, and it showed no benefit." But that's counterintuitive. Do you have any insight on why?

DR. CASALINO: Let me just attach a question to that. Were any of the outcomes close to statistically significant?

MS. BARR: So could it be study design?

MS. O'NEILL HAYES: So one point -- and maybe this is a little bit more to Larry's, first off, but the way that they presented results was not necessarily just these beneficiaries had worse outcomes. But it was relative to beneficiaries not enrolled in the demonstration. So there may have still been limited improvement but not as much as enrollees not receiving the enhanced services, so just a point of clarification on that, not that really makes it --

MS. BARR: Well, it's interesting because, I mean, the timing of that study, because only in the last five to ten years have we really focused on medication reviews and made medication reviews part of the workflow in the ACO world. We've been training people like crazy. So

were those matched beneficiaries not -- you know, were they also getting medication therapy management, but nobody knew?

MS. O'NEILL HAYES: So one thing that I think might answer your question somewhat is there was a lot of difficulty, plan sponsors that were surveyed and the study analysis found that, A, only 40 percent of the eligible beneficiaries even received any services under this demonstration. So you're not even hitting at least half of your eligible beneficiaries. So there's a tremendous outreach issue.

And then on top of that, they also talked to providers. So the people writing the prescriptions in the first place, they talked about challenges in coordinating with the plan sponsors. They talked about plan sponsors not understanding the prescribers' goal of the therapy, so why they were put on it in the first place. And so it seems that there were some coordination challenges between the plan sponsors and providers themselves and trying to figure out what medicine should patients be on.

And then, like I said, also just outreach issues, trouble reaching patients, a significant number of the

beneficiaries eligible are low income and eligible for the LIS. And a lot of the folks participating said that they had trouble reaching those beneficiaries, in particular. Either they had poor contact information, or they weren't coming in to pick up their scripts to begin with, things like that. So I think that's part of it.

MS. BARR: Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Great work. You did a wonderful job of making sense of a lot of complex topics.

The question I have is, since I know that the Commission has had made many previous recommendations regarding changes to Part D, some of which were incorporated in the IRA, do we know what the major previous recommendations we've made that were not incorporated in the IRA?

MS. SUZUKI: Within the 2020 recommendation, we had parts of the recommendation that had to do with giving plans flexibility to manage spending, and in particular, there is a section that talked about LIS cost sharing. And right now, low-income subsidy beneficiaries have two types of cost sharing, either zero or very low nominal amounts

for generics and another nominal amount for all other drugs.

So we thought there could be more incentives for plans if they could distinguish between the preferred brands and non-preferred drugs, and that was one of the pieces of the recommendation.

There are a couple other things, like with the protected classes. Maybe the policy to require coverage of all drugs would be restricting plan's ability to negotiate better prices or manage spending.

UNIDENTIFIED SPEAKER: [Speaking off microphone.]

DR. CHERNEW: That's what I have as well. I also have Stacie kicking off Round 2. Stacie?

DR. DUSETZINA: Thank you so much. And you both know how much I love this chapter. Everybody in this room knows how much I love this chapter.

[Laughter.]

DR. DUSETZINA: So I'll try to keep this as brief as possible.

One of the questions I had first was around the cost increases that we would have observed in the base premium or in the premiums this year. So it mentions a

couple of times that we would have had a 20 percent increase, except it was held to 6 percent. And on page 4, you mentioned that will be borne by -- that additional cost will be borne by the Medicare program, and I was trying to work out how that would happen, because I thought that was one of the reasons that it was the supplemental premium would go up and the beneficiaries would be paying that additional amount. And so I wanted to hear if there was a brief response to that. That would be great. But if not, maybe a little bit more of a description in the chapter would be helpful for readers who are as in the weeds as I am on that space.

MS. SUZUKI: So this only relates to the basic benefit, and so supplemental is a separate process. And so for the basic benefit plans, bids came in 20 percent higher, and normally, that would have been split between any beneficiary premiums and Medicare subsidy. And subsidy would have been 74.5 percent.

But because the beneficiary -- base beneficiary premium is limited to 6 percent growth, that difference is now part of a subsidy that Medicare pays, and that's why we're saying that it's a higher subsidy rate because of the

cap in the bene premium.

DR. DUSETZINA: Got it.

MS. SUZUKI: Does that help?

DR. CHERNEW: Was that clear, Stacie?

DR. DUSETZINA: It is clear, but it would -- if there is a possibility of putting a text box to explain that, because I think that those issues are really very important for thinking about plans' motivations in their bids, but also what is going to be happening to beneficiary premiums, which I'll get to in a separate comment.

DR. CHERNEW: I want to reiterate what I think the answer is, and then I want to ask a follow-up question related to this.

First, the answer is, when you make the change and, therefore, the bids go up and, therefore, because the government pays a portion of that -- it would be paid more -- the magnitude is such that the percent the beneficiary should share is capped, leaving some left over. That leftover portion is paid for by the government, meaning the government is paying more than they otherwise would have if there was not the cap. And so that's why you get a higher subsidy share than the normal share, because you've

constrained the beneficiary portion not to go up more than 6 percent. That's what I think the answer was.

The question is, as we go forward, are we going to converge back up to that 74-point-whatever percent number? So even if premiums are quite flat going forward, the premiums would still go up 6 percent to get us back to that ratio because now we're under the ratio, if you will, or how does that work?

MS. SUZUKI: The 6 percent cap is essentially going to be true going forward, and so as the bid is submitted -- and presumably because of the generosity of the benefit going forward -- the bid growth will have to be capped on the bene side, and we expect that subsidy will have to increase to cover that extra growth.

MR. MASI: And, Shinobu, can I jump in for one moment to add one additional clarification to your clarification? I think the 6 percent cap on the growth of beneficiary premiums exists until, I think, 2029, but we can double-check the date for you, at which point I think the actuary makes a calculation as to what the new premium subsidy should be. And there is a cap on that. I think the federal subsidy cannot go higher than 80 percent at

that point, but that is, I think, in a future date, in either 2029 or '28. Long story short, we can clarify this complicated set of issues in the chapter to make sure it punches through.

There's one related question about stepping back. How does this affect competition between plans? And I think one thing to keep in mind is that while the base premium is -- this is affecting the base premium. The extent to which beneficiaries are choosing between different plans, this may not have as large of an effect on the relative prices of plans when they're stacked against each other, but this is going to be something we're going to monitor.

DR. CHERNEW: And again, what I think Paul said was the cap is an aggregate cap, but some plans premiums can go up much more than 6 percent. It's not constraining the maximum increase to be 6 percent. It's sort of the average.

DR. DUSETZINA: I promise the next ones are not quite as hard, because it took at least four people to explain that one.

[Laughter.]

MR. MAASI: It was a team support.

DR. DUSETZINA: Yes. But yes, clarification there would be really important. I just think it has some important consequences for thinking about the other premium increases we will see for beneficiaries that are like different pieces of it, and a figure would probably go really far there.

The other comments I had were a little bit out of order, but the section that you have on beneficiary satisfaction, I really like very much in the paper.

I did have a couple of thoughts on -- like, there was a comment about people getting cancer drugs being maybe less sensitive to higher cost sharing, and I think some of that is really happening because of things like patients' assistance programs and teams that are set up to help individuals with certain conditions better navigate and afford their drugs. So I think that might be -- I might pull back a little bit on that footnote just because I think it really is just a dynamic of what support is available for people.

I also think there are a couple of places where you talk about the Medicare current beneficiary survey and

people reporting not taking their medication because of cost and showing that those individuals are still paying more out of pocket. It might be good to just caveat those numbers again with reminding people. This is among people who are saying they are not filling their drugs. So their costs should be lower, their reported costs. So this is even -- it would be an even bigger difference if they went ahead and filled their prescriptions.

I also thought it was super interesting, the piece of information on -- this is page 46 -- where you talk about people's considerations when picking a plan, and I assume that's among everybody, not just specific to like people using high-cost drugs or something like that. And it seems like when people are enrolling into Medicare, they're thinking a lot about the drug benefit as like the one of the biggest considerations of picking a plan altogether. And it just kind of reinforced to me why it's so important we have the Plan Finder be right and helpful and easy to navigate. It's like if this is really how everybody coming into Medicare or a large portion are picking their whole plan, that seems even more critical.

And I go to the Plan Finder a lot, and one of the

first things is, do you want a traditional Medicare standalone plan, or do you want an MA plan? You're not comparing those side by side. You're making a decision up front. So the order in which you have to make selections about what you see is maybe not optimal for helping people make that decision.

There are obviously many other things that could be improved in that picking-a-plan space, but that just sticks out to me.

For the sections on the Part D benefit design changes, I'll send a couple of just small comments of places we're having -- you know, just reminding people how great some of these things are, like, how much we're expecting people to pay for a brand-name drug this year, then next year. These are all kind of mentioned, the dollar amounts if we could get like a ballpark of what those look like for people, just in the chapter. And I'll flag a couple of places.

I didn't see that much on the prescription drug payment plan, and I wondered if there might be an opportunity -- the smoothing, like, if there would be an opportunity to think about at least referencing the

guidance documents that CMS has put forward about really being thoughtful about who really will benefit from that and who may benefit less and really trying to think through targeting beneficiaries for it.

I don't know that we want to go down this path, but it might also be nice. There's a section on the high-cost enrollees where we talk a lot about the people with LIS being more likely to be in that group. It seems like it's a place where we could talk about what we might expect with the capped benefits starting this year and next.

We very likely will see a lot more non-LIS beneficiaries in that high-cost group because they can now afford to fill their drugs. So I think it just might be worth saying explicitly that behavioral changes, especially among non-LIS groups who are taking high-cost drugs or prescribed high-cost drugs are things we have to anticipate and want to monitor.

And then the last is kind of a big kind of looming thing is the differences in the premiums in the standalone market and the MA market. I think it reinforces why it's so important to show those separate.

We talk a lot about the average premium for a

Part D plan. From a recent analysis from Kaiser Family Foundation and in the materials, it's very clear that the dynamics are going to look really different if you're on a Medicare Advantage plan versus a standalone plan.

If you're not shopping for a new plan on the standalone market, you are in trouble. Your premium is probably going to go up for you because of those increases in the supplemental premium, and I think that's really not great news, because we know people don't really shop. But I would like to make sure that we're really highlighting that issue.

You also do a great job of talking about the smaller number of standalone plans over time. According to the Kaiser Family Foundation analysis from a couple months ago, they say that there are only 11 firms competing anymore in the standalone market, and that 10 out of 11 of those firms offer both MA plans and standalone plans. So I think it really is starting to feel like there's not real true price competition in the standalone market, and I think that will be something we want to keep an eye on.

This is absolutely my favorite chapter. You all are -- I will -- I've loved this chapter before MedPAC, and

I will continue to use it all every year after MedPAC, so thank you so much for the great work.

MS. KELLEY: Gina.

MS. UPCHURCH: Plus-one to everything Stacie said. She needs to step aside, because I love it more than she does, the Part D chapter.

DR. DUSETZINA: It's not possible.

[Laughter.]

MS. UPCHURCH: We're going to argue about that one.

But I just want to give a shoutout. It is tremendous work that you've done, and I really don't have any -- we've communicated already some specifics, but I just have a few comments for the group here, five comment themes: the Part D redesign, late enrollment penalties for people with incomes right above low-income subsidy, DIR fees, vertical integration and preferred pharmacies, and finally MTM.

I'm so thankful to the Commissioners, CMS, and ultimately Congress for redesigning the Part D benefit. The redesign simplifies the drug benefit for consumers and those trying to help them navigate it. It ensures that

those who need very expensive medications can obtain those, oftentimes lifesaving medications, without cost barriers. When medications are accessed and used safely and effectively, they can be some of the best, most cost-effective tools in our toolbox. It aligns financial incentives to ensure plan sponsors, standalone and MA-PDs, are rewarded for supporting access to medications while also trying to better control drug expenditures.

We have learned that the 70 percent discount for manufacturers in the current design has had PBMs often favoring a rebate system based on percentage of the drug's list price rather than seeing the PBM role as to drive formulary management that ensures access to medications while also looking at therapeutic value.

Having said this, I want to make sure we monitor a few things of the redesign as it's underway, starting in 2024, as we shift and the beneficiary paying to nothing once they reach the catastrophic phase, which is about $3,300 for the average person taking brand-name medications.

There will be a potential loss in price sensitivity so that the brand purple pill might be chosen

over the less expensive white generic pill once someone's in the catastrophic phase. I imagine the plans will be sensitized to manage this. We need to pay attention to it.

I have a concern about some of the groups that wrap around the current design -- the organization I work with does that -- and how they might respond to the redesign. This includes the drug manufacturer's patient assistance programs that Stacie just mentioned that people may have relied on for very expensive medication assistance. Some beneficiaries will still need that assistance because they cannot afford the cost sharing up to the catastrophic level, and the drug manufacturer's copay foundations have already made some changes. And I noticed that one of them has said their annual cap is going to be $3,250 in 2024, obviously responding to the redesign.

Also, states that have Part D wraparound programs, including many of the HIV/AIDS programs, may find the redesign will save them a great deal of money. I hope some group will monitor this, not saying it's the MedPAC's job, but the straight prescription savings, maybe they can go towards home-based services for older adults. One can only hope.

I believe in 2025 or as soon as possible, it's time to revisit the Part D late enrollment penalty for individuals with incomes up to 2- or 300 percent of the federal poverty guideline. Many of them have relied on FQHCs or free clinics or drug manufacturer assistance programs for branded meds or bottom-basement cash prices for generic medications instead of joining Part D.

In their minds -- and I know many of them have shared this with us -- they assumed they had creditable coverage. They didn't know what the word "creditable" meant. They had coverage in their minds. Now many are learning that their free clinic is leaving or that the medicine is not on their FQHC formulary. However, the late enrollment penalty is a major financial barrier to entry.

If you are eligible for Part D and haven't had credible coverage since July of 2006, when I began SHIP counseling and when Medicare D began, you are 211 months late, and your late enrollment penalty is $73.20 every month. Plus, you're 17.5 years older, and you're now 83.

Note that many of these individuals have likely saved Medicare a lot of money through the years by relying on other methods to obtain their medications. Of course,

those with LIS have always had their late enrollment penalty waived.

Now focusing on pharmacoequity, I believe we need to support a policy that encourages those with incomes just above low-income subsidy to join the Part D benefit pool by waiving or greatly reducing their late enrollment penalty so they can access necessary medications.

DIR fees. For years now, some pharmacies, especially smaller ones with less purchasing power, have literally lost money when dispensing medications, especially brand-name meds. The performance measures created by the plan sponsors were never regulated, audited, or made transparent to the pharmacies. Pharmacists just know that money was clawed back months after the medication had been dispensed. Even this month, when the performance measures or pharmacy concessions or clawbacks come off at the pharmacy counter, the pharmacy has no idea at the time of dispensing what the medication reimbursement for the plan is and what the DIR performance fees are. It would be good to track if and how much pharmacists are now going to be rewarded for improving those metrics, those mysterious metrics.

As I understand it, many of the metrics' plans used for DIR are related to the Star metrics that are used for Part D and focused on the heavily weighted Star metric of adherence.

I highly recommend -- and I'll share with the MedPAC team -- an article that appeared yesterday in "Health Affairs Forefront" by Dr. Annette DuBard and colleagues at Aledade, and the title says it all, "Why the Star Ratings Medication Adherence Measure Must Go."

Briefly, preferred pharmacies are not always less expensive for beneficiaries, and many of you probably don't know that. And having to switch between pharmacies annually to get the cheaper widgets can be risky because medications aren't widgets. And annual pharmacy switching may break long-term relationships or even limit access to additional services like home delivery, filling pillboxes, syncing medications, et cetera.

We should monitor vertical integration with plans, PBMs, and pharmacies to ensure that their preferences don't disproportionately impact smaller or more rural pharmacies that are critical to access across the national landscape.

Finally, MTM. Enhanced MTM demonstration outcomes are disappointing but not at all surprising. Please, let's not throw the baby out with the bathwater. There are some key takeaways from their effort. The timing of MTM matters. People who need MTM and understand that they need a thorough medication review -- or their family members understand -- most critically during transitions of care are when medications change.

Geriatric and drug epidemiologist Dr. Jerry Avorn once said, and I'm paraphrasing, if you take a new medication or you have a medication change and something changes in you, assume it's the medication until proven otherwise. Sage advice.

Many of the enhanced MTM interventions were telephoned with pharmacists unknown to the Medicare beneficiary or targeted mailings. I know from 30 years of experience that in-person MTM is a relational practice that is built on trust, not simply transactional intervention. And when working with people of color, it's critical that these individuals can relate to the people working with them so they feel they belong and can trust a system that has their best interests at heart.

I would also submit that CMS should not only look to see if MTM saves A and B dollars but also D dollars. Pharmacists are at the intersection of understanding how medications work and how much they cost Part D plans. Real-time tools at the provider's office aren't where they need to be quite yet.

Pharmacists know about generic and therapeutic substitution. Sadly, geriatrics is not a required class in most pharmacist schools. But we know that less can be more, and de¬-prescribing needs to be incentivized in team-based care settings focused on patient outcomes and function.

Finally, if promoting team-based care, pharmacists conducting MTM, who know the patients, should be seen as an extension of a provider's office, offloading some of the provider's work while working at the top of their pharmacy license. Pharmacists who are not considered providers and, thus, cannot directly bill Medicare but need to be part of the team and having them conduct MTM makes common sense, that Lynn referred to, and is often highly valued by providers who work closely with them.

If we're focused on promoting policies that truly

improve health outcomes, we need to address medication-related problems, including polypharmacy or medication overload. This is an undervalued public health program in our country where we take more medications than people in other countries, and we're less healthy. Team-based MTM with pharmacists and other clinicians trained in geriatrics who know the Medicare beneficiaries they're serving is our best chance to improve health outcomes related to medication optimization, especially for those taking multiple medications.

I think I just beat Larry in terms of long comments, I'm just saying, but thank you for the chapter and just wanted to make those key points. Thanks.

DR. CASALINO: I'll respond by saying wow. Jeff Stensland is a national treasure, but I think we should just erect a statue to you. It seemed like you were reading those. If those are readable notes and you would turn them around, I think that would be very useful.

MS. UPCHURCH: Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thank you. I had my comments next to the archives and then people said several interesting

things, so I'll respond to those first.

First of all, I agree on MTM. We don't want to necessarily kill it when there's probably more granularity there, in particular, the nearly 20,000 independent community pharmacies, and the pharmacists that work in them, may offer a different experience and a more personalized, customized experience of MTM than a large chain. I realize that we might not be able to parse that, but that is probably language that's good to add.

And another thing, there was a concern mentioned, I think by Gina, about branded drugs and substitution. I'll note that the state generic substitution laws probably will circumvent most attempts to prefer branded drugs, so it will overrule the formulary.

So I also then, one more thought before I get into my organized comments, the Plan Finder, I 100 percent agree with Stacie that the Plan Finder is not useful for beneficiaries in its current form, especially with the divergence between pick your Part D plan, wander over here, versus pick your MA-PD plan. That's not helpful. I also, to wander around the Plan Finder, encourage my graduate students to do so.

So now I wanted to get to my organized thoughts. So one thing I want to know is that we're talking about the pharmaceutical industry, and I, you know, come at this from an integrated perspective as a former FDA reviewer and also somebody who worked at CMS, does a lot of policy research. And I note that the folks who have the most expertise about the pharmaceutical industry, who many of us probably disagree with on many issues, are not present here at the table. Namely, there is no representative of the pharmaceutical industry here on MedPAC.

We discussed the IRA on page 13, and we note the innovation arms for decreasing incentives for product development. I think that this chapter should have a section on innovation harms, because they are very real. The incentive for small-molecule product development is significantly less, due to the differential length before they are subject to administrative pricing, as compared to biologics. Small-molecule drugs are incredibly important for treating a lot of chronic diseases. Heart failure, for example, Entresto is a life-changing, small-molecule drug for those with heart failure with reduced EF.

And I think also that the orphan drug issues in

the IRA, which will be magnified through Part D, could potentially affect access because the products might not be invented because the manufacturer doesn't have the incentive to, for patients with rare diseases, which I think will significantly damage health equity in the long term. This is not an effect that we're going to see in the next year or two, or even in the next three years. This is a 10- or 15-year effect, which will be bad because we will not have these therapies necessarily available. And so innovation losses I think is a section that absolutely needs to be included in this chapter.

I think the other thing that we also need to note is sort of managed care effects, which are really interesting. So I noted that MA-PD plans, on page 21, said that -- correct me if I'm wrong -- 76 percent had no deductible, which expands access to treating disease and lowers the downstream cost of care because it insulates the beneficiary.

Because of the benefit design change and we are shifting liability from the government, the plan sponsor, the Part D redesign will change how plans design their pharmacy benefit, and there are a couple of dials that they

can pull. One dial is you can change premiums, but those are capped for 6 percent per year for the next five years. I expect that premiums will probably go up significantly more after that.

Another answer is they can change the tiering of drugs, and that could inadvertently affect access in a very negative way. Prior authorization and utilization review, of which all of us have probably been subject to at some point or another at this point in our life, something that will also probably increase, again, potentially restricting access to products for consumers.

The other thing that I think is going to happen is plan exit. So we have expressed a lot of concerns, and other Commissioners have in other sessions, about the ability of beneficiaries to switch between Medicare Advantage and fee-for-service, that people should be able to move reasonably easily or more fairly between the programs. If you have very few PDP plans, because the plan liability has increased and they can't increase premiums and they leave the marketplace, we've effectively shot the fee-for-service program in the foot, which is unfair for beneficiaries.

Because for some beneficiaries, an MA-PD plan is the right choice for them, and for other beneficiaries a fee-for-service plus a Medigap plus a PDP is the right choice. But if you don't have many PDPs to choose from, because they've all exited the market, that's a huge harm to beneficiary choice and, frankly, beneficiary autonomy and how they access their taxpayer-funded health benefits.

Higher premiums, of course, that will happen in the long term, are going to hurt the poor the most. We have a cap for five years, and after that we will be functionally creating a two-tier Medicare system through our Part D redesign, where those who are able to afford the few remaining PDP plans will be able to participate in fee-for-service, and that just doesn't really seem like an equitable policy choice for the elderly and disabled population.

There was a comment, I believe, that right now we don't necessarily have price competition in the Part D market. I do think we have excessive price competition in the Part D market, which, as I said, this transformation of benefit design may actually eliminate. The prescription drug plans right now are almost as much of a commodity as

gasoline.

I think one of the other things that's really important for us to note in this chapter is the transformation of how the federal government addresses the prescription drug benefit for the Medicare program. So the IRA, through its administrative pricing, is functionally transforming a Part D program into a bit more like a Part B program, through administrative pricing. That is not really a good thing for cost control in the long term, especially with high harms to innovation. I think there are other things that will happen from that. You know, we'll see higher launch prices and other unintended consequences from administrative pricing.

We have a 60-year history of administrative pricing in the fee-for-service Medicare program that has utterly and completely failed to control costs. I do not see why this is going to do any better here by transforming Part B into more of a Part D-administered type benefit.

So I just think that we need to add a lot more nuance and balance to this conversation, and I hope that the staff and the Commission will broaden the scope of this chapter to include a more diverse set of views than are

currently present. Thank you.

MS. KELLEY: Lynn.

MS. BARR: Thank you. I will be brief. I just wanted to, when thinking about next year's chapter -- we do these every year, right? It feels like that. When we think about next year's chapter, I do have a concern about the -- and I don't know if this is next year or coming up -- but I do have a concern about the new rules about giving the rebate price at the point of sale and how that will affect small, rural pharmacies. And I believe Senator Grassley has been pretty vocal about this. I don't know if you guys have been talking to him. But it's a cash flow issue. These are very small businesses. And so they're going to have to take this money out of their pocket, and we are very concerned about the closing of rural pharmacies.

So would you somehow work that into your work plan of carefully monitoring that, because I think this is one of these policies that just forgot about like a whole bunch of people, and we're going to have very negative, unintended consequences. Thank you.

MS. KELLEY: I have a comment from Greg, which I

will read.

Greg believes that MedPAC has provided excellent guidance on this topic in the past, and he is grateful that many of the recommendations, especially the 2020 recommendations, have found their way into implementation. The chapter is excellent, and as far as the addressed topics go, he would only suggest that we should be a bit more critical of the rebate programs and their ongoing role in obfuscating the total price paid and the hidden inequity that arises from that.

Greg would also like us to consistently mention fiscal goals that we should aspire to with pharmaceuticals, whether it is in Part D or in Parts A, B, or C. Technologies in other sectors of the economy have pushed enhanced capabilities while lowering total cost. In health, many current and prospective drugs have the potential to lower total cost of care by eliminating the need for costly, labor-intensive interventions.

So a potential goal, number one, could be drug policy that lowers total cost of care for the beneficiary population as a whole.

A second potential goal might reasonably be that

the U.S., in general, and CMS, in particular, should not pay a dramatically disproportionate cost for identical drugs when compared to other first-world nations. He's not suggesting that these goals be incorporated into this chapter explicitly, but he does believe that they, or potentially other overarching goals, should be referenced whenever we discuss drug or technology strategy and payment.

Again, he says, thanks for a really clarifying and meaningful chapter.

I have Robert next.

DR. CHERRY: Thank you. I'm always impressed with the chapters on pharmacy. It's like taking a Rubik's Cube and aligning all the colors on the right sides so that all of us can understand it. And even then, I'm still asking the question, is that a Rubik's Cube that I'm looking at?

You know, the question I have relates to page 13, which has to do with the benefit redesign. It's alluding to this, but I don't think it's fully clarified. And like I said, it's more of a question than a comment.

But let's suppose it's 2025, 2026, whatever year

you pick, and the plan is undergoing this redesign, and I'm a patient who needs a high-cost biologic. But for whatever reason, the health plan has decided to kick this off of formulary. And I realize there's supposed to be CMS guidance. I don't know exactly what that's going to look like, but it's not there.

What happens to this patient in these future benefit redesigns? Is the patient going to be then subject to higher premiums the following year or is there an exhaustive preauthorization process that will lead to delay in care and treatment, or are they just out of luck?

I think it's an important issue to address because these high-cost biologics are becoming more common as far as treatments for certain individuals, yet it's not going to solve the affordability problem, potentially. So I just wanted to get your thoughts on that.

MS. SUZUKI: So all Part D plans have to cover at least two drugs in each class type, which restrict their ability to exclude a particular drug without therapeutic alternatives entirely. So that's one thing, and that's going to continue after the redesign.

The other thing is in case it is not on formulary

and the therapeutic alternatives are not appropriate, there is the exception in the appeals process. And under Part D there are certain timelines that plans have to meet in order to provide beneficiaries response about coverage determination.

So they're not going to be completely out of luck with this drug that's not on formularies, and if it's approved -- and I think we've looked at this before -- it's hard to get the right statistics to see what the approval rate is. But when they reviewed the coverage denial approval it did not seem like plans were denying all of the appeals. And I think the independent entity that reviewed the process, when beneficiaries do not get the decision that they were looking for, I believe that independent entity often agreed with the plan's determination.

DR. CHERRY: Yeah, so I think it's something to take a look at because in certain cases there may not be two drugs. It may just be that one drug. And then if the patient is denied that could be problematic, depending on their clinical condition, whether that's an essential drug or not. And if there's an appeals process but it's still the health plan's decision is upheld, I think those are the

types of things that I think we want to track in the future, to understand what those denial rates are, and most importantly, what are the clinical outcomes and impacts for the patient if that happens.

MS. KELLEY: Scott.

DR. SARRAN: Just one comment. I'm really struck, on Slide 16, by two of the data points there. We reference that the list price of Humira is essentially $80,000, and that some of the biosimilars have put on the table an 80 percent, or at least in that range, right, discount. So I'm concerned that the market forces may not effectively work their way through the program as the program is constructed and administered currently.

What I'd like us to keep track of is what happens to the total cost of Humira over time. If I'm simplistically thinking about this correctly, and if the manufacturer is able to presumably make some profit, at $16,000 a year, and understanding there may be a little time lag for the relevant biosimilars to have interchangeable status and to have the right formulation that providers think is required in high concentrations, et cetera, over a short period of time, though, the total cost

of Humira per beneficiary, net of CMS, plan sponsors, and beneficiaries, should drop to $16,000 plus what are reasonable dispensing fees. And again, if I'm thinking simplistically about this correctly, then anything greater than that reflects a failure of the program to achieve market forces that I think we want to see achieved via biosimilars.

But I'd like us to sort of track and see what happens to the net cost, again, net of CMS, plan sponsor, beneficiary, right, and see if, in fact, it does come down that far. And if not, then I think we should dig into why that's not happening.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. As many discussions as we have of Part D, I still find them a humbling experience, really. It's so hard to understand. You guys have done a great job once again. And Gina and Stacie have obviously been very helpful. I'm actually very impressed by any of the rest of us making any intelligent, seemingly, comment about Part D.

I have just a few comments, which may not meet that test, but are at least brief. One is that -- and I

can't remember who said it, but I do think -- I'm not suggesting that we, that the chapters we've had, uncritically accept rebates as a mechanism. Far from it. I don't think we've done that. But I think we could do more, and maybe even have a stream of work that we start with, where we really take a look at rebates and what do they get us and what do they cost us. We certainly know they cost us in transparency a lot. So I think that could actually be very, very valuable.

And my second comment is very brief and has no particular point to it, but just I was interested to see if I read the two chapters correctly, Medicare spends about $91 billion a year, Medicare, on beneficiaries, on physician services, clinician services, and now that $117 billion on drugs. And I'm not suggesting that's a bad thing. As a physician it doesn't make it fairly good. But obviously we have drugs that can do really marvelous things, that we couldn't do a short time ago.

But still, I think it's worth keeping in mind the magnitude of the costs of the Part D program compared to the magnitude of what we pay for clinician care.

MS. KELLEY: Stacie, go ahead.

DR. DUSETZINA: Yeah. Is that an apples-to-apples comparison, though? Because I think that it's going to be fee-for-service only in the one calculation and MA and fee-for-service in the other. So we might be talking about 50 percent of the market versus 100 percent.

DR. CHERNEW: There is not a magic share of what we should pay on drugs or physicians, and of course, physician stuff is often separated between the fee schedule and the facility part somewhere else. But I do think the general question of, are we paying too much or too little, are we paying the right way, are we protecting people from the risks, are we encouraging innovation, I think those issues arise.

Some of them, the innovation is more salient than drugs and perhaps physician fees, but I think the notion that -- I think you saw this in the Part D initiation. The role that medications play broadly in the American health care system as over the large arc of time changed dramatically, and it's become more salient, therefore, what we spend, but also more salient than what we get. And so I think that --

DR. CASALINO: I don't mean to suggest that this

is a bad thing. And Stacie is right. We probably should double the physician cost to $180 million.

[Laughter.]

DR. CASALINO: No, no. I mean if we take MA into account.

DR. DUSETZINA: I would like to stay on the record, I'm not suggesting that.

DR. CHERNEW: Yeah, it's hard to know.

MS. KELLEY: Kenny.

MR. KAN: Thank you for the excellent chapter.

Like Stacie and Gina, I'm wildly enthusiastic about improving Plan Finders significantly to help beneficiaries navigate changes in Part D as health plans adapt to margin pressures from the IRA.

For future updates on this chapter, like Brian, I'd like us to monitor and analyze the impact of the IRA on drug innovation, even recent publicity that some drug makers have delayed the rollout of certain drugs.

This is a very complicated issue. It would be very helpful if we can explore fiscal principles and tradeoffs between innovation, access, and drug cost affordability, which Greg mentioned, for future updates on

the chapter.

Thank you again.

DR. CHERNEW: Just to say, again, I think we're going to go to Cheryl in a second, but this issue was a really important issue. And in the drug work that we did in the past, we actually included a text box on this issue of innovation and drug prices in a range of ways, and it's been one of the things that I think has been really salient in some of the debates.

So we did do that. We happen to have done that in our chapter before. That doesn't mean we couldn't do it here. I'm just saying that for people at home, there is both an issue we're aware of and, in fact, one that in the previous cycles' discussions came up a lot, and we responded with an associated text.

I think we're at Cheryl.

DR. DAMBERG: Thank you.

Thank you very much for this chapter. I really appreciate all the great work. I also appreciate the various comments made by my fellow Commissioners.

And, Gina, again, wow.

I'm not going to repeat some of what's already

been said, but one of the areas that is still nagging for me, which you spotlight on page 29 around vertical integration, I think we have to continue to make some headway and better understanding that space and hopefully finding some way to get more transparent information in terms of how these entities are related to each other, related party transactions, and what the impacts are in the marketplace, because as we know, this is a pretty heavily concentrated market. So I definitely think we need to sort of keep our foot on that particular pedal.

The other thing that I would note -- and this is more of a context kind of comment, and I'm not exactly sure where it goes here. But I don't know what people's experience of going to a pharmacy has been of late, but anytime I'm in a pharmacy, the place seems overwhelmed. And I don't know whether it's a workforce issue, do we have enough pharmacists, or how things are staffed. But we've now created sort of a pharmacy as like this -- I don't know whether it's a primary care center. It is sort of all things to people.

So I was getting my COVID vaccine recently, and just watching the interplay of what people were coming in

for, the whole place is overwhelmed. The pharmacist does not have time to spend with patients doing the type of counseling that Gina is describing, to build those trusted relationships, to do anything in the way of any kind of medication management.

So I kind of feel like we have left out an important context factor of what's going on in the market and the experience of the beneficiary, and not just in Medicare, but writ large about trying to access drugs, but also make sure they're used properly and we don't have drug-drug interactions. So that's that comment.

And then given all the changes that are happening as a result of the Inflation Reduction Act, I just want to double down and say there's so much that needs to be explored about what are the positives, what are some of the unintended consequences, whether that relates to innovation, and what may be some positive spillover effects in the marketplace.

DR. CHERNEW: Gina was going to make a follow-on point to a point that was before, and then I think we're going to go to Betty.

MS. UPCHURCH: Actually two follow-ups. I'll

just comment on that too.

So pharmacists are super busy adjudicating claims, all the different formularies, all the different licenses, giving vaccines. There's just too much going on. That's why you see them walking off the job. So we are not working at the top of our license.

I am a pharmacist, for those of you don't know.

We're not working at the top of our license, and we should be, everybody in the health care field. So there needs to be some adjustments there.

But to the Plan Finder comment, so I've used the Plan Finder forever. You start by putting in the person's medications. Then you have to decide, are you traditional Medicare or are you Medicare Advantage? And that's a whole big conversation, and then you start going through the details. And the Plan Finder does not have the level of details. Local groups have to create their own cheat sheets to help people, including networks of what providers take what plans, what's the dental/vision/hearing, what's the -- who gets a $30 card for food versus monthly versus a $15 quarterly. I mean, it's all over the place. That's why I believe in standardization.

But the Plan Finder does help with the medications, and some years is better than others, but it's pretty good right now in helping with the medications. But it doesn't go that next level in detail, in the granular detail we need with the Plan Finder.

I will say one thing we could improve right now; the Plan Finder is at CMS.gov. So it's Medicare.gov. SHIP volunteers have to then go in to the ACL federal website and enter similar data for the ACL program to do the Stars ratings. That is having SHIP volunteers quit. There's too much administrative burden for SHIP volunteers to help a person, and then you got to go to this whole other system to document everything. Those two federal systems should work together and not punish the SHIP volunteers, because they're quitting. We're underfunded, and then we're quitting. Senior pharmacist gets about 10 percent -- just as an example, 10 percent of what we're paid. We spend way more than that. $30,000 a year in three different grants. We spend $300,000 to do the SHIP counseling. So we have to do something to make the counselors more happy to do it and doing away with some of that back-end reporting would help.

But the Plan Finders, good for the drugs, but

there's a lot more to counseling than just the drugs.

MS. KELLEY: Just so the transcriptionist knows, Betty.

DR. RAMBUR: Thank you. Thank you very much for this chapter. I think it's actually very interesting.

I would just say this is my fourth year on the Commission, and this has always been through a glass darkly, even now. But I just want to share my appreciation for how well you've made things clear of the figures you have. 11, 1, and 2 are extremely helpful.

And the comment that was made earlier by, I think, Stacie about flushing that piece out is really helpful, because at least as a reader, it is not intuitively obvious to me.

A few other things I just wanted to share underscore things that I've said. I strongly agree with Gina looking at eliminating late enrollment penalty. I understand why it's there so people don't enroll when they get sick. But the ethical standard I always think about is knew or should have known, and I think it's very hard for people to know that they should have enrolled.

De-prescribing teams of trust are really

important, and again, that takes time, which goes back to Cheryl's comment. My understanding is that throughout the United States, enrollment in pharmacy programs are going down, PharmD, and there's been a lot of angst with the pharmacy techs. So it really is just like much of the rest of the workforce very, very strained.

I agree with Greg on the cost-bearing medications. That's really, I think, an important concept, and Larry and Greg's point on rebates, I think it's important to continue to focus on.

Scott's point on market forces, keeping an eye on that, I think is very important, and also this intersection of innovation and the IRA that Brian and Kenny and I think Mike mentioned.

So that's where I'm at in all this, but I really, really want to thank you for your excellent work and love those diagrams that help me say, oh, that's how it works. Thank you.

DR. CHERNEW: Dana, that's what I have.

All right. So there's a lot of love. Universal. So that's good. Congratulations. I will plus-one to that.

There's a lot of material that's very confusing

that is presented very well. So thank you for that.

There's a range of issues that are very complicated, and so we can always work to clarify where some of those things are, but I think you heard several of them. I won't belabor them.

I think the biggest challenge that I have with this chapter, just in general is, as I said at the onset, the world in this space is changing a lot, and it's nice to know that we will have a status chapter going forward. And so we will continue to monitor all those things as they play out.

Just so people understand, we're not planning, this cycle certainly, broad sets of discussions on new redesign. I think because we're in the midst of a lot of transitions, it's unlikely -- I won't say one way or another, but it's unlikely that we would say you're just implementing this benefit design in 2025. Here's what you should do in 2026, right? So we're going to have to wait and see how this plays out.

Only other thing that I'll say, which is a little bit more of a personal comment, I think there's universal belief that the world would be better with a better Plan

Finder. That's true in part -- the world would be better with a better Plan Finder. If we could choose things better, the world would be better. If people really understood what was going on, and that's -- however you think it's working in Part D, in Medicare Advantage, I think it's an even more challenging set of things, which we will have a discussion of.

What I think it's important to come back to is to think through -- and I spoke with some folks at CMS about this. Realistically, what is the likelihood and ability to really come up and solve some of these problems? I think if you look at some of the stuff that CMS has done, they are quite aware of some of these issues. They are working to try to do a better job in a range of ways, and it's certainly the case that we would like to wish them Godspeed in all of those types of things.

So we will have to see. Hopefully, it will work better, and hopefully, we'll be able to manage the interplay between the MA-PDs and the PD plans, standalone PD plans and stuff like that. But for now, at least where we are at this moment in history, is we are simply reporting the status of where the program is and raising

some of the issues that we are going to continue to monitor and think about, and at some point, and I -- luckily, I don't have to -- will not commit to when. When we know more, we will then think about if there have to be new changes, but I think there's going to be some period of time where some of the existing changes are going to have to be implemented until we get a sense as to what happened.

So that's where we are. Again, thank you very much, Tara, Shinobu. That was really outstanding.

We're going to take -- let's just take a five-minute break and try and come back in around 4:20, and we'll talk about ambulatory surgical centers and get a status report on that.

So again, thank you and we'll be back.

[Recess.]

DR. CHERNEW: All right. We are back for our final session of what has been a wonderful, albeit busy, day. And we're going to get our status report on the ASC, ambulatory surgical centers, and for that it is Dan.

DR. ZABINSKI: All right, thank you Mike. In this session, we will discuss a status report on ambulatory

surgical centers, or ASCs. For the broader audience, as usual, a PDF version of the slides is available on the control panel on the right side of your screens. Also, due to a data limitation, I want to let you know that the number of ASCs that we report is through the first quarter of 2022, while all other data presented are through all of calendar year 2022.

The topics we cover in this presentation include background information on ASCs, beneficiaries' access to ASC care, growth in ASCs' Medicare revenue, and a restatement of MedPAC's recommendation to collect cost data from ASCs.

On this slide, we present some background on ASCs to provide some context for the rest of this presentation. The general purpose of ASCs is to provide outpatient surgical procedures. The most common types of procedures include cataract, gastroenterology, and pain management, while knee and hip replacement are rapidly increasing, and cardiology is expected to rise over the next few years.

For most services covered under the ASC payment system, CMS bases the ASC payment rates on the payment rates from the outpatient prospective payment system, the

OPPS, which is the payment system for most services provided in hospital outpatient departments.

The general process of the setting payment rate for a service under the ASC system is to multiply the relative weight from the OPPS for that service by a conversion factor that's specific to the ASC system. And this ASC conversion factor is much smaller than the OPPS conversion factor. Consequently, the OPPS payment rate for most services is about 84 percent higher than the ASC payment rate for the same service.

An overview of the status of ASCs includes the number of Medicare-certified ASCs was about 6,100 in the first quarter of 2022, while for all of 2022 the number of fee-for-service beneficiaries served was 3.3 million, and the number of surgical procedures provided to fee-for-service beneficiaries was 6.2 million, and Medicare fee-for-service payments to ASCs were $6.1 billion. Also, the ASC payment rates have received an update of 3.1 percent in 2024, which is the same update that hospitals received under the OPPS.

Regarding beneficiaries' access to ASC care for 2022, we found that the number of ASCs increased by 0.2

percent from the end of 2021 through the 1st quarter of 2022.

For all of calendar year 2022, the share of fee-for-service beneficiaries served in ASCs increased by 4 percent, and the volume of ASC procedures per fee-for-service beneficiary rose by 2.8 percent.

Even though the number of ASCs has been steadily increasing, the geographic location of ASCs is rather uneven. Among states, the number of ASCs per Part B beneficiary, which includes both Medicare Advantage and fee-for-service, varies from a low of 1.4 ASCs per 100,000 beneficiaries in Vermont to a high of 36 ASCs per 100,000 beneficiaries in Maryland. A factor that appears to affect the number of ASCs in a state is whether the state has certificate-of-need laws.

There is also a difference in ASC concentration between urban and rural areas, where we define urban areas as being in a metropolitan statistical area. In 2022, 93 percent of ASCs were in urban locations, and only 7 percent were in rural locations.

According to industry stakeholders, an underlying reason for this discrepancy between urban and rural areas

is that rural areas often lack the surgical specialists and population density to support the ASC business model.

Finally, ASCs are much more likely to locate in areas with low social risk factors than in areas with high social risk factors, where social risk is measured by income, unemployment, education, and housing quality.

The geographic differences in ASC concentration illustrated on the last three slides suggest that beneficiaries in areas with low ASC concentration might have difficulty accessing ASC services.

A measure with very high growth among ASCs is Medicare revenue per fee-for-service beneficiary, and that measure has been accelerating. From 2012 to 2017, Medicare revenue per fee-for-service beneficiary grew at an average annual rate of 4.3 percent. The growth in this measure rose to 8.2 percent from 2017 to 2021, and by an even 10.0 percent from 2021 to 2022.

Much of this growth in ASC Medicare revenue was from increased provision of relatively complex services such as implant of spinal neurostimulators, knee arthroplasty, and hip arthroplasty. This increased provision of complex services was likely due, at least in

part, to CMS's decision to move some complex procedures off the inpatient-only list.

An issue that limits our analysis of ASCs is that the ASC Quality Reporting Program, the ASCQR, currently has only three measures that can be used to evaluate how ASC quality has improved over time. However, CMS recently has added measures and will be adding more over the next four years, and these additions will improve the ASCQR program.

However, we think the ASCQR program could be improved by including the following four kinds of measures. First is measures that are applicable to both the ASCs and hospital outpatient departments, because there's a lot of overlap between those two settings. Second, claims-based outcomes measures that in some way represent all ASCs, and outcome measures for eye procedures, pain management, and cardiology would be especially helpful. Third, a measure for the rate of surgical-site infections. And finally, measures based on specialty-specific guidelines. For example, the American Cancer Society produced a guideline in 2018, that patients aged 85 or older should not receive colorectal cancer screening.

An issue regarding ASCs that we've frequently

addressed in the Commission's payment adequacy work from 2010 through 2022 is that ASCs are the only health care facilities that don't submit Medicare cost data. Stakeholders have argued that submitting cost data would be overly burdensome on ASCs because they are small facilities. However, other small facilities such as rural health clinics, home health agencies, and hospices all submit cost data.

In addition, submission of cost data is important. Without it, CMS cannot create payment rates that accurately reflect ASCs' costs, and CMS cannot create an ASC market basket that could be used to update the ASC payment rates. In addition, without cost data MedPAC cannot make fully informed assessments of ASCs' financial standing.

Because of the limitations from the lack of cost data, beginning in March 2023, MedPAC publishes a status report for ASCs rather than an update chapter.

A summary of the status of ASCs is that the limited data on the number of ASCs indicates that it increased through first quarter of 2022. Also, the volume of ASC services and Medicare revenue rose in 2022, with the

growth in Medicare revenue accelerating. In addition, ASC concentration varies widely among geographic areas, so access to ASCs could be difficult in some areas.

Note, however, that services provided in ASCs also can be accessed in hospital outpatient departments and, in some instances, in physician offices. However, the cost to Medicare and beneficiary cost sharing are always higher in HOPDs than in ASCs.

Finally, the lack of cost data from ASCs prevents a full evaluation of their financial performance.

With this lack of cost data in mind, in the March 2023 report to the Congress, we reiterated MedPAC's standing recommendation on collecting cost data, and we intend to do so again in March 2024.

This recommendation reads: The Secretary should require ambulatory surgical centers to report cost data.

Our reasons for reiterating this recommendation rather than providing a new update recommendation include that without cost data, the Commission cannot fully assess ASCs' financial status. Also, ASCs account for only a small share of Medicare spending, just 0.5 percent of the total. And MedPAC has made a similar recommendation each

year from 2010 to 2023.

For today's discussion, we'll address the Commissioners' questions and comments. Also, we want to determine the Commissioners support for reiterating the March 2023 recommendation listed on the previous slide. Finally, if anyone has fresh ideas on how to encourage the collection of cost data from ASCs, we would like to hear them.

Thank you, and we turn back to Mike for questions and discussion.

DR. CHERNEW: All right then. I think we're going to jump right into Round 1, and if I have this correct, Amol is the first to get in the Round 1 queue.

DR. NAVATHE: Thanks, Dan. As usual, great work.

I have what hopefully is a very quick question. On the bottom of page 7 of the reading materials there's a footnote that says that -- this is about the co-insurance -- that for a small percentage of billing codes covered under the ASC payment system, beneficiary co-insurance exceeds the inpatient deductible. And I was curious if we have examples of what those billing codes are.

DR. ZABINSKI: Nothing specific, but they almost

exclusively are something that involves implanting a device, which doesn't happen a lot in ASCs.

DR. NAVATHE: Okay. Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks. I have a couple of quick questions. So in terms of the quality measures, do you know why, or can you remind me why, the ASCs are not being paid for performance, but just pay for reporting?

DR. ZABINSKI: I mean, it's kind of standard through Medicare. Like in the hospital outpatient it's the same story. And I can't really explain specifically. I just know this is a decision that CMS has made.

DR. DAMBERG: Is this something that MedPAC would consider?

MS. TABOR: I can speak to that. So Congress would have to uncreate the program, and they have not done so.

DR. CASALINO: They'd have to what?

MS. TABOR: What's that?

DR. CASALINO: What program?

MS. TABOR: Value-based purchasing program, or like a value incentive program. They'd have to create it,

yes. So that's why. So the quality reporting program is in legislation, but the --

DR. DAMBERG: Pay for performance is not.

MS. TABOR: Yeah.

DR. DAMBERG: Okay. Thanks. And then when I look down the list of quality measures, I'm looking at the one for cataracts and visual function, that seems to be, I guess, the only patient-reported outcome, and it says "voluntary." So is that voluntary reporting?

DR. ZABINSKI: Yes. And only about 180 ASCs report it, and there are over 1,000 ASCs that provide that sort of service. I feel like the information that you get from it really isn't all that indicative of what's happening among them, the providers.

DR. DAMBERG: Yeah, it's incomplete. Yeah, yeah. And then maybe this is more of a comment than a question. On Table 10.1 you have combined consolidated and closed, and I was thinking it might be helpful to separate those.

DR. ZABINSKI: Okay.

DR. CHERNEW: That's what I have, and I have Jonathan kicking off Round 2.

DR. JAFFERY: Great. Thanks, and thanks, Dan,

for this sort of Sisyphean task you do every year.

You know, first off, I would be supportive of continuing to make these recommendations. I think they're the right things. You won't be surprised to hear I don't have any clever ideas for how to get report costs. They clearly don't want to, and I guess nobody is forcing them to. So it's sort of going to be up to Congress to say.

But I guess, you know, having seen this chapter for, you know, six years now, I guess, one thing that struck me, even though I've seen it before, but it really struck me this time was, you know, looking at the areas where ASCs concentrate, in terms of specialties. You know, they're mostly single specialties or double specialties. And, you know, of course they're on these things that are really high paying, right. So they're the high paying. And I'm thinking about this in the context of all of our discussions about site neutral.

So while it seems, you know, on the surface the concept of site neutral is pretty straightforward, right, and we were just talking about it -- Medicare shouldn't pay more for the same thing at different places if you can get it cheaper -- and so conceptually that just seem obvious

and intuitive. And yet what we have is a really complex ecosystem that ASCs are not independent, they operate separately from all these other parts, or HOPDs or physician offices or any other. So we've got a distorted payment system that has been created over many decades. So back to Betty's comment earlier about the rocks, right, and bringing in the cataract example.

Cataracts make a ton of money compared to somebody sitting with a complex patient for 30 minutes or even 20 minutes. And as we know, over time, you can gain efficiencies in doing things like that, cataracts or other procedures, that you can't gain in having a conversation with a patient and making a diagnosis.

And so ASCs have capitalized, for good reason -- you know, it makes sense that they would -- and create even greater efficiencies there that you can't get in other places. And so that's not to suggest that we should say, well then, forget about the site neutral because of that.

But the point I'm trying to make is that what do we think is going to happen if, in the context of our distorted payment system, if we implement that sort of policy in a setting where you've got something like ASCs,

which can, in fact, essentially cherry-pick the services that pay really well. I mean, over time, what you're going to have is you're going to have some places that are only left with things that either don't make very much money or lose money, and are doing it for more and more complex patients.

So I just think we should bear that in mind, and maybe there's something in the chapter that talks about -- I don't know if "cherry-picking" is the exact right term here. You probably wouldn't use it, or you might choose not to -- but thinking about how they're focused on these areas that are really well paid, and how that has ripple effects in the greater ecosystem. Yeah, there's the cherry-picking of patients as well.

DR. CHERNEW: Yeah. And Jonathan, I'm sorry. I didn't mean to interrupt.

DR. JAFFERY: No, no. That's good.

DR. CHERNEW: So this issue, and how we think about site neutral are intimately related, and what we want. And as we recall from the site neutral conversation, one of the big issues was are these things really the same? Are these patients really the same? How do we deal with

that?

One of the ramifications of this is you would see hospital profitability go down as ASCs enter, just by the nature of what you were saying. And when we observe that in the hospital data, we would have a reaction in the hospital update factor recommendation. That's how we would manage that type of thing, and, where possible, we would agree with the principle that you stated before, which is if you can do the same thing for the same person in two different sites, you want to pay the more efficient site neutral rate.

But if you're cherry-picking these healthier patients and you're leaving the less-healthy ones or the more expensive ones in a different setting, we have to figure out how to manage that support for that other more expensive setting. And we are constantly trying to balance that with the limited set of tools that we have.

DR. JAFFERY: Absolutely. I guess what I'm trying to just introduce is that there's another level of cherry-picking that not about patients. It's about what they're actually --

DR. CHERNEW: Yeah, exactly.

DR. JAFFERY: Right.

DR. CHERNEW: And yes.

DR. JAFFERY: It's about the perversion of the payment system, because if heart failure was as profitable as cataracts this might not be an issue, but it's not.

DR. CHERNEW: Yeah, I agree, and I want to go on to Brian in a minute. My guess is he has thoughts on this. But the broader point there is we would also, of course, support accurate, relevant policing for all these things, and you mentioned cataracts, which is known to have a higher price, and then for a bunch of reasons change, and whether or not the system adjusted rapidly enough is a topic beyond what we'll discuss --

DR. JAFFERY: Yeah, but -- and I'll shut up after this. But, you know, our recommendations carry a lot of weight and have ramifications. And so we've got a site neutral -- we have a more nuanced site neutral policy than we used to have. Policymakers on the Hill are not necessarily looking at that, and they could easily implement a site neutral very quickly, a baseline, you know, the original site neutral policy, that would create a whole bunch of problems, and we're catching up by asking

for an extra 1.5 percent here, when it's 13 percent --

So yeah, thanks.

MR. MASI: I want to add one thing real quick, and Dan, you should correct whatever I say. I wanted to pull in the idea of submitting cost reports and how that may have benefits both in how we think about ASCs, kind of just that payment system, but then to your point, Jonathan, how we think about ASCs in this environment where there are some services that are provided across different settings, across different payment systems. Better understanding of relative prices in the cost reports that would help support that analysis, could be one more reason why this has been something the Commission has been supportive of in the past. As always, I want to see if Dan wants to add anything there.

DR. ZABINSKI: No. That was really good.

MR. MASI: We didn't plan that.

MS. KELLEY: Brian is next.

DR. MILLER: Thank you. Two small technical comments before I get to more substantial policy thoughts. There is a concern in the chapter about pain management procedures. I do not do those pain management procedures

myself but I am aware that there is debate as to the value of them. Do you think maybe a way that rather than saying they're low-value or high-value we can express that they are probably an alternative to opioids? And that's probably an important nuance to put in the chapter.

Another one, noting, of course, that I support equalization of quality metrics around HOPDs and ASCs for procedures, I think that that is a great concept that we should emphasize more, adding a surgical site infection quality measure is great.

I do note that the colorectal cancer screening, based upon age greater than 85, as a quality measure of something that we shouldn't do is potentially problematic because it probably should be more of an individualized patient-physician decision. Some 85-year-olds have very high functional status and actually reasonably long life expectancy, and it may be appropriate to continue that screening. For other patients it might be very inappropriate to do a colonoscopy. So we should probably try and reflect that.

The technical comment side, policy thoughts, one is I think we should add the inpatient-only list as a

policy issue in here. It's a list that CMS maintains about procedures that can only be done in an inpatient setting. It's an administrative rule. It prevents competition between ASCs and hospitals, and are potential ways to save costs for the Medicare program. It was repealed in one administration and put back in place in another administration, so I think we should include that, because competition is important for lowering costs.

I don't think that there's any clear evidence that ASCs are cherry-picking patients. I do think if cherry-picking were occurring, which I don't think that there's clear evidence that it is, there is another important way to frame so-called cherry-picking, which is specialization. If an ASC specializes in procedures or a certain acuity of patient, that is a focus factor with higher quality, you should pay them less because they're focusing on a lower acuity of patient. And then the facility that is focused on, then, the higher acuity patients that are left should be paid appropriately, those higher acuity, multi-morbid patients, which sort of gets to what our Chair said about paying appropriately and accurately for the service and the patient that is

delivered.

So I think more thoughtful payment tied to the patient acuity is probably the answer for that.

I categorically oppose the submission of cost data, and there is a reason why. ASCs are one of the few competitive markets left in health care service delivery. Where people are outside of certificate-of-need, which I appreciate that being mentioned in the chapter, this is one of the markets where facilities are actually competing on price and non-price factors. It shows a regulation administrative cost, quality regulation, and I do support some quality regulation in this space, and I do support as a general principle, pay-for-performance in this space.

But quality regulation has crushed and, in general, regulation for participating in Medicare, due to conditions of participation, has crushed almost every small business in health care delivery, and that is bad, one, because you have consolidation which drives up costs, but then non-price competition, which my colleagues at the Federal Trade Commission and Department of Justice Antitrust Division often emphasize, is even more important in this space.

What does that functionally mean? If you are an 85-year-old beneficiary who has multiple conditions -- you have heart failure, if you're DCF, you have COPD, you have diabetes, you don't get around so well, maybe you have a walker or a cane -- and you go around a 200,000-square-foot facility, going to multiple check-in desks, first at the main hospital, then at your specialty, then you get taken back to another room, that's not easy to navigate, and often that sort of care environment, while it may be appropriate for some services, is not the most customized and easy-to-navigate for that beneficiary, even with the assistance of their family. Whereas small businesses -- small clinics, small hospitals, small pharmacy, small, independent businesses -- provide that personalized, customized experience that beneficiaries, frankly, need and want.

And so I think that we need to -- and I am not the economist here, but there are definitely other ways to determine what appropriate costs are. Cost reporting, I joke, is like a highly customized gap that only five people in the U.S. understand. Like you have to hire a highly specialized consultant in order to do Medicare cost

reporting. It's hard to compare that across businesses. And so we should think about other ways to appropriately assess costs.

We all pay prices for every item and service that is in this room, be it, you know, the government paid a price for installing the lights and building the building, and we pay space, pay a fee for renting it, my glasses cost a certain amount of money, as did my laptop, my watch, and my shoes, everything, auto insurance because I drove here, I paid for that.

So we need to find another way to measure cost, and appropriateness of cost, not requiring an arcane accounting system and crushing the last small business that exists in the delivery system. Thank you.

DR. CASALINO: Yeah, this is for whoever can answer it, Dan, Brian, anybody. How hard is it really to submit a Medicare cost reporting? If you were an ASC run by two physicians, would this make you throw in a towel?

DR. ZABINSKI: Well, it's hard to say whether you would throw in the towel, but I will say that, you know, in the past when we've talked about having ASCs submit cost data, we emphasized that we'd probably aim for a more

streamlined type of cost report that's less burdensome than, let's say, a hospital has to provide, you know, keeping in mind that these are small facilities.

DR. MILLER: May I have an on-point response?

DR. CHERNEW: Well, I want to give a quick response and then --

MS. KELLEY: I think we would also add too that other small organizations, such as home health agencies and hospices, do submit cost report data.

DR. CHERNEW: So let me respond to that and then I'll let Brian respond. In many ways, like Brian said, I think we don't need cost reports to understand, in some ways, that ASCs are profitable, because you just have to look at the number of ASCs. I do think there are other reasons and merits to getting cost reports. When we had this discussion in years past, we had exactly this discussion, of is the administrative burden worth it in a range of ways, and how we think through it.

The one thing that came up there, that, Dan, you didn't answer, and I may have this wrong but I'm old. I think Pennsylvania or some other state required them to submit cost reports, and it really wasn't a problem, is my

understanding of that experience. And that was the sort of empirical underpinning of why we felt it would be nice to know and nice to be able to do some other type of analyses.

Is it necessarily essential? Not necessarily clear. But I think our reasoning was that the burden of it was a lot less because of experiences that happened in other places where they are required to. That was my recollection.

DR. MILLER: So my on-point response is that I think we overly burden home health agencies, hospices, and other small businesses in their delivery system with cost reporting. And the entire rest of the economy we figure out how to pay and price for things without having people set detailed data. Businesses and consumers make decisions about all kinds of other purchases, with and without taxpayer dollars, without submission of a highly esoteric form that requires a highly paid consultant to do it.

I think we also need to be aware of administrative creep over time. Quality regulation, which is well intentioned -- as I said, I am supportive of quality metric reporting and pay-for-performance limits, realizing that it quickly spirals out of control. I think

our latest example is MIPS, which did not go well in terms of execution. And at the time people suggested MIPS said it would not be burdensome and it would transform physician payment, put on a risk order.

Again, I personally support putting physician payment on a risk order, but also 100 percent recognize that the administrative burden of MIPS was, and is, frankly insane for many practices, and I worry again that the small businesses in the health care delivery system, be it the ambulatory surgery centers, home health agencies, whatever it is, if you are a small business, an additional administrative reporting requirement might not kill that business today, but in the long term that will discourage entry, increase costs, or potentially promote exit over time, or mergers and acquisitions, and further drive consolidation and raises costs.

So I don't think this is a good idea, and I think we need to do hard work about thinking about other ways to figure out what a better competitive price is, or better competitive prices.

DR. NAVATHE: So I think being thoughtful about the administrative burden totally makes sense. I think one

of the differences, or one of the challenges here is that we end up in sort of circularity because we're trying to set prices, you know, Medicare is trying to set prices. And in the vast majority of other markets there is competitive forces. There is a market. There's not really a market here. And if we try to go and look at what other insurers are setting as prices, a lot of times they're basing that based on what the Medicare prices are. So that creates a circularity that's hard to penetrate, which is, I think, why, conceptually, if we come up with some sort of streamlined way to collect cost data that would really help to create a more rational payment system, which would support site neutral and other things that, Brian, you and others support.

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

MS. BARR: And then Larry. Thanks. So, you know, I've got a lot of experience with cost reports. Obviously, you wouldn't want to give them a hospital cost report. But most if the information they need to submit is information their accountant puts together every year to do their tax return. So this is not a -- you're not asking a

physician to spend 10 more minutes or 20 more minutes in front of an EMR. We're asking data that you collect for your business; you send to us. I don't think it's a large administrative burden versus the potential for benefit to the program.

DR. MILLER: You know they're part of the economy.

DR. CHERNEW: We're delving into a Round 3 back-and-forth between particular people, which we're not going to do. So if it's okay let's just -- again, you can say all this, and get in the queue. When it comes around to you, you can respond to whatever it is you want to respond. But there are other people that are in the queue that are not able to say their things because we're running back and forth on this issue, and they may actually want to say something on this issue.

And that brings us, if I have this correct, to Tamara.

DR. KONETZKA: Thanks. Yeah, so I will start by responding to that issue and then move on to my main point. On that issue, I think I would support a couple of recommendations. One, I do support the recommendation that

we require cost data to be submitted by ASCs, for all the reasons we just said. It's perhaps not that burdensome, and it's a little bit odd to have this one sector for which we don't have this information, while we're trying to think about appropriate prices.

And I think, at the same time, we can recommend, as we've talked about before, that we move toward better cost reports, cost reports that are more useful and also not burdensome. And I think we can kind of move toward those simultaneously.

But my main point was really very similar to Jonathan's about these broader market effects. So I want to just elaborate on that in a slightly different way and make a few specific suggestions.

From the beginning, when ASCs start to grow, to me, in the literature, the main concern was this sort of siphoning off profitable procedures from hospitals, procedures like orthopedic procedures, for example, that hospitals, or course, use in a very classic, cost-shifting, cross-subsidization kind of way. And so I think the concern would be that we would see unprofitable services like psychiatry start to be closed or not offered because

hospitals no longer have the sort of more lucrative, or have fewer of the more lucrative procedures.

So my suggestion there, and I know that in the spirit of site neutral payment and if ASCs can do this more efficiently, if we don't want to support that kind of system. But at the same time I feel like in this chapter, whenever we talk about the growth of ASCs, there should be a discussion about this. And then I think at the same time we could sort of monitor that, moving forward. Like in markets where ASCs really grow, what seems to be happening to sort of hospitals in the area, and just try to keep track of some of those broader market forces. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Well, thank you for this interesting and well-done report and interesting conversation.

One smaller point, then, following up on the conversation we have been having. I did appreciate the footnote on Maryland at the bottom of pages 8 and 9, because I think the growth of ambulatory surgery centers in a state that has all-payor rate-setting for the hospital sector just shows how the costs just squish out, and in my view, it needs to be all-payer, all-setting. I know that's

not really part of this report, but I appreciate that in there.

I think you know I'm a firm believer that reasonable people can look at the same thing and come to different conclusions. So, respectfully, I have to say I am just on the other end of the arc from Dr. Miller, because I would be in the no cost data, no reimbursement. That would take care of it, right? You could bet with next staffing alacrity it would happen.

And the reason I'm so concerned about this is what I see out in the field, but health care is a vulnerable purchase, and supplier-induced demand is real here. And so I'm very concerned about that.

I'm concerned about the questions that Jonathan and Tamara raised about not just reimbursement that's lucrative but fast. You know, think how many cataract surgeries are done in a day, in a focus factory, and then yet we don't have to have a reporting of visual improvements afterwards. So to me, the quality metrics of surgical site infection, visual improvement being required, is really important for the data but also kind of a sentinel effect.

And finally, I'll just say that I actually like the colonoscopy piece because I am concerned about overuse of colonoscopies. And if all physicians and nurse practitioners and PAs really policed themselves, we wouldn't have this problem. But I see or hear about, all the time, about people have real complications from the purging they take, and their electrolytes are off. And if it gives you ten years, what does that mean even if you are a functional 89-year-old?

So I don't know if there can be some more nuanced reporting, but I did like the suggestions we have on page -- well, you know the pages. I can't find it here. So thank you. That's where I'm at on that.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. A really nice presentation. And just regarding your question about what to do with the cost data, I think the only really simple solution to this is to have a strongly worded recommendation in the March report that basically says everybody should be doing what Pennsylvania does, which is the streamlined cost report that is mandated and submitted, more to understand how healthy or not healthy these ASCs

are.

You know, short of that there may be some workaround. You know, I'm sort of thinking there are maybe three different buckets of getting at least the margins of these ASCs. So if they're privately owned, if they're submitting IRS tax returns, and I imagine many of them are publicly available, and that's one way of assessing margin. You know, for large corporations that are kind of swallowing ASCs whole for lunch -- and we know who they are -- they should be in their quarterly shareholder reports. So I imagine that the margin is listed and embedded in there.

And then, of course, there are the hospital-owned ASCs, and that should be readily available through the Medicare cost report. I imagine margins can be extrapolated in that way.

So there could be an indirect way of getting at the problem. I don't know why it's not mandated, but because it hasn't been proposed I imagine it may take some time before this gets enacted. And looking at sources that are publicly available may be helpful in the meantime.

But thank you. Great report.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks.

I just wanted to note that I support the recommendation of reporting the cost data, and I'm pleased to hear that it would not be terribly burdensome. So that's good news.

I was also struck in, again, reading the quality of care measures, there's a number of things done here that I think could benefit from developing measures around patient-reported outcomes, and it's not just in this setting but more broadly across a lot of CMS programs. So I would hope we would try to emphasize that in the report.

Similarly, given the concerns about low-value care, it strikes me that whether you want to talk about pain management, as an example, this really gets down to the issue of appropriateness criteria, and I suspect we're operating in a space where there are good appropriateness criteria. And so this creates this gray area where we don't know to what extent these are clinically necessary versus inappropriate.

So I think as we navigate this space, I might also encourage consideration of developing appropriateness

criteria, because I think one of the things I struggle with, particularly in the area of pain management -- so I don't know whether it's a substitute for opioids or whether these are people who are delaying knee surgery or back surgery, so it's a temporary stopgap measure for a couple of years. And I don't know how we think about that, whether it's appropriate or not. But I think it's a complex area and requires some additional unpacking.

And then the last thing -- and I know I've been talking about this a lot today -- given all of the purchasing of different entities in the health care market, I would hope we could have more transparent information on ownership relationships.

MS. KELLEY: Larry?

DR. CASALINO: Yeah. I wasn't going to mention this, but I second Cheryl about ownership relationships.

In the past four years on the Commission, I've been kind of outraged by the fact that there were no cost reports, but today's discussion has made me think that maybe it deserves a little bit more thought.

I think Robert gave an impressive list of indirect ways of trying to get a sense of cost. But I have

to think a little bit about who would gather all that information for 6,000, or whatever it is, ASCs. That would not be -- every year. That might not be practical.

I think I'd like to understand more about the extent of the burden. If it's just what Cheryl is saying it is, if it was no problem in Pennsylvania, that seems like kind of a no-brainer, as I've thought over the years, to require the cost reports.

I would be interested to know if -- and this might be simple to look at in a kind of back-of-the-envelope way at least what happened in terms of consolidation or closure of ASCs in Pennsylvania, after cost reports start to be required. Did the number decrease, or what? Do you happen to know that, Daniel?

DR. ZABINSKI: To put it this way, they've been collecting the -- Pennsylvania has been collecting that information since I started working on ASCs. So it's been a while.

What I do know is that the number of ASCs in Pennsylvania has continued to increase.

DR. CASALINO: It's increased?

DR. ZABINSKI: Yes.

DR. CASALINO: I mean, it's increasing everywhere, so it's a little tricky, but --

DR. ZABINSKI: Yeah.

DR. CASALINO: Yeah. So that's good information. And also, one can look at what their cost report requires, and is it indeed something that the ASCs -- an accountant can just do with the taxes? And then it is a no-brainer.

If we -- and so if we thought that, then I would say let's push that recommendation and continue it just as it is.

We had -- if we thought it was more work than that, one could think about making it voluntary for ASCs with revenue below X. If they didn't submit the data, then we'd be using margins to make recommendations from bigger ASCs. If they didn't like that, then they should submit voluntarily. But that could be done.

DR. ZABINSKI: One other thing about Pennsylvania, in terms of the concentration of ASCs per person, they're right in the middle among the states. They also have a Certificate of Need law. They have a CON, a Certificate of Need. So all this comes into play.

MS. KELLEY: Amol?

DR. NAVATHE: A very quick point, which is I think folks have hinted at this, so Tamara and Larry. There is an academic literature in economics and otherwise that looks at the efficiency of ASCs, some of the questions about ownership. I think that may be counter to other areas. I think in ASCs, it's actually been more reassuring around treatment patterns and patient selection and the like.

And I think there could be -- I don't know that the literature perfectly, but it could be additional literature that also is looking at some of the questions around impact on hospitals. So that's what I thought.

DR. CHERRY: Michael Richards.

DR. NAVATHE: Yeah, Michael Richards has done -- that's the paper I was thinking about in terms of ownership as well.

So, Dan, it might be helpful to incorporate what we do know from the literature, at least what the literature has found around some of these different dimensions that I think Commissioners are understandably curious about.

MS. KELLEY: Scott?

DR. SARRAN: Yeah, just a quick reinforcement in terms of quality measures. A lot of these procedures are just so well suited for patient-reported outcomes, real simple ones, right?

Pain management, it's all about pain and function, hips and knees on low-risk people, because if they're high-risk people, they'll be in the hospital. So by definition, these are low-risk people, and it's just pain and function at 30, 60, 90 days. And increasingly, as likely interventional coronary vascular procedures, similarly pain and function. So I think this is a space where we could really see a leadership position for CMS in terms of gathering and effectively using, if for nothing else other than public display. It doesn't have to be attached necessarily to value-based payment. Using pain, patient-reported pain and function measures, it just cries out for it.

DR. CHERNEW: And Dana is giving me the nod, which means that, like me, that was the last person in the queue. So let me make some general comments.

There's a few themes here that are important that I'd like to just draw out. The first one is the issue of

what data we get and the administrative burden of gathering that data is important. It is true not just for the cost reports and ASCs, but just to be clear, that is true in every quality measure-type thing that we discuss and a whole bunch of other things. And I think given the American health care system, at least being cognizant of the administrative burden, same is true for IT requirements. You go through the list about a whole bunch of things, and I do think it is something we need to keep in mind.

In this particular case, when we had that discussion, it actually was -- that's how I knew about Pennsylvania. The point about taxes, I had forgotten, but it was also made, and it just shows you how old I am. So I think the feeling was that it is not that administrative burden. Where it's happened has not been that deleterious.

That said, it is also the case that if we wanted to know if ASCs are profitable, we can do that without cost reports. We know that.

Where the ASC system has been particularly complicated is ASCs can provide services in a way that we believe is less expensive than if they're provided in other

organizations, but they can also pick patients or procedures that are less expensive to do than in other organizations.

And so I don't know if Brian DeBusk is listening. I hope he is. Hi, Brian. When we had a discussion about ASCs, Brian was constantly focused on these issues and appropriately so, and his point would be if you think ASCs are the innovative sector to provide these set of services in a range of ways, why would you want to lower what you pay them? You need to encourage that level of innovation.

We don't know, without the cost reports, are we encouraging them at a 25 percent margin, which would be very different if we were encouraging them at a 5 percent margin or some version? And so I do think there would be some value in understanding that basic number, which would have to be weighed against the cost of doing it, which at the time we had that recommendation, we tried to weigh, and therein lies the challenge.

I think when we talk about access to any of the type of services that we talk about -- and we talk about access a lot -- it makes sense when you think about the patient getting the service. There's no particular reason

why we care about access to ASCs or, for that matter, access to HOPDs, as long as patients can get the service in a particular other setting where they are. And so it is challenging to know what one would do in the ASC setting, and so we live without margin data. We work for site neutral in a range of ways. We understand the ramifications of site neutral on the hospitals, and we think through how to manage any potential deleterious consequences of that with the basic goal of trying to get patients treated at the highest quality, most efficient setting. and within the setting, the highest quality, most efficient providers. That's what we would like to do. It's just the system and the policies we're working with are not well suited. They're not the level of granularity that will allow us to do a lot of things you would want to do.

So as a result of all of that, we have moved to a status report chapter for the ASCs. And, Dan, I think you heard a lot of interest in it. I do think it is valuable. We will take back the comments that we heard here as we think about where we go with this in general, given the sort of principles I outlined before. But that's sort of

what we have in this particular area.

There's infusion centers. This trend, this broad trend of things moving out of hospitals into freestanding something, because technology allows us to do it, is both really important, because those centers are often better. They can be cheaper to do, but they also can exploit payment limitations and patient heterogeneity in ways that are challenging, and because health care inherently is a system where we're all connected in a bunch of ways, it becomes very problematic if certain types of patients or certain types of procedures are getting picked off in some settings and others are left somewhere else. And while it's aspirationally easy to say, well, we should just get it right everywhere for everyone all the time -- that might have been a movie -- it's just hard to do. So we're left in sort of a second best world, and we try and work through that.

So that's where I am on this. I think I will close with first to the people at home. Thank you for listening. I hope you found it useful. Please send us comments at MeetingComments@medpac.gov. We do want to hear what you have to say. There are other ways to reach us as

well.

And again, particularly thank you to Dan and to all of the staff who presented before him. It has really been a voluminous amount of work. For those of you that are looking forward to the March report, 500-plus pages, all of which has to go through production and editing and a whole range of things, it is a mammoth set of things. And so the ability to just physically get it done is hard. So some of these things may appear in March. Some of them may be things that just work their way into the chapters next cycle, and the staff will do their best to get as much as they can in here. That's where we are.

So anyway, thank you all. For those at home, if you want to join us tomorrow, we will be talking about Medicare Advantage. So stay tuned for that.

Again, thank you. Be safe.

[Whereupon, at 5:19 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, January 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

GoToWebinar

Friday, January 12, 2024
9:01 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[9:01 a.m.]

DR. CHERNEW: Hello, everybody. Thank you for joining us. This is our Medicare Advantage Friday for our January meeting. We have two sessions this morning, both of which focus on Medicare Advantage.

So I will just say something briefly before we start. Medicare introduced private plans into the program literally decades ago, but I think in doing so it wasn't really designed or intended to be a dominant part of the program. But now we have over half of Medicare beneficiaries in Medicare Advantage plans, and I think that reflects the value that the beneficiaries are getting from the Medicare Advantage plans, which is wonderful, and I think it is clear in the materials that are supportive of having plans serve Medicare beneficiaries.

That said, I think the trajectory of growing enrollment we're on is unstable, for a bunch of reasons that are sometimes mathematical, just the way that the benchmarks are set. And there is a range of imbalances across the Medicare program related to Medicare Advantage.

So there is a lot to be done as we move to a

world with really prominent Medicare Advantage programs, so we are going to be spending a lot of time focusing on this issue.

And we are going to start with our status report, and I think, Stuart, you are up.

MR. HAMMOND: Thanks, Mike. Good morning, this presentation updates our findings on the status of the Medicare Advantage program. I'd like to thank Pamina Mejia for her help with this report.

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

This year's March report will include a separate chapter that details the changes to our methods for estimating the effects of coding intensity and favorable selection. That material was presented to the Commission in September and November. Prior to publication, Commissioners will have an opportunity to provide comment on both that material and the MA status chapter, which we will present today.

To start today's presentation, I will present our analysis of MA enrollment, plan availability, and MA

rebates for 2024. I'll then discuss our ongoing concerns regarding quality, and finally present an overview of the MA market structure, vertical integration, and insurer financial condition.

Andy will then introduce MA plan payment policy and provide an update on the trends and variation in MA risk coding intensity.

Then, Luis will provide an update on favorable selection in MA and will present our comparison of MA and fee-for-service spending, which now includes the effects of favorable selection and reflects our updated method for estimating coding intensity.

We'll start by describing trends in MA enrollment. Medicare beneficiaries who have both Parts A and B have the choice of enrolling in an MA plan or in fee-for-service Medicare. The majority of all eligible beneficiaries are now enrolled in an MA plan.

In 2023, 52 percent of Medicare beneficiaries with both Part A and Part B coverage were enrolled in MA, a substantial and growing difference from 26 percent in 2011.

The Affordable Care Act of 2010 established changes to MA payment rates, essentially phasing in a

reduction of payment rates by 10 percentage points between 2011 and 2017. Despite some initial projections that the decrease in MA payment rates would result in enrollment declines, MA enrollment has continued to grow rapidly.

In 2023, MA enrollment grew 8 percent to 31.6 million enrollees. The proliferation of MA enrollees has coincided with an increase in the number of plans bidding.

Medicare beneficiaries have a large number of plans from which to choose, and MA plans are available to almost all beneficiaries. For 2024, nearly 100 percent of Medicare beneficiaries have at least one plan available, and 99 percent have a zero-premium option that includes the Part D drug benefit.

The average Medicare beneficiary can choose from 43 plans sponsored by 8 organizations in 2024. The number of plans available increased relative to 2023.

Most plans have funding through a plan rebate to provide extra benefits to their enrollees in addition to the Part A and B benefits. The average rebate that plans have available for extra benefits in 2024 is $194 per member per month, nearly at the record high set in 2023.

MA plans allocate the largest share of rebate

dollars toward reducing cost-sharing for Part A and Part B services. However, the share allocated to non-Medicare supplemental benefits, such as gym memberships and discounts on dental services, has grown in recent years. Coverage for these supplemental benefits varies widely by plan, and data on their use is unavailable, making it unclear whether these benefits are being administered efficiently for both beneficiaries and the Medicare program.

The level of rebates, currently at 17 percent of total payment, reflects MA plans' ability to reduce the growth in their bids relative to the growth in payment benchmarks.

Next, we'll discuss quality in MA. The Commission has, for several years, concluded that MA quality cannot be meaningfully assessed through the current system, which does not promote the use of high-value care and should not be used as the basis for distributing bonus payments.

As described in your mailing materials and at length in previous Commission reports, the QBP has several flaws, including assessing quality for large contracts with

geographically dispersed enrollment, using too many measures, and not providing beneficiaries information about plan quality in their local market. Despite these issues, the MA quality bonus program now accounts for at least $15 billion in annual bonus payments to MA plans.

In our June 2020 report, the Commission recommended replacing the quality bonus program with a value incentive program that would focus on local markets, use a smaller number of measures, and distribute plan-financed rewards. We have begun identifying and analyzing other indicators of MA quality and plan to present our findings in the spring.

We turn now to an overview of the structure of MA markets and the financial health of MA organizations.

MA enrollment is nationally concentrated in a small number of large, for-profit insurers that compete in most markets across the country. High enrollment concentration, particularly at the local level, can be a cause for concern if it dampens the competitive pressures that might otherwise drive insurers to maintain or improve quality, make care delivery more efficient, lower premiums, or provide supplemental benefits.

We assess local market concentration using the Herfindahl-Hirschman Index, or HHI, a metric commonly used to quantify the degree of concentration in a market. We find that the concentration of local markets has decreased slightly in recent years.

The dashed orange line in this figure shows the rising share of MA enrollees enrolled in the three largest insurers nationally. In 2023, three insurers -- UnitedHealth, Humana, and CVS Health -- enrolled 58 percent of all MA enrollees.

Some of the growth for the large national insurers is a result of their entrance into new markets that were previously concentrated. These expansions have coincided with a modest decline in concentration of local MA markets, as shown by the solid black line in the figure. However, most counties continue to exceed the Federal Trade Commission's threshold of "highly concentrated," indicated by the dashed horizontal line in the figure.

Despite being highly concentrated, most local markets are served by multiple insurers; beneficiaries can typically pick from plans offered by eight organizations. Nevertheless, enrollment is generally concentrated in plans

offered by one or two insurers, as shown in the figure on the left side of the screen.

The dark blue segment at the top of each bar in the figure shows that the top insurer in a county generally covers between 40 and 50 percent of enrollees. Continuing down the bars, we see that the second-largest insurer in a county typically covers roughly a quarter of enrollees, and the third-largest covers roughly 15 percent. This pattern holds in most areas of the country, including in both urban and rural areas.

In 2023, more than 60 percent of MA enrollees lived in a county in which a large national insurer enrolled the largest share of MA enrollees locally. In other counties, the largest insurer was typically a Blue Cross Blue Shield affiliate, or a plan owned by a provider organization such as a vertically integrated health system.

The continued growth in MA enrollment, the substantial number of plans being offered, and plans' ability to provide generous extra benefits, point to continued strong financial health in the MA sector. We have historically analyzed the profit margins that MA plans report in their bids as an additional indicator of

financial health.

The margins for plan-year 2022 are presented in your reading materials. However, we have become increasingly concerned about the appropriateness of focusing on plan margins.

One concern is that MA margins may not be comparable with the margins of other health insurance lines of business, and that other metrics may be more appropriate for characterizing insurers' financial condition.

A second concern relates to the fact that many insurers are vertically integrated, with plans and providers owned by the same organization. Because bid data report the margin for only the plan, they might not provide a full picture of an organization's financial health.

To better understand the extent of vertical integration in MA, we assessed information reported in plan bids. This figure shows the percent of plan expenses that each insurer expects their members to receive from an entity owned or controlled by the same parent organization.

The left-most trio of bars shows the level of vertical integration for the five largest non-provider-owned organizations for 2022, 2023, and 2024, shown in

orange, green, and purple, respectively. The middle trio of bars describes provider-owned organizations, and the right-most trio describes all other organizations.

We find that vertical integration is highest in provider-owned plans and appears to be increasing for most organizations. This aligns with trends in vertical integration of the provider sector as well as the acquisition of provider businesses by large insurers.

These findings suggest that vertical integration could pose a significant barrier to our ability to interpret plan-specific financial metrics. The Commission plans to continue monitoring these trends and their possible effect on enrollees.

Now, I'll turn things over to Andy.

DR. JOHNSON: Thanks, Stuart. I'll now briefly go over the MA payment system. Payments to MA plans are the product of a plan's base rate and the average risk score for plan enrollees.

The base rate is determined by a comparing a plan's bid and benchmark. MA plans submit bids each year for the amount they think it will cost them to provide Part A and B benefits.

Benchmarks are the maximum amount Medicare will spend in a county. Counties are divided into quartiles, and benchmarks are calculated as the fee-for-service spending in the county multiplied the quartile percentage, which ranges from 115 to 95 percent.

A plan's benchmark can be increased by a quality bonus of 5 percent, or 10 percent in some counties, for plans achieving a rating of 4 or more stars.

Nearly all plans bid below their benchmark, and so plans are paid a base rate equal to their bid plus a rebate, which is calculated as a percentage of the difference between the bid and the benchmark.

Beneficiary demographic characteristics and diagnoses are used to calculate a risk score for each beneficiary. Risk scores are an index of expected spending relative to national average spending, where the national average is assigned a risk score of 1.0.

Risk scores increase or decrease MA plans' base payment rate to account for enrollee health status. And also, risk scores are used to standardize the fee-for-service spending estimates that are the basis for benchmarks so that the spending estimate for each county

reflects spending for a beneficiary of average health status.

The risk adjustment model is developed using fee-for-service beneficiary data, so risk scores reflect the expected spending that would occur for the average beneficiary in fee-for-service Medicare and also reflect the relationship between spending and diagnostic coding patterns in fee-for-service Medicare.

Each year, the Commission compares spending on MA to what Medicare would have spent if MA enrollees were instead enrolled in fee-for-service. This comparison accounts for differences in health status, including the effects of favorable selection, and differences in diagnostic coding, geographic distribution, and coverage between the two programs.

Relative to fee-for-service, MA spending varies due to changes in plan benchmarks, coding intensity, and favorable selection.

Plan benchmarks can affect overall MA spending through changes in the accuracy of the underlying fee-for-service spending projections, the distribution of MA enrollment across the county quartiles, and the share of

enrollment in plans receiving a quality bonus.

Since about 2017, and with the exception of two years under the pandemic, benchmarks have only had a small influence on overall MA spending, so we will not spend more time on those factors today. We will describe the effects of coding intensity and favorable selection over the next several slides.

First, we'll discuss coding intensity. MA plans have a financial incentive to document more diagnoses than providers in fee-for-service Medicare, leading to larger MA risk scores and greater Medicare spending when a beneficiary enrolls in MA.

Several studies have used a variety of data sources and methods to estimate the effects of coding intensity, and the results generally align with MedPAC's estimates. One study found that, when controlling for differences in health status using Part D prescription data, MA risk scores increased about 1 percent per year faster than fee-for-service risk scores.

A second study applied a difference-in-difference approach to risk score data, and found that risk scores for MA stayers, grew 1.2 percent faster than fee-for-service.

A third study, using county-level data, found that in the first year after MA enrollment, risk scores increased about 6 percent faster than fee-for-service, and about 2 percent faster in the second year.

Finally, the GAO used a risk score prediction model to estimate coding intensity for 2010 through 2012, and those estimates align very closely to MedPAC's.

In September, we assessed the coding intensity estimates based on Kronick and Chua's demographic estimate of coding intensity method. We reconciled differences between estimates from that method and from MedPAC's long-used cohort method, by making revisions to each. Estimates from the two revised methods were within about one percentage point for all years from 2008 through 2021.

The coding intensity estimates presented today are based on MedPAC's revisions to the demographic estimate of coding intensity method. Also, in a change from prior years, we project coding intensity estimates for 2023 and 2024 based on a recent 5-year trend.

For 2024, we estimate that MA risk scores will be about 20.1 percent higher than they would be if MA enrollees were instead enrolled in fee-for-service

Medicare.

In this figure, the numbers at the top of each bar show our coding intensity estimates over time. The Secretary is mandated by law to reduce MA risk scores to account for coding differences, but this adjustment, shown in dark blue, has never accounted for the full impact.

Uncorrected coding differences, shown in green, result in higher payments to MA plans. For 2024, net of the coding adjustment, MA risk scores are about 14.2 percent larger and payments are about $54 billion higher due to MA coding intensity.

New risk model versions have reduced coding differences in the past, as shown by the smaller bars in the figure for 2014, '16, and '17. A new model version is currently being phased in, and we have accounted for that impact in our 2024 estimate.

The main point demonstrated by this figure is that MA coding intensity, and the impact on payments to MA plans, continues to grow rapidly.

We also remain concerned about the uniform coding adjustment, given the variation in coding intensity across MA organizations. Each bar in this figure shows one MA

organization's coding intensity relative to fee-for-service for 2022.

The coding adjustment of 5.9 percent generates payment inequity by penalizing MA organizations left of the vertical line, and by failing to account for overpayments to organizations right of the vertical line.

Note that the penalized organizations tend to be smaller, representing 17 percent of all MA enrollees, while the overpaid organizations tend to be larger, enrolling 83 percent of all MA enrollees.

However, even among the eight largest MA organizations, shown here by the orange bars, there is a 15-percentage point spread in coding intensity.

Higher-coding organizations have a competitive advantage because they receive larger payments for enrolling the same beneficiaries as other organizations, and they can offer more extra benefits, and attract new enrollees, simply because of their coding efforts.

Finally, this year we conducted an analysis to assess the share of coding intensity that is driven by health risk assessments or chart reviews.

Health risk assessments often document patient-

reported medical conditions. Chart reviews allow plans to submit additional diagnoses based on a secondary review of a patient's medical record. Both mechanisms contribute to higher MA coding intensity because they are used less, or not at all, in fee-for-service Medicare.

The figure shows payment years, reflecting diagnoses submitted from prior year services. We identified coding intensity associated with a health risk assessment or a chart review when there was no physician or hospital service documenting the same diagnosis, during the calendar year.

Overall, health risk assessments and chart reviews accounted for roughly half of all coding intensity between 2020 and 2022.

In 2016, the Commission recommended policies to address both excess payments, and the competitive advantage that some organizations have, due to higher coding. The Commission's strategy first focuses on addressing the underlying causes of coding intensity, by removing health risk assessments and using two years of data to improve diagnostic documentation, and then an adjustment would be applied to account for any remaining effect of coding

intensity.

In the results shown on the previous slide, we find that chart reviews are another underlying cause of higher MA coding. The OIG has also noted the role of chart reviews in increasing MA coding, based on assessments of earlier years of data. MA organizations use health risk assessments and chart reviews to varying degrees, which contributes to the variation in coding intensity across organizations.

Eliminating these underlying causes is a necessary component of fully addressing MA coding intensity.

Now, I'll turn it over to Luis.

MR. SERNA: In addition to the effects of coding intensity that Andy just described, favorable selection would also generate higher payments to plans. The effects of favorable selection are absent any intervention from plans.

Favorable selection occurs if risk standardized MA spending would have been lower than the local fee-for-service average. This means that risk scores would over predict MA spending and lead to higher payments.

Given the availability of data, the effects of selection are difficult to measure directly, but selection could have important implications. MedPAC has been examining the effects of favorable selection, and we continue to refine our estimates.

In 2012, we estimated the effect of selection one year prior to enrollment, and we expanded on this method in 2023 to estimate the cumulative selection for all enrollees. Most recently, we refined our method for estimating the effect of selection and presented to the Commission in November. We emphasize that selection is separate from coding and the two effects are additive.

MA plans may influence favorable selection through care management restrictions that are unlikely to occur in fee-for-service, such as preferred networks and prior authorization. In contrast to comprehensive Medigap coverage, MA plans also have an incentive to require at least some cost sharing for many services to avoid unnecessary care.

Beneficiaries may respond to these plan tools by self-selecting into or out of MA. Perceptions of limited networks and delays in care may influence selection and

defeat for service.

In addition, beneficiaries who expect to use more medical services may prefer to stay in fee-for-service and purchase comprehensive Medigap coverage. On the other hand, those who seek less care would likely find MA to be less costly.

In November, MedPAC estimated that favorable selection alone led to 6 to 13 percent higher payments than fee-for-service annually from 2017 2021, which is largely consistent with the findings of other researchers as we described in November. We will continue to explore ways to refine our estimates.

Because MA benchmarks rely on risk standardized fee-for-service Medicare spending, they reflect the higher level of costs associated with the fee-for-service population rather than a plan's enrollees. This results in MA plans experiencing favorable selection.

To the extent selection occurs, it allows plans to bid lower than fee-for-service spending before producing any efficiencies in care delivery. This creates both higher payments for MA plans and introduces bias in the comparison of risk standardized spending between MA and

fee-for-service enrollees.

Every year, the Commission compares MA payments relative to what fee-for-service spending would have been for MA enrollees.

Starting with our March 2023 report, we incorporate retrospective estimates that use actual payments, risk scores, and enrollment when the data are available. When the data are not available, we use prospective estimates, which are informed by our retrospective analyses, MA bid data, and CMS's projections of local area risk-standardized fee-for-service spending.

Our analyses of MA payments relative to fee-for-service spending, start with a base comparison in which MA payments are compared with local area fee-for-service spending and adjusted to have the same risk score profile as MA enrollees.

We then adjust fee-for-service spending for unaccounted differences and risk scores that we explained in prior slides, coding intensity, and favorable selection.

We include uncorrected coding and selection into our analysis so that the MA and fee-for-service populations are comparable. With these adjustments, we project that

benchmarks in 2024 are 132 percent of fee-for-service spending.

Plan bids in 2024 are an estimated 106 percent of fee-for-service spending.

Overall, we estimate that coding and selection cause MA payments to be 23 percent above fee-for-service spending in 2024. That difference translates into additional MA payments that are projected $88 billion.

These higher payments would also increase Part B premiums for all beneficiaries, and we estimate premiums will be about $13 billion higher in 2024 because of spending above fee-for-service levels.

We estimated MA payments relative to what fee-for-service spending would've been for MA enrollees over a longer period in 2007 through 2024. Here, we show MA payments as a percentage above or below fee-for-service spending.

Prior to the effect of selection and coding, the dark blue bars show that MA payments were generally similar to fee-for-service spending since 2017 when ACA benchmarks were fully phased in.

During the pandemic in 2020 and 2021, there was

some divergence due to prospective payments being less accurate. The orange bars show the estimated effect of favorable selection. Between 2011 and 2016, the estimated effect of favorable selection decreased but began to increase starting in 2017, coinciding with changes to CMS's HCC model that made dual eligible beneficiaries more favorable than in prior years.

The gray bars show the estimated effective coding, which has risen consistently since 2017. The sum of all three effects is shown at the top of the stacked bars. We estimate MA payments were at least 10 percent more than fee-for-service spending for comparable beneficiaries in each year.

We project that MA payments are more than 20 percent above fee-for-service spending from 2022 through 2024. Given the increasing share of Medicare beneficiaries enrolled in MA, these differences translate to a substantial amount of MA payments above fee-for-service spending in dollar terms.

Here, the percentages above or below fee-for-service spending are converted to dollars.

Since 2007, we estimate that MA plans will have

been paid $613 billion above fee-for-service spending. Over half of the MA payments above fee-for-service spending will have occurred in the last five years, from 2020 through 2024. These payments in excess of Medicare fee-for-service spending are increasingly driven by coding intensity, which we estimate accounted for the largest share of payments above fee-for-service spending from 2022 through 2024.

For the next steps, we will answer your questions on the topics presented today. We plan to publish this material in the March MA status chapter.

As we mentioned earlier, we will also plan to publish a March chapter covering our methods for estimating the effects of MA coding intensity and favorable selection, which we presented in September and November.

Now we'll turn it back to Mike.

DR. CHERNEW: That was an amazingly important and very impressive and comprehensive presentation.

So I usually say this at the end, and I will say this at the end today, but I will emphasize it now. For those at home, if you want to reach us, please, you can get it, get us at MeetingComments@medpac.gov. We do want to

hear your thoughts.

This has been the result of a longstanding body of work that we continue to refine, but I think for me, for example, the connection of what we've been doing through a wide range of other literature and a bunch of other things provides some comfort that this is just some number that we've come up with, which I happen to know what you've done, so I know that wasn't the case. But in any case, this is really a comprehensive look at a really important part of the Medicare program, and I appreciate that work.

So without further ado, we'll hear from the rest of the Commissioners on their thinking, and this will continue to be a topic top of mind. But I think the first person in the queue is Kenny. Round 1.

MR. KAN: Thanks, Mike.

Thank you for an insightful and excellent chapter.

My Round 1 question is the chapter mentions that payment to MA plans at 23 percent higher than fee-for-service spending for 2024. I believe this 23 percent number encompasses both coding intensity and favorable selection, which differ from what had been published in

prior years.

So for an apples-to-apples comparison, even though I think I know the answer to that, I would like to get this in the public record. What would be the appropriate 2023 number that corresponds to the 23 percent in 2024?

MR. SERNA: Yeah. So, as you mentioned, favorable selection is a large component. It's about half of the component of that. So favorable selection is about 9 percentage points, and then the other 9 percentage points is for multiple factors related to coding, which Andy can describe.

DR. JOHNSON: So we don't have an exact number of what would have been the coding intensity estimate, because we didn't use the same method that we have used in the past to estimate coding intensity. We've updated the method. That updated method accounted for about 3.7 percentage points.

One additional year of coding intensity accounted for about 3.3 percentage points, and then, in a change from prior years, we used to say -- well, last year, we said, our coding intensity estimate for 2021 was about 5

percentage points, and we're going to assume that it's the same in 2023 as it was in 2021.

This year, we said we've got data through 2022. We're going to project to 2024 using a recent five-year trend, and that had counted for additional couple percentage points of the change.

MR. KAN: So would it be the 23 percent then on page 26?

DR. JOHNSON: That's correct.

MR. KAN: Okay. So there's no change, if we were to do an apples-to-apples. If we could restate the March chapter, it would have been 23 percent, similar to what could be the number in 2024. Is that a fair statement?

DR. JOHNSON: You're saying if we use the same methods to do the comparison as in last year as we're doing this year?

MR. KAN: Yes.

DR. JOHNSON: It would have been a couple slides back. It would show, yeah, 23 percent.

MR. KAN: Thank you.

MR. SERNA: I think the only small caveat is that we wouldn't have had an additional data year of coding.

MR. KAN: Thank you.

MS. KELLEY: I have Gina next.

MS. UPCHURCH: Thank you.

Thank you so much for this chapter and all your good work on it.

I have some questions that I believe I sort of asked last time a little bit, but just to get my head around it since we're going to be talking potentially about standardization a little bit later -- and I figure you guys know this. So, in the last few years, there's been a real blurring of the lines between the type of networks and how they work and, consequently, what providers are in or out of network and that kind of thing.

And just a reminder, when a lot of people think, oh, network is just your provider and hospital, it's so much more when people have to make decisions about Medicare Advantage plans and SNFs, and certainly, IRFs, if you know ahead of time that you may need an IRF, as many of them aren't accepting some of these contracts, home health agencies and so on.

So when I see the word "flexibility" in plan development, it makes me real anxious from somebody trying

to coach people in the health literacy challenges, health insurance literacy challenges that people face.

In fact, some Medigap policies are now offering gym memberships and discounts on things. So they're starting to look like Medicare Advantage plans with open networks. So it gets really difficult to explain to people how these plans are different from each other.

So my question is we have HMO POSs. We have a lot of those in North Carolina this past year. Does that fall under page 15, table 12-1? Does that fall under HMOs?

MR. SERNA: Yes.

MS. UPCHURCH: Okay. And trying to explain to somebody when HMO POS is really complicated with confidence. So I think some of the counselors trying to help people navigate, we're questioning, and then you have PFFS. There are fewer of them, but are they going away? When did they go away?

MR. SERNA: They are slowly going away as long as there are not -- as long as there -- what is the rule?

DR. JOHNSON: Two other -- if there are two plans in the same county that offer a plan that includes a network, then the private fee-for-service plan also has to

have a network, and at that point, it seems that the organizations decide, if we're going to have a network, it might as well be an HMO or PPO more likely.

MS. UPCHURCH: Yeah. Trying to explain to somebody, no, this is Medicare Advantage, but it's called private fee-for-service, I mean, it just is -- it's over the top, complex thing to explain to people.

And even the HMO POS, it's difficult. Like you're an HMO, but you could go outside the network, and they may only charge you in-network rates, but we don't know, and we don't know who those people are. They just -- you know, they look at you. Like, there's a little more flexibility in POS than HMO, but I can't really tell you how it works. It's tough. So I'm just putting it out there.

Then lastly, the other trend that we've seen is that a lot of the -- even HMOs will say we have a travel benefit. So 12 months a year, you could be somewhere else across the country and find in-network providers, but you're in an HMO that's supposed to be a local HMO. So it's gotten really complex. I just wanted to put that out there.

Thanks.

MS. KELLEY: Brian?

DR. MILLER: Thank you for this chapter, and plus-one to Gina's comments about complexity happening, consumers navigated -- so it is not a giant morass is really important because you're making these decisions. They're important decisions.

I actually have a pretty simple clarification question. I know that this is a big program. There are 32 million beneficiaries in it. They have a 78-page chapter, which I read, and I know that the staff, the direction of the chair of the -- or the direction of the executive director and the chair. I read this chapter, and my impression was that the tone of this chapter reads like attack journalism as opposed to balanced and thoughtful policy research.

We should aim to be neutral and equalize the treatment of the two programs in the Medicare program overall, traditional Medicare Advantage report.

So noting my impression of that tone, my question is pretty simple. I was wondering if you could name three things that are good about the Medicare Advantage program

for taxpayers and beneficiaries, because I could not see that in this chapter.

Thank you.

MR. MASI: Thanks for that, Brian, and I'd certainly invite others to help me out as I make my way here.

We certainly strive for balance in tone, and we'll look forward to the Commissioner conversation and take on board -- do our best to reflect the Commissioner conversation in the chapter.

I think I'd echo what Mike said earlier that the Commission has a long history of supporting the importance of private plans existing in the Medicare program, and then --

DR. MILLER: But can you name three things that are good about -- can staff name three things that are good about the Medicare Advantage program? Because I didn't see that in this chapter.

DR. CHERNEW: I'm going to jump in now. We're not going to have a back-and-forth about all of that. If you want to send specific comments, that's fine, but I think --

DR. MILLER: I think this is important for the public record because it gets to how balanced we are and how we approach the two programs, and this didn't really feel very balanced in the tone. And as I said, I'm concerned if we collectively can't name three things that are good about a program -- there are plenty of bad things definitely that need to be improved that we should talk about and we will talk about today, but I think it's really important again that it's a neutral, thoughtful policy analysis organization that we can voice good things and bad things. And I didn't see that in here, hence, my question about the tone.

DR. CHERNEW: On this point, Betty?

DR. RAMBUR: Quickly, to help move things along, I would just say that in the time I've been here, there's been growing momentum of concern. And I can say personally, as a taxpayer. the good things about it is people can have a less expensive premium, and they can have gym membership and things like that. But the concern that I feel very deeply is that the magnitude of the spending is a serious difference, and those beneficiaries get less services. And--

DR. MILLER: And --

DR. RAMBUR: Just let me finish. But maybe less services is better. I don't know. But I didn't feel this to be inflammatory at all, because it's part of a conversation, at least that I've experienced.

DR. CHERNEW: I understand --

DR. MILLER: And --

DR. CHERNEW: Brian, just wait. We are going to go through the process that we follow, which is clarifying questions. You've asked your question. We can talk about it later. We're not going to go around and have a debate about that in the midst of Round 1, let alone Round 2. So we are moving on to the next question, and the next person in the queue, Dana, is?

DR. MILLER: I was going to say let the record reflect my question hasn't been answered by the staff. Thank you.

DR. CHERNEW: The record will reflect everything you say, and we appreciate your comments.

Dana.

MS. KELLEY: Amol?

DR. NAVATHE: Thanks for the excellent work here,

obviously, a super important sector, important area.

We have a lot of beneficiaries voting with their feet, moving into Medicare Advantage for a variety of reasons, and I think that reflects the value that the program is offering them.

The question that I have actually is probably a very ticky tack, but I'm just curious about it, which is on -- in the analysis -- I think it was page 50 of the materials in slide 19 -- we differentiate where the HCC codes are coming from, the health risk -- health care risk assessments -- health risk assessments versus chart review. And I was just curious analytically how we're able to differentiate where -- whether they're from either of those sources.

DR. JOHNSON: We started from the encounter records and built up from the physician claims and the inpatient outpatient hospital claims that are the basis for the risk adjustment model and use the same filtering mechanisms that CMS uses to identify HCCs. But in our analysis, we're able to say this encounter is a health risk assessment, this encounter is a chart review, and then we did a comparison of once we have all of the beneficiary HCC

combinations, which of them are only an HRA or only a chart review and were not one of the other, from another physician or hospital service.

DR. NAVATHE: I see. So, essentially, the encounter data actually permit that ability to parse.

DR. JOHNSON: Yes.

DR. NAVATHE: Okay, great. Thanks. Appreciate it, Andy.

MS. KELLEY: Jonathan.

DR. JAFFERY: Yeah, thanks. And yes, thanks for an excellent chapter.

Do you know of any data sources that might be available that would show denial rates and maybe denials that get overturned for MA plans?

DR. JOHNSON: That is something we are working out. There is a question of how carefully we can do that with the encounter data, but Stuart is deep in the weeds on many aspects of trying to figure that out. I think we think we need a little bit more information that we have in our current data available, but that's something we are working on.

DR. JAFFERY: We'll stay tuned. Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. I have three, hopefully, brief questions. The questions are brief. Hopefully, the responses don't need to be too long.

My impression is that brokers have a pretty big role in the growth of MA, and the chapter doesn't -- I think the word "broker" only appears once, and it doesn't really discuss this at all. And I think it's a topic that I at least have known very little about over the years and still don't know much about.

So I guess my question is, do you think it would be worth some more objective discussion of what brokers do and how that might or might not play into the growth of MA and how brokers are paid?

DR. JOHNSON: We can think more about how to include some of that information. We also have, in the past, not had much information aside from what other researchers have done to interview brokers and do surveys with beneficiaries and things like that. So that's the types of information that's available to date.

DR. CASALINO: I think it would be good to have that in there. I mean, I increasingly get the sense that

they have a pretty large role, and that they're paid quite a bit to enroll people in MA plans. So that would be worth, I think, talking about, because the assumption tends to be the growth of MA is all because of people's preferences. And so far, as what I've just said about brokers is true, that might not be completely accurate.

Second question. On slide 26 -- or maybe if slide 26 could be just shown. It could be the case that MA is being overpaid for the reasons you guys are talking about, coding intensity and favorable selection. But it could be the case that MA still does a good job on decreasing, let's say, unnecessary medical spending or keeping people healthier. Let's leave the second out for the moment.

Is there any way to kind of get a sense of -- I mean, I know there's been articles in peer-reviewed literature, but from your work, any way to get a sense of the magnitude of that appropriate decrease in spending, if any? And there's the blue bar on this slide. Does it kind of show that, no, it actually goes the other way? I'm not sure I understand.

DR. JOHNSON: I don't think we can parse out

appropriate decreases in care. I think what is implicitly part of Luis's analysis of the bids relative to fee-for-service is that the bids in total are 106 percent of fee-for-service, but that includes the administrative expenses and profits that are necessary for the plans. But that does imply that their medical expenses are somewhere lower than fee-for-service, so that the medical spending is lower. But there is not an easy way to parse out the portion of that that is --

DR. CASALINO: Yeah, I should have mentioned appropriate versus inappropriate. In the interest of balance it might be worth, if you can, say anything that you feel confident about, to what extent are plans actually reducing medical spending, you know, apart from what happens to the diagnostic coding and favorable selection.

And my last question is, you know, it's interesting that there's been pretty substantial increase, year on year, in diagnostic coding intensity. What is your sense of how that happens? One might think that once MA gets a patient they do a health risk assessment, they have various tools at their disposal to increase the number of diagnoses for that patient. You might think that once

they've done that it's pretty much done. But they seem to be getting better and better on it, year on year.

Why do you feel that the increase has been going up, year on year?

DR. JOHNSON: Part of the answer, I think, is due to other organizations that were not engaged in some of the coding efforts early on, recognizing that this is a way that affects the competition that they have with other organizations. So as a necessary component of their being able to offer the same level of extra benefits as organizations that they are competing with they have to increase their risk scores in order to provide those extra rebates and compete that way.

So I think that is part of the story.

DR. CASALINO: Is it -- and this will be my last question. It would be interesting to know, if this isn't too hard, how much increase is due to what you just said, that plans who haven't been doing so well on increasing diagnostic coding are now doing better on it, and to what extent are plans that already are good at it still increasing the diagnostic coding intensity? That's not worth a lot of extra work, probably, but it would be

interesting to see, if it's easy. Thanks.

And, by the way, magnificent chapter.

MS. KELLEY: Lynn.

MS. BARR: Thank you so much. This is a fantastic chapter. I just have a couple of clarifying questions.

One of them is what are the demographics of the fee-for-service population versus the MA population? Like how are these patient populations different, and how is that changing over time? I don't know if you have that information, but it would just be very interesting to me to sort of understand, is there a pattern here that can help us understand what's going on? Have you looked at that?

MR. SERNA: So in Andy's September paper, when he looked at the changes in the way that we estimate coding, there was a chart that looked at the share of full duals, partial duals, LTI, in MA and fee-for-service. So over time, especially post-2017, you do have a higher share of duals, both partial and full, who are enrolled in MA.

MS. BARR: And that was because of a change in legislation that gave them more money for that, right?

MR. SERNA: It coincided with that. I don't want

to say --

MS. BARR: I didn't say "because." But could we go deeper on this? I think some parsing of the data. So one of the reasons I ask is because there is exponential growth in rural just over the last couple of years. There's something new happening that's extremely threatening, and we need to, I think, identify when we start seeing these changes. It's like what's going on here?

For example, in 2018, they relaxed the network adequacy rules, and then suddenly rural penetration of MA went from 20 percent to 40 percent in a couple of years. And so that's a wild growth rate.

So I was just wondering if there are differences in the population, if we're saying that there's selection I want to know more about that selection. Because it could be that our policies are driving that selection in some ways. So we relax network adequacy and they start selecting rurals, you know. So we could better understand that, I'd appreciate that information.

And what was in the other category on Slide 19, is my other question. Yeah, the HRA chart reviews is

another.

DR. JOHNSON: That is a combination of factors. We aren't able to quantify how much is associated with each, but we have seen and heard evidence that there is an increasing coding intensity when there are capitated arrangements because the incentives to code more are passed on to the provider, and the provider is directly seeing the patient and can document those directly on each E&M visit or any encounter.

We have also heard, in interviews and focus groups, from providers who receive patient assessment forms from plans, where they say this beneficiary had this list of diagnoses in the past and we will pay you extra money to ensure that these diagnoses are included.

So they're not things that we can exactly quantify, but there are a number of other strategies that we've heard about.

MS. BARR: Thank you. Thank you very much.

MS. UPCHURCH: Just related to Lynn's question, is that in the other category? If I'm part of an ACO, fee-for-service ACO, and I'm a primary care provider, or a Medicare Advantage plan, am I equally incentivized to code

things? Because I think people in ACOs, providers in ACOs, are also rewarded for more coding. Okay, it's capped at 3 percent. Okay.

DR. CHERNEW: The ACO program has a bunch of different rules to address coding in ways that are different. The other thing that's different is the MA program is calibrated to fee-for-service, which is a separate program, whereas the fee-for-service program includes the ACOs, and so the normalization works differently. And then there are a bunch of caps that work in a bunch of different ways in the ACO programs.

DR. CASALINO: I think, Andy, you were talking kind of quietly and I'm not sure I heard everything you said. But we have also heard, in interviews, frequently, that physicians are paid directly, as individuals, to in one way or another cooperate with the health plans bumping the diagnostic codes. We've heard numbers like $100 per patient. That's anecdotal. I can't say whether that's true or not, but I don't think this is a trivial issue.

MS. BARR: Can I just do one little follow-up question on my Round 1? Have you ever looked at, since we're basing the codes on fee-for-service patients, right,

HCCs are only based on fee-for-service, which is a problem now because we've got more MA than fee-for-service, and these might be two different populations. That's why I want to really look at the demographics.

Have you ever modeled what would happen if MA, if HCC was only based on MA coding?

DR. JOHNSON: We talked about that in front of the Commission probably six years ago.

MS. BARR: There are no new ideas.

DR. JOHNSON: There are significant challenges to doing that, mainly that you need to know how much spending there was for each MA beneficiary in that year, and then you need to know the diagnoses, which we do know. But I think there has been some work to be closer to that other part of it and to try and model a risk adjustment model on just the MA data itself.

MS. BARR: I'd love to see that analysis. Thank you.

MS. KELLEY: Wayne.

DR. RILEY: Good work. Somewhat piggybacking on Lynn's query about network adequacy, but not directly tied to it but derivative of the quality discussion around

Medicare Advantage is the whole issue of prior authorizations. What can you share about your work looking at that, because we're hearing a crescendo of commentary around the country about authorizations being a big issue now with physicians who take care of MA patients, and from MA patients.

DR. JOHNSON: Some of our colleagues are digging into that more carefully, and I think we will have an update in the spring or in one of the chapters in June. So I think if we can add more information into one of those areas that would be helpful.

DR. RILEY: No, I think that would be very helpful to contextualize our whole discussion about MA and quality, because again, hopefully as a Commission we will look at the whole breadth and depth of the program. So thank you for that future direction.

DR. MILLER: I just wanted to second Wayne's comments and say that I think that adding prior authorization into the MA chapter would add color and context that is currently not present in looking at how the programs, between fee-for-service and MA, are different. One of the key differentiations in MA is the, shall we say,

assertive use of prior authorization for items and services, and I think it is important that the chapter reflects that in order for it to differentiate between that and fee-for-service, which is administered by the MACs.

MR. MASI: Thank you for that commentary. And I'm looking at Dana to correct me, but I think our work around MA prior authorization that we talked about earlier this fall, we're planning to include that in our June report to the Congress. Is that --

MS. KELLEY: Yes, that's right.

MR. MASI: Okay.

DR. CHERNEW: And I would add the theme that we had in our previous discussions around the update recommendations in December emphasized sort of the impact of all of this on the actual provider sectors in a range of ways. And so to Larry's earlier point -- and I'm sorry, I'm not sure if Wayne was last in the Round 1 queue, Dana, yeah. So we're about to transition to Round 2, so let me make a few broader points, because remember, Round 1 is for clarifying questions, and Round 2 we can say everything that you all want to say.

I think academic literature would suggest that

the MA plans spend less money and sort of broadly, on average, provide similar quality, maybe better quality, actually. If you just looked at my work you would find them cheaper and better quality. There are changes over time. It's hard to know what the balance is of where we are now. There's a ton of heterogeneity there across plans. So to make conclusions like we typically make -- MA is doing blank, we're not -- that's a hard thing to do.

But one of the reasons we're going down this path, and I think we're going to be doing more of this, is to understand not just issues around prior auth from, saying "Oh, MA is using prior auth." But again, there is some academic literature on the type of things, the prior authing and the quality of that, and I think by and large they're not causing big harms. There is growing literature on issues about what this means for hospitals that are having claims denied, which isn't quite the same as a prior auth and stuff, but it's becoming a growing issue. I think that's becoming an issue across a lot of sectors we have to look into.

So I think there's a lot of stuff to think through about Medicare Advantage and how the quality

measures work and the impact on the provider system and the system writ large and stuff. In the status chapter we are going through the basic sense of what we know, with the data that we have, on how much they're paid, on what the competition is, on how the quality measures work, and types of things like that.

But again, I said this at the beginning, before we started this, and I will say this again. It says this very clearly in maybe the second, maybe it's the third chapter, third paragraph of the paper in the executive summary. The Commission has believed, and I think continues to believe -- I think the exact words -- I have them up here -- is some version of -- the exact quote is some version of --

MR. MASI: Luis has it.

DR. CHERNEW: "The Commission strongly supports inclusion of private plans to the Medicare program," and that, I think, continues to be the case about where we are. And it's really, as I said at the beginning, an issue of how we balance. Again, in that paragraph it notes that there is added benefits, which Betty said, which we acknowledge, and they are valuable, and there is higher

payment, which we acknowledge and we're concerned about. And so that's, I think, at some level the core tradeoff. So we will go through that.

But I think the message that is laid out in the executive summary of the chapter is a program that offers beneficiaries a lot of extra stuff, and it does so, in part, because of efficiencies, and in part because they are paid more. And we aren't drawing any conclusions now about what should happen, but we are just reporting the facts as we see them, particularly around the issues that you guys spoke of.

So we are now going to go to our Round 2 queue, and people can comment on those particular things.

MS. KELLEY: Yes, Kenny.

MR. KAN: I appreciate the analysis. Thank you. I do struggle with the methodology and assumptions, underlying that 23 percent higher spend, and need help with five things -- trustees report, 85 percent minimum medical loss ratio guardrails; the MA landscape; employer plans, and key technical issues.

I know that we have a very tight timeline for the March report, but I would be very grateful if we can shed

more light on these issues, if possible.

First, the trustees report. Implicit in the MA chapter is that a high percentage of MA would lead to higher risk fee-for-service population, due to more payable selection in MA.

However, Dr. Gail Wilensky, a former MedPAC chairperson, and Ms. Deborah Williams, pointed out in a recent letter to MedPAC, "2023 Medicare Trustees Report stated Medicare fee-for-service spending per beneficiary has declined, in part, due to the movement of dual eligible to MA." This would suggest there is no favorable selection for MA.

I'm confused. How do I reconcile this inconsistency of favorable selection between both reports? Maybe I should take it one question at a time.

MR. SERNA: So all of these analyses are on a standardized basis, so obviously if someone had spending that was 20 percent above the average and their risk score was 1.2, their risk standardized spending would be the average. If someone had spending that was 20 percent below the average and their risk score was 0.8, their risk standardized spending would be the average. They would

have exactly the same standardized spending.

So it's more of a function of risk standardization. So when we talk about favorable selection, we're talking about it in terms of how it affects payments. So in payments, the fee-for-service rates are risk standardized.

DR. CHERNEW: I'm going to give you another take on this, and you guys can correct me if I'm wrong. There is selection on the level -- like duals might be sicker -- and that's reflected in the trustee's report, for example, and if you get more duals you're getting sicker people.

The issue here is selection within that risk standardized amount, so there's a residual, in a sort of regression sense, for every person. You could have someone who has a very high predicted value, say someone who is dual, that still has a quite negative residual on their spending. So the correlation between the residual, the selection, if you will, and the regression, and the level of predicted spending is not necessarily strongly positive. So I think that stuff like that is what's going on mathematically.

I will say the letter that was sent, that was

referenced -- I think it's Williams and Wilensky -- is really quite thoughtful and well-reasoned in what they did, and the staff is looking through the specific things. We will be posting a letter, and I've actually already mailed them, to try and make sure that we have a dialogue of what goes on, as we have with other people, Rick Kronick, for example, who has been very interested in a lot of this work and has done a lot, that we have reached out to. There have been a number of meetings people have had about these things.

This is a complicated analytic issue. It's hard in public sessions to have responses that involve residuals in regression models. I will try not to do that.

[Laughter.]

DR. CHERNEW: Yeah. But I do appreciate the need to reconcile certain facts that you would see, like the trustee's report, and then sort of method and understand how the dots can be connected. One of the reasons why, I think, the staff went through a whole series of other papers about how they did this is to not just tell you that but to show that a range of methods have similar things. And there's other work that comes up with sort of similar

ballpark numbers overall. They change. There's a split between coding and selection in a bunch of different ways. This is a complicated area.

But then was my basic math loosely -- well, let's just see if they're going to agree with me or not.

DR. JOHNSON: Yeah, that's correct. And I think we want to be careful not to assert that enrolling dual eligible beneficiaries is unfavorable. And I think underlying, if you're just going off the raw spending, that that would be the implication, but that's not an indication.

DR. CHERNEW: A dual beneficiary with a negative residual could be favorable selection, relative to what they're predicted to be. I'm not saying that's what's going on. I'm just saying there's aspects of that math that could be happening. You can't just draw the conclusion that someone is high predicted spending and therefore they're high residual, if you will.

DR. JOHNSON: And in that 2017 change to the risk model, where there are separate segments for full, partial, and non-duals, that made the predicted spending accurate for each group. But on average we can still find that they

have actual spending lower than their predicted spending.

DR. CHERNEW: In each group?

DR. JOHNSON: In each group.

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

DR. NAVATHE: Yeah. So I just wanted to try to wrap some of this stuff to clarify in general.

So I think that the comment that was made, as I understand from the Williams-Wilensky letter, is kind of like a trustee's report, is a total Medicare program kind of level view, right? And so these are not at all in tension with each other.

Basically, I think what's happening is we know this. There's good academic research, and colleagues have published on this in Health Affairs. It shows that there's a larger -- there's a growing number and share of dual eligible and low SES and marginalized minority groups that are moving into Medicare Advantage.

So you could have, which is I think what the comment is, that on average, the risk scores or the severity of people or the predictive spending of people is going up in Medicare Advantage over time, right? I think

that's what the trustees are essentially commenting on, that, hey, look, Medicare Advantage is getting a sicker population over time, right?

What this point -- and Andy hit on it very nicely -- is that the risk adjustment model, however, is separate for dual eligibles. So the fact that you have this compositional shift does not mean that there can't be, quote/unquote, "favorable selection," because that's conditional on how the risk adjustment model is working. And that's separate for duals.

So I just wanted to make sure that we clarify that there's a big difference between the compositional shift, which is very well described to be happening, and what is happening underneath, if you will, the risk adjustment model, which is segment by segment, as Andy described.

DR. CHERNEW: So I think we've beaten to death the math point, Kenny. We are happy to have longer conversations with you about that point, but I think just to get around, you have four others, and then we have a bunch of other people.

DR. MILLER: I just tried not to --

DR. CHERNEW: Oh, I'm sorry. Go ahead, Brian.

DR. MILLER: Thank you.

I noticed that the Chair mentioned that Kronick has been in communication with the Commission about this issue. I was hoping that that correspondence, just like the plan to share the correspondence from Williams-Wilensky, will be shared with the other Commissioners because I'm unaware of Kronick's correspondence with the Commission.

Thank you.

DR. CHERNEW: I think in part what happened was Rick came for a meeting. I think there were actually two meetings. I don't think those meetings have specific correspondence to them in varying ways. If you want to talk about what Rick said, I'm happy to have that conversation with you.

DR. MILLER: I think it would be helpful if a summary were shared with the Commissioners since this is such an important topic, and the transparency within the Commission of how things work and decisions are made is important.

DR. CHERNEW: Thank you for voicing that. We

will consider that. We certainly can give you a summary of how that conversation went.

MS. KELLEY: Kenny.

MR. KAN: Question two, 85 percent MLR guardrails. So regarding the 23 percent implied overpayment number, it is important to also emphasize -- and I know the report did allude to that, but it's also important to emphasize that there are built-in checks in the system, like an 85 percent minimum loss ratio requirement and RADV audits, which protect against carriers earning excessive margins. With these guardrails, I believe a few of the large national players make mid-digit, single-margin percentage based on my understanding of the Wall Street public earnings guidances and what is referenced in the bids as the chapter alludes to.

But let's not forget that many of the other smaller community-rooted nonprofit plans lose money or make low single-digit margins. These are not excessive margins. It's just an observation.

Question three on issue number three.

DR. CHERNEW: I don't know if we're going to have time to go through a bunch of answers. I would like to

give some quickly, if I could. If you guys want to take a stab at it, you can, or I could go, and then you can correct me, whichever you guys prefer. These are important questions, I understand, but I also am very, very sensitive that there's a lot of people in the queue that we have to get to. So we're not going to be able to go at quite this pace, but this is an important one.

DR. JOHNSON: I'll just make two points that are in the paper that there's -- that there is about 17 percent of total payments now go to extra benefits. So the 85 percent applies to all of that, but that is a larger pool of dollars going to the MA relative to fee-for-service to begin with.

And the second -- and Stuart's analysis shows that there's the vertical integration that's happening at a greater extent, where the price is paid to providers. What's a little unclear is how much profit is being passed into those prices and how much is being retained by the organization.

DR. CHERNEW: And so a few things. The MLR includes a lot of where this extra money is going, and we clearly acknowledge, if you look at the rebate data, that

there's a lot of that money is going to beneficiaries, right? A lot of that 23 percent is going to -- there's no claim that that 23 percent is all profit that's being passed through.

The only thing that Andy didn't answer that I was going to say is -- and we acknowledge in several charts -- there's widespread heterogeneity across the plans. This is -- when we make a comment about Medicare Advantage, we are making a comment about things on average. There is heterogeneity across the board. In fact, if you look at those charts, that some of them were put up just on things like voting and selection.

I was astounded at the steepness of the slope and the heterogeneity across plans on some of that data.

MR. KAN: Three. Basically, Mike, I'm a plus-one with Mike. It's basically the heterogeneity of the Ma landscape. There is significant variation among the MA plans, as on page 18, which Andy has pointed out. Let us be careful not to throw the baby out with the bathwater, or there will be significant collateral damage. There needs to be a tiered coating intensity adjustment if we decide to do further analysis down this path.

MA is not a monolithic, homogeneous entity but it's comprised of a heterogeneous landscape of MA plans, which include the big national players, provider-sponsored plans, and small nonprofit community-rooted plans. Let us be careful of unintended consequences. If we're not careful of this by recommending steep cuts, this will make it harder for small plans to compete, and they end up exiting the market leading to increased consolidation.

Issue number four, employer group waiver plans. Why are more group MA employee group waiver plans representing 6 million lives switching their retiree plans over and staying in MA? As most or all of these groups use savvy benefit consultants who use sophisticated analytics to analyze the value prop of MA, would this not suggest that MA offers higher quality care at a lower price?

I'm a plus-one with Mike and Larry on this growth, on the importance of really examining the growing body of literature, suggesting that MA plans help to save money while improving clinical outcomes and would like us to look to include some of this in future updates.

DR. JOHNSON: We have not done analysis on why employers are switching from personally underwriting a plan

versus offering an MA plan. But I think according to some of the news articles, it does suggest that it's cheaper for the employer to have their employees, retirees on an EGWP versus a plan-sponsored -- or I'm sorry -- an employer-sponsored commercial plan.

MR. MASI: Yeah. I agree with all that, Andy.

Thanks for asking this question, Kenny.

And I think kind of stepping back at a higher level to some of the other questions that have been raised earlier, I think it's clear that Medicare Advantage does offer value to beneficiaries, to name a couple or a few.

A lot of enrollees have lower premiums than Medicare Advantage. Some enrollees have lower cost sharing in Medicare Advantage, and then, as you know better than I do, Medicare Advantage has flexibility in terms of designing benefit packages and things like that. So I'd say at the staff level, those are some different things where Medicare Advantage offers some value that could be speaking to what you're talking about.

MR. KAN: And finally, key technical adjustments and assumptions. I promise to do a better job than my lousy bowling game from last night.

So how does the analysis reflect reversion to the mean, survivorship bias, selective attrition, and CMS V28 risk model change, which appears to be one-third or 2 percent?

I understand that CMS believes that the change to the V28 risk model especially would help to allay most of the coding intensive differentials that exist currently. How can we be comfortable that we've adjusted for these key technical issues and assumptions appropriately?

DR. JOHNSON: Our current explanation is in footnote 28, which uses some of the CMS's numbers where they are able to estimate the effect of both moving to the V28 model and the normalization factor, which was about a negative 3.1 percent combined effect. And so based on two things, one, looking at the prior year's normalization factors, they were about negative 2 percentage points, but they've been trending down. So assuming about 1 percentage point of that 3.1 is normalization seems reasonable.

And also, the last time CMS did a very similar update to the risk adjustment model from 2013 to 2014, where they explicitly identified HCCs, where there was a differential coding in MA and fee-for-service and removed

those from the model, the effect was about 2 to 2.5 percentage points. So we said 2 percent seems reasonable. They're phasing that in over three years. So we took one-third of the 2 percent and applied it to our projection of 2024.

MR. KAN: Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. First, again, kudos for a really excellent job. My sense is you did a particularly great job of wading through a lot of things that might have been gray or murky and coming out in a rigorous way with some solid conclusions, so excellent work.

Two very brief comments, one a little bit longer.

First, in terms of availability of MA, in the pre-read on page 18, we referenced that 78 percent of beneficiaries live were SNP-served institutionalized beneficiaries. Technically true, but that doesn't mean that those beneficiaries have access to choose an institutional SNP, because the nursing facility has, in essence, an explicit veto power. And there's good reasons for that, but I think we should just qualify that comment, and that relates to other downstream work we've got on our

plates.

Second brief comment, the 85 percent MLR, I just don't think that is as useful a guardrail as it was envisioned to be for -- and we might reference -- we might choose to reference some of the reasons why. One is the proliferation of capitated, delegated arrangements, where essentially, you're just moving the 85 percent to a capitated provider who has very similar motivations to the MA plan, inclusive of code capture, et cetera.

The second reason why that may not be as helpful is that, in reality, there's a fair amount of discretion as to what gets put in the 85 percent in a compliant legal fashion, but there is a fair amount of discretion.

And the third is, in a world increasingly characterized by a set of opaque vertical integrated arrangements, there's all sorts of ways to move, again, in a compliant fashion, profits around. So I just don't think we -- I think it's worth referencing that that may not be as useful a guardrail as had been intended.

The broader comment I have is I think you teed this up, but I think we could perhaps say it even more strongly. The key question, I think, for the MA program

is, how is the playing field structured? Specifically, what are the levers available, the profitability levers available to plans? Right? That's the rubber meets the road of how the program is structured.

And I would posit the following, that in decreasing order of importance -- and you point out some of this, but we could go, I think, even further. The most impactful levers for an MA plan are coding intensity, and again, we've talked about that. There is a huge amount of compliant but very discretionary work that can be done to pump up the risk score.

Selection, some of which is baked into the program, some of which is under control of the plan, by their network composition. You leave out the cancer centers. You leave out some IRFs, right? You've just ramped up the impact of selection.

Market clout. Third, market clout with providers, particularly -- and we've talked about this in the SNF chapter, the ability of plans to -- large plans to beat up on relatively disaggregated small SNFs and push both the rates and the length of stay way down. That's market clout, and it's not helping the beneficiary. And

it's distorting a key -- it's really impacting key players in our system in ways that I think we're not all comfortable with.

And we've talked -- Wayne and Jonathan, you've referenced this. Yeah, UM is great if it's preventing the need for an unnecessary MRI scan that might lead to downstream, harmful interventions. But it's incompletely, at best, understood. It's got all sorts of potential for adverse impacts on beneficiaries and the appeals mechanisms. Although they are explicitly available and can be pursued, are extremely cumbersome and in reality, are not used because of that reason, even when they really should be, so again --

And then the last thing really, I think, as most MA plans have on their list of levers to pull, is make the care better in a way that keeps chronically ill beneficiaries out of the hospital. That's the pot of gold at the end of the rainbow, but it's really the weakest lever.

Again, I think we perhaps could sort of dissect that a little bit. What are the levers that are available and used today versus what do we want from a public policy

perspective? We would want a program that's structured in a way that leads the MA plans to put more emphasis on the lever around improved care coordination, et cetera, for high-risk beneficiaries.

So, again, great work, guys.

MS. KELLEY: Stacie?

DR. DUSETZINA: Thank you, and great comments. Plus-one to Scott, and I'm going to pile on a little bit on that space.

I'll also say the chapter is excellent, as always, and I think one of the things that came up earlier from Brian's comment about tone being negative, I actually think that I didn't read it that way, but part of the reason why I think you might be able to get that feeling is that we're a data-driven organization, and we have clearly said over and over and over again that we have a lack of information on what is happening, the quality of the program. We can't assess it in the same ways, and so I think that can sometimes filter through in a way that maybe makes it seem -- because we have incomplete information that we can't really say one way or another, but we know we pay a lot for Medicare Advantage.

And one of the things that I reflect on often is that Medicare Advantage seems to be really great for many beneficiaries, but then it's not -- when it's not great, it's really not great. And maybe this context goes more in the work you all are doing separately on prior authorization that was mentioned before.

But I think having a nod to the importance of being able to evaluate the access to timely specialty care, it's a thing I've brought up a few times is thinking about the network adequacy for some for cancer centers, for other really high-cost services that do require specialized care. To me, that's the crux of where I think this could really break down for beneficiaries.

And it's often something that's hard to measure when it's not going well because it's a relatively small part of the population. So when you look at those averages of how people are experiencing their plan, it might look really good, but then beneficiaries with very high needs may be having a really different experience.

Maybe a long-term goal is to think about how to better capture those negative experiences of beneficiaries who have high needs, and maybe long-term goal, having that

baked into the quality is beneficiaries' assessments of delays in their care and access to those high-value groups.

I will also give a nod to NPR, and Kaiser Health News had a piece last week about an experience of someone in a Medicare Advantage plan who was locked in because of an inability to be able to get the cancer care that they need.

And then I wanted to just also note -- and this maybe, again, is not necessarily for this chapter, but just big picture thinking about how people are getting into plans and making those initial choices around MA versus fee-for-service and the importance of if they're coming in through Plan Finder or they're coming in trying to think about their health now. How do we help people think about their long-term health needs? Because when you're 65 and aging into the program, your health at that time, you may not be thinking about your long-term needs, which would push you to think harder about the specialty networks that you may have access to or not.

But I'll say I think this is a fantastic chapter and great work. Very important. I would love to see a little bit more on the context of some of these quality

measures emphasized.

Thanks.

MS. KELLEY: Cheryl?

DR. DAMBERG: Thank you.

I just want to start out by saying this was such a meaty chapter. There's so much to chew on, and I think that's evident from all of the comments you're receiving. This is excellent work, and I think this is a very complex landscape, as Kenny noted, a lot of heterogeneity in trying to really unpack that heterogeneity and understand what it means for different subgroups, different types of plans. And I think that you are making good progress trying to go down that path.

You know, certainly more can be done in that space, but overall, I think you conveyed something that has been sort of nagging for me, which I think you have conveyed a sense of urgency around these various issues, which I very much appreciated. You know, particularly as the role of MA has grown, we have to be mindful that we're appropriately paying and that we're not overpaying, and trying to unpack that. So I very much appreciated the care with which you were trying to triangulate your various

estimates, because I know this is very complicated to try to unpack.

And I think the reason I feel this sense of urgency is we keep coming back to this issue that MA has never yielded aggregate savings to the Medicare program, despite that being one of the core goals of that program. And as a taxpayer I am concerned about the cross-subsidies that are occurring from taxpayers and beneficiaries to support MA. So I think we have to be mindful stewards of resources that are used in this space.

And to that end, we know that extra benefits are a significant portion of MA, and that they are valued by Medicare beneficiaries. But I think we lack data to really understand the use of those benefits and whether they are conveying value to the beneficiary. So I would continue to underscore the need to have data on the utilization of those benefits be made transparent, not only to the public but to those of us who are trying to understand what's going on and set appropriate policy.

The other thing that I would note, I am concerned about vertical integration in the industry and sort of our lack of understanding, and I think more can be done to

improve the data that's captured, to try to understand all of these different relationships between plans and their different providers and what the impacts are, in terms of how care is delivered as well as what it means for quality and ultimate prices.

I want to give a plus-one to a number of things mentioned by other Commissioners, in terms of including data on denial rates, information on brokers and how that space works, Lynn's comment about additional demographic information, to understand how this population has shifted over time.

And I would also note, and I think this is something that Stacie was getting at, which is I think we can do more to unpack the quality and access information to try to understand disparities, and whether that's by duals versus non-duals, disabled, different racial/ethnic groups. I think that would be an important add.

And then lastly, in terms of adjusting for coding intensity, I agree that the uniform approach is not optimal, and that the proposed tiered approach to doing adjustments would be a significant improvement.

Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thank you, and I hope that I'm able to make my comments without interruptions. They fall into several categories.

First, just a brief on-point response to Stacie's comment. I 100 percent agree that sometimes it appears that the chapter may seem to be negative because we have more information, and that we are data, or strive to be a data-driven organization. Two caveats I note for that. One, the Medicare Advantage program has a star rating, but the fee-for-service program does not have a star rating. And I am fully supportive of having a quality, regulation, and oversight system that treats the fee-for-service plan and the MA plan on an equal footing. And the fee-for-service marketplace does not have a star rating or a star quality rating bonus program, and that is something that should be addressed.

I think, secondly, on the data-driven organization component, the Commission, from my understanding, strives to be that way but it ignores valid analytical concerns, and we are not a data-driven organization. So we are a decision advisor.

So my comments go into a couple of areas. I have some broad comments and then I have some specific comments. In the interest of time I'm not going to post specific questions.

With this chapter we ignore a wide range of analytical and policy concerns that I have expressed multiple times. As a consequence, the record is incomplete and the analysis that we undertake is fundamentally flawed. I am disappointed, as I have previously provided this input to ensure complete lists and accuracy of the record in order to strengthen the analysis, and it has been ignored.

Policy discussions are complete and engage in a wide range of ideas, options, and frameworks. It is not lost on me that this discussion is occurring immediately prior to the CMS Medicare Advantage rate notice, which we can expect to see in the coming days to weeks. The Chair has noted that he is in regular communication with CMS leadership. This gives the appearance that MedPAC as an independent and thoughtful policy organization is being hijacked for partisan political aims.

While the organization's analysis appears to be slanted to arrive at a foregone conclusion in order to set

up and provide political cover for a massive MA rate cut, I note the many intellectual inconsistencies in this document, which I have spent untold hours reviewing, that result in intellectual somersaults.

For example, Figure 12 appearing on page 31, suggests that overpayments have doubled under the current administration. What conclusion should I reach, that CMS leadership is unable to oversee the MA market or that the recent and appropriate RADV audits are totally ineffective? My sense is that both of those conclusions are wrong.

Other inconsistencies remain unpressed, such as the inclusion of protein calorie malnutrition in DRG, complicating condition payment adjustment but not in MA risk adjustment. As a clinician, the patient who is starving and has muscle wasting with cachexia does not change if Medicare pays a hospital or a health plan.

I will now focus my thoughts here on coding intensity. As I mentioned, at our previous discussion in September of 2023, we must adjust for undercoding in fee-for-service. My sense was that we agreed. I also mentioned that we need to address multiple methodologies and compare across multiple academic scholars, not just the

work of Kronick, in addition to comparing to MedPAC prior methods and industry Milliman methods in order to ensure the validity of the analysis and the defensibility of our position. This suggest was also completely ignored.

I also have continuously noted the need to account for the three components of coding intensity in discussions about IRFs, hospitals, and Medicare Advantage.

Coding intensity has three components -- clinically appropriate coding intensity, abuse and upcoding, and fraud. Nowhere have we entertained in this document that some degree of coding intensity may be, in fact, clinically appropriate.

As a Commission it appears that we do not like chart reviews and health risk assessments, which is a valid concern that I share. Much of this information, though, is clinically useful and may be missing in fee-for-service, as many other Commissioners have noted.

Paying for a diagnosis that is not clinically addressed in a plan year is a failure, but it is a failure of regulatory policy, not a failure of payment. The impetus is on CMS to find a way to incentivize plans to use this additional clinical information to meaningfully help

improve beneficiary health and functional status. Again, pragmatic solutions are ignored in the blind pursuit of a political aim of a payment cut. As I previously suggested, why do we not suggest that we use artificial intelligence to crawl charts across the fee-for-service and Medicare Advantage for diagnosis codes to help answer this important question about coding intensity?

Another ignored suggestion that I have made is that if we think that this is a serious issue for Medicare Advantage, we should recommend to Congress to spend several million dollars to do the hard work of chart audits so that we can appropriately scope untold billions in savings.

In conclusion, our work on coding intensity is incomplete, and ironically, using a term here that I truly hate to use, cherry-picked, all with the goal of supporting a partisan political agenda.

I will next turn to favorable selection. I mentioned this at our November meeting, yet my concerns were also ignored. We have included EGWPs in our analysis, as my colleague, Commissioner Kenny Kan mentioned, a change that is not valid, that is not a plan option available to the general public.

We have also not addressed the alleged increase in favorable selection as MA penetration has grown from 33 to 51 percent. As I mentioned at that meeting, intuitively it seems like selection would decrease as market penetration increases. If anything, this suggests that fee-for-service was, in fact, healthier when MA penetration was lower or that the MA population historically was sicker, something that is not consistent with our past reports. This suggests that our analysis methodology may be fundamentally flawed.

Another question that is unanswered in November, and again, unfortunately, unanswered today here, in the following calendar year, is that in the setting of appropriately increased marketing and advertising regulation, including under this current administration, which has done an excellent job policing untoward broker behavior, what do we propose as the operational business mechanism by which the plans are harvesting, if true, healthier beneficiaries? Policy must be executed in the real world, not just in a book chapter.

Another question unanswered in November and today is that knowing that many plans have multiple related lines

of businesses built around core administrative functions as national plan carriers, do we see this degree of favorable selection in other markets, namely the Medicaid managed care organization markets, and have the staff discuss these concerns with MACPAC.

As a former special advisor at the Federal Trade Commission, much of the market concentration discussion is just plain wrong. While we may not like CVS or United Health Group, a carrier offering plan products to 80 to 90 percent of the market is not problematic. Rather, having 80 to 90 percent market share is.

As an example, I am also confused at the assertion on page 54, which reads that, quote, "Between 2022 and 2023, the National Medicare Advantage marketplace concentrated further." The Department of Justice Antitrust Division, in Aetna veterans. Humana, rightly asserted that the geographic market for Medicare Advantage is at the county level, as plans compete at the county level. Do we think that the Department of Justice is wrong?

I share the other Commissioners' concerns about market concentration in the Medicare Advantage marketplace, but we must do this analysis correctly and following the

example of the excellent work at the Department of Justice under multiple administrations.

My other comment about consolidation is why do we not discuss the high regulatory barriers to plan entry? What is the annual programmatic compliance cost in terms of labor hours and dollars? The attack on vertical integration ignores longstanding evidence in this space. I share my fellow Commissioners' concerns that vertical integration promotes a lack of transparency in a marketplace and an unclear display of how funds are used and distributed for beneficiaries and support beneficiary clinical care.

That being said, when we write and say that coding intensity is the likely driver of vertical integration, on page 65, and we do not mention clinical integration as an equally valid rationale for vertical integration, our position is not defensible.

My concluding thought is that MedPAC is a 25-year-old policy institution, and I, along with the rest of the Washington policy community, will not stand by idly as it is hijacked for partisan political aims. Thank you.

MS. KELLEY: Okay. I next have a comment from

Greg, which I will read.

This chapter is remarkable, comprehensive, lucid, and meaningful. I'm a huge MA fan, but unlike the author of one letter that we all received, I don't think that all MA plans add value, and certainly not equally.

Greg mentioned in our last couple of meetings a study by Faegre Drinker that found that integrated health plans, plans owned by providers or integrated with providers where providers ultimately carried the capitative accountability, statistically outperformed other MA plans on 70 percent of 114 measures, and they were also higher on most of the remaining metrics, but not at statistically significant levels.

Greg thinks that this illustrates that there are two ways to succeed in MA -- be successful at coding and risk adjustment documentation in order to maximize payment, as consistently illustrated in MedPAC reports and presentations, most recently in September and November, or two, actually manage care to reduce costs and enhance health.

We should obviously encourage the latter. Streamlining, or even eliminating individual-based risk

adjustment payments -- there really are ways to do this, and as it's been successful in commercial and Medicaid programs -- is a path we should constantly pursue. And we should encourage all MA plans to provide correct incentives to providers. Most MA plans currently pay most providers on a fee-for-service basis, negating the real purpose and potential for which MA was created.

Furthermore, encouraging provider-focused financial accountability and mitigating the risk adjustment industry would significantly reduce the tailwind fueling consolidation. Greg believes that MedPAC can provide guidance in both of these areas, which would enhance the benefits that MA provides to both beneficiaries and the Medicare program.

And next I have Jaewon.

DR. RYU: Thanks, Dana.

First of all, following Greg's comments, I completely agree with everything that he said. I also agree with many of the comments made earlier about the chapter. I thought a huge body of content, and trying to summarize all of that, I thought you all did a great job of that.

I think it hits on all the key points around the program as any good update should, and I think the growth in the program underscore -- someone used -- it may have been Kenny. Someone used the term "value proposition" earlier. I think the growth inherently demonstrates there is a value proposition to the program, and I do think that there are a lot of redeeming qualities of the program as well.

I just had a couple comments. One, I like that there's a high-level attention called to the growing challenge around the framework. I think you make mention of it -- it's on page 17 of the reading materials -- that as MA grows in share, some of the framework is inherently challenged, right? The benchmark approach starts falling apart when fee-for-service share drops below certain levels. And I think we're quickly approaching if not beyond that. So I wish we had called even more attention to it versus a quick sentence or two that's referenced, because I think it places a lot of the other work and other recommendations against a pretty good context. Whether it's the risk adjustment discussion or the benchmark discussion and recommendations that we've made, I think

it's really important to keep orienting people to the fact that the current framework isn't set up to achieve those things in an elegant way, given the environment we find ourselves in with MA share being 50-something percent.

The second point -- and I think there was earlier discussion on heterogeneity -- specifically geographic variability, I like that you all mentioned and had some discussion around this. The Figure 12A, in particular, with identifying California and Florida -- and I think they tend to be the ones more on the outlier side of the skew with risk adjustment -- I think there's maybe even an opportunity to go further. Are there other outlier markets beyond just California and Florida? And if you remove them from the analysis, how much, quote/unquote, "overpayment"? How much of a factor remains? Because I think there is a significant story of outliers here that may be contributing to what on average may appear to be at levels beyond what may actually be the case. So I wish there was a little more discussion on the heterogeneity specifically as it pertains to geography.

And then lastly -- and this gets back to Greg's comment on the vertical integration -- I completely agree.

Vertical integration can be a great thing. It can be a not-so-great thing. I think the clinical integration aspect and trying to strive for a program that incents and sort of recognizes those efforts versus just being a coding or risk capture game, I think that's where we should strive to be.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I'll just have to do a plus-one on Jaewon's comments, particularly using a fee-for-service as a benchmark. I think I raised that at my very first MedPAC meeting, and I didn't realize how complicated that simple statement would be. So I just wanted to plus-one those.

Thank you for such an illuminating and complex chapter, and in the interest of time, I'll be very brief. I'm really putting my comments as a taxpayer and a potential Medicare recipient.

I appreciate the details on the paradoxical nature of consolidation and also the points that Kenny brought up as well as Scott's on vertical integration and others. I think that's important.

I wanted to go back to Larry's comments about the

importance of brokers and driving. I was not familiar with that. I did not know that, and this is really important to me because there's pretty clear evidence that people are very unclear about what they're buying. And transparency is essential for any kind of market to work efficiently. So I certainly think that that's incredibly important.

It goes back to what Stacie said about high-risk people, and I think Larry and others have -- and Greg have talked about the utilization piece. I'm very concerned overall in health care about overuse of low-value care. So when I look at the lower use of services in this group, I can't tell if that's because they're really being effectively managed or if they're not getting services that they need. And I think that's an absolute razor's edge, and so to the extent that nuanced quality measures could be really evolved over time, I think it's really important.

And then Cheryl said it so much more eloquently than I did. So I'll just say I also feel a sense of alarm. I feel concern. I am not concerned that companies make money. However, if they are having the kind of revenue not returning anything to the taxpayers and if people are not getting the services that they need, particularly as they

become more high risk, that to me is a really serious ethical issue.

So I'm really thrilled with the work that we've taken on, and I know there's a lot more to do, but thank you very much. And I appreciate the Commissioners' comments as well.

MS. KELLEY: Lynn.

MS. BARR: Thank you, and I also really, really appreciate the staff and the work that you guys do and feel that you are very unbiased and highly ethical. And I admire you all very much, and I want that on the record.

The slide on page 18, there was some comments about trying to understand the difference between the types of providers. My experience in that, in that graph, is you've got 80 percent of the beneficiaries -- or 83 percent of the beneficiaries that are on the high side, right? And then you've got 13 percent -- or 17 percent are on the low side. I've worked with a lot of provider-based health plans. I would guess that that's who's there and like local nonprofits which are really focused on patient care. And many physicians that I've talked to are a little disgusted by the whole coding game. That's not what

they're there for, and so that's not their focus. They're trying to do it the hard way, and I think they're being penalized by the large organizations that are doing more aggressive coding that they can afford to do as well, right? So there's a lot of capital that's required.

I was wondering if on that graph, if you could label those, color code them perhaps as provider-based nonprofit so that you could get the visual of who's really being disadvantaged by this. I would appreciate that.

In my opinion, Medicare -- we have overpaid Medicare Advantage tremendously. I believe this is what the data shows, and that we have allowed MA to buy the market. And that is why MA is growing. It's not because the quality is so great. People don't love the prior auth. People are leaving their plans a lot, right, for people that don't tend to change health plans?

So this is not the big, lovely, glowing success that everybody says it is, and we continue to create policies that drive people into these plans.

And I was shocked when I looked at -- the benefits are irresistible. We're talking about free premiums, right? Has anybody looked at what -- with the

new income requirements on Medicare beneficiaries, do you know what a Part B payment looks like now for a high-income beneficiary? It's $6,000 a year. $6,000 a year. Now, I don't know. That's not going to work into the MA plan, right? So if that person goes into an MA plan, they don't pay the $6,000 a year. The MA plan doesn't pay us the $6,000 a year, do they?

DR. JOHNSON: Beneficiaries are still responsible for their Part B premium when they join MA, but there are some MA plans that reduce the Part B premium. I think they're capped at reducing it to the -- not the high-income share but the base amount.

DR. CASALINO: More clarity on the Part B premium issue would be very helpful, I think, in the chapter. It's not easy to understand, and I'm not sure I understand it still, actually.

MS. BARR: Yeah, I'm struggling to kind of put it together.

But I'm just saying we're a capitalist society. I am not ashamed of that. I will do things for money, right? I'm an American, and so if you put enough money in front of me and say, "It will be great. Don't worry," I'll

do it. All right? You know, if it seems like it's apples to apples.

And so I think that we've created untenable incentives for people to be in Medicare Advantage, and then we pay brokers $600 to recruit them, and they get $300 a year every year they stay in that MA plan. That's 6 percent, right, 6 percent up front, 3 percent per year.

By the way, a really successful ACO would make 3 percent. All right? For all the work we would do, we would make 3 percent, the same amount that we pay a -- that a broker gets paid for just putting them in an MA plan. I think that's highly unfair.

So these numbers to me are untenable, unsupportable, and are -- and we, because we are fee-for-service, are skewing the markets. And by giving these huge amounts of money to these plans, that they can then give away to patients, so they come into their plan, and they have -- and all they have to do is code. They don't have to actually give better care, and we don't really have evidence of better care.

So I don't believe that we've achieved our goals from a policy perspective, and I think we've got to do

something to reduce these payments to Medicare Advantage. And what I would love to see us do is just let them risk-code against themselves.

If their HCC scores are -- because fee-for-service people don't code. I mean, I've spent 10 years trying to get doctors to code for ACOs so we could get our 3 percent bump. They don't code without these huge incentives. And so we -- so basing HCC coding on a subset of providers that don't code is ridiculous. And that's why there's such easy arbitrage for them and why the money's so big and why they are the most profitable insurance companies in this country and the most profitable plans. And that is a problem that where Medicare is the least profitable payer for doctors, the least profitable payer for hospital, except Medicaid -- don't forget Medicaid -- and at the same time, we give all the money to these plans. It is unconscionable.

Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you.

I do think that the chapter in its final version is really going to be a strong resource for others because

it has a lot of really good information. So I think it's going to be a good primer for those that don't know much about Medicare Advantage who are looking for a read to understand it a lot better. So congratulations on pulling all this together.

The other thing too is I just want to acknowledge the tireless efforts and, in my opinion, the nonpartisan leadership of our Chair. I think he's done an admiral job in leading this body, and I just wanted to put that on the record.

I'll dive into my comments, and I just wanted to start off with the positive first, because I think it's really easy to kind of beat up on MA. But I do think that over time, this can be still a viable path for providing cost-effective and high-quality care.

I think what's happening is that as the number of beneficiaries are choosing MA, we've crossed the 50 percent threshold where we're gaining this experience in terms of how the program is behaving or not behaving relative to our goals. And we're understanding in a better way where the opportunities are for controlling costs as well as providing value.

I do think that from a patient perspective, there are some advantages. The benefits that are being provided around dental, vision, and hearing are rather attractive. Some plans even offer medical transportation for its beneficiary. There's some advantage to all of that.

And most importantly, an increasing number of patients when they're matching up fee-for-service versus MA are thinking that this is a better fit for their health care needs. So there is some positive things going on here.

The concerns that many of the Commissioners articulated, though, are valid. The primary drivers for profitability for the health plans are actually concerning. The selection bias, because we use preferentially the fee-for-service beneficiary databases, is problematic, although I do think it's fixable. We just need to be able to pull the MA data into the analysis so we can create better models for bidding and so on.

The coding intensity is problematic too, but I think it is very fixable through some sort of adjustment factor.

I think one of the things that I do want to see

on my wish list, anyway, within the report is to differentiate a little bit between coding intensity and, at least from a quality perspective, the need for accurate documentation, that it should still be encouraged in order to understand the beneficiary security complications when they occur, the clinical outcomes, and the prevalence of certain types of comorbidities within their patient population. And that information is really important over the long term as we improve upon the program to make it more value-added so that these MA plans can be incentivized to actually create interventions to be able to improve the clinical performance of their patients and have better outcomes. So I think that's a critical differentiation there.

Right now, though, are they improving care? I think it's an open question. I don't think we have the data yet, and as far as what measures should we be looking at, I'm just going to reserve those comments until later, because you're looking at a transition from quality-based metrics to value-based metrics. So I'd like to see what the team comes up with.

I think all of this really does -- as a

precursor, we need to have better data, of course. That's been an ongoing theme. We need to have data that is accessible so that we can utilize it for advantage.

It's really unclear to me, though, also with the MA program, particularly following yesterday's meeting on payment updates and our strategy, how that actually translates into the contract negotiations that MA plans may have with different hospitals and providers. And are we actually aligned in providing value-based care and improving primary care as a function to really make sure that the beneficiary's clinical outcomes and their quality of life is optimal and how we're serving vulnerable populations? So I'm not quite sure if our fee-for-service approach is actually translating into our MA strategy.

With that being said, a lot to do, a lot of work ahead. I think it's exciting work, and I think many of these problems are inherently fixable over time. And we'll just kind of keep working at it. So thank you again for your report. I really appreciate it.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, gentlemen, for the fantastic work here, and it's very striking, listening to

all the Commissioner comments and having read the reading materials, just how complicated this is. And I think Stacie does a nice job of articulating that. We're a data-driven organization, but it is hard when there's not complete data.

And the complexity also is -- it's, you know, program and policy oriented as well. There's a number of factors here that make MA and fee-for-service comparisons very, very challenging. There's differences in benefit design. There's the Medigap, Med Supp differences. The ability to move in and out of MA is challenging. That certainly may play some role along with the fact that MA has the maximum out-of-pocket and fee-for-service doesn't.

I think, in some sense, at a macro level, we shouldn't be surprised that there are differences across the program, and I think doing our best to try to pull the data together, of course, helps us to better understand what's happening underneath the program. And then we have external factors, I think, just sort of plus-one-ing other Commissioners around the brokers and the incentives there that are certainly complicating.

And I think at a very high level, try to

synthesize all the complexity, I think it would be easier if we weren't in a situation where we're kind of, as a society, paying more to get more. It would be easier if we're paying less to get more. It would be straightforward. If we're paying more to get more, I think it's much more complicated to understand what is the value of how much more we're paying to get what we're getting more. And that's very challenging, I think, and part of the reason is because we don't have all the data, and perhaps even if we had all the data in the world, it would still be challenging. So those are kind of my high-level points.

There are a few points I just wanted to quickly highlight, particularly in terms of hopefully areas either kind of echoing other Commissioners or, in general, that we might be able to push forward more broadly on the kind of Medicare Advantage front.

One thing I think that's worth noting is, because of some of the points that Kenny and others have highlighted, there has been this pretty substantive shift over the past decade of groups from minority populations, from low-SES populations, end-stage renal disease

populations now that have shifted or are shifting into Medicare Advantage.

So when we think about equity across our sector, I think it's impossible to think about equity without thinking about what's happening in Medicare Advantage.

And yet I think a lot of our analysis, a lot of our data in this space ends up coming from fee-for-services, just because we have easily -- more easily accessible data.

And so that's one thing I just wanted to point out, that because if you look at the population overall, of course, for example, Black race beneficiaries are a minority, and so they're a minority, but if you actually look at it from the perspective of what share of Black beneficiaries are in Medicare Advantage versus fee-for-service, it's a very different picture. That goes, I think, for other minority groups as well. So I think it's an important lens for us to have as a Commission as we go forward, thinking also about our goals around equity of care.

Second point I wanted to make is also sort of plus-one-ing other Commissioners -- Kenny, Cheryl, and

others -- around the plan variation, and I'm hoping that over time -- I know we have a very full plate, but that analytically we can pursue that more and more because I think there is -- there are very different flavors of Medicare Advantage. I'm not sure I would actually quite dichotomize it the way that Greg did in terms of there's a right way and a wrong way. I think there's a milieu of different strategies, and I think they're probably being pursued in a bunch of different ways, but nonetheless, I think they're -- the effects for patients, the way that the benefits are constructed -- and I'll talk about benefits in a minute -- I think all those things vary. And it would be helpful to understand how that variation actually plays out.

Plus-one to Larry about brokers. I think if we could take a more concerted effort to look at that, I think that would really help.

And then the last thing I wanted to highlight is coming back to this point around the data. I think one of the other challenges for us is, thinking back to the Dartmouth Atlas, we have understood a lot about our nation's health system through the Medicare fee-for-service

program, just again, because of data availability. And so I just wanted to highlight for us that we're getting better data for Medicare Advantage over time, but I think that our ability to actually understand what's happening under a tax-paid benefit is really fundamentally important, not only for the perspective of administering MA versus fee-for-service but also for the national -- for our ability to understand what's happening nationally in the health system. And I think that that -- I don't think that belongs in our reading materials or chapters. I think it's just an important point, again, for us to understand.

Thanks.

MS. KELLEY: Larry.

DR. CASALINO: Look, there are strong conceptual reasons to think that Medicare Advantage can do good things for patients and for the country. And I won't go through them now but they're fairly obvious. And I think there is a lot of heterogeneity among plans, as other people have said, not only in their coding intensity but in the value they bring. And it does seem, more anecdotally than anything else, that the plans where physicians are heavily involved -- some of them, like Kaiser -- do seem, to some

extent, to live up to the conceptual advantages of MA. And then there are others that are probably on the opposite pole.

So there's no question that conceptually MA could do good things. The evidence for that is not so strong right now, right? I mean, the program's like four decades old, something that, and as a couple of other Commissioners said, it still hasn't saved a penny for Medicare or the country, and quality is still uncertain, on average.

So two things can be true. One, the program could be great, right, which I think is pretty good. It isn't great, but it could be good. But the other thing, still being way overpaid. And I think that the chapter doesn't spend a lot of time on why Medicare Advantage could be good, but it does say that it could be good, and it points out, I think, as we always do it, the Commission has been very supportive of Medicare Advantage for many years. But still, that doesn't mean it should be overpaid.

And looking at the figures from the staff, they could be wrong by 50 percent and they would still be stunning, right. So $88 billion for coding and selection, some of which is under the control of plans, as Scott said,

not all, and another $15 billion for not a very effective quality, that's $101 billion a year in overpayments.

What is that $101 billion used for? It's used to buy other smaller MA plans, get rid of them, so we get more and more concentration. It's used to buy physician groups. And actually, if you look at an organization like United-Optum, it's used to buy many other parts of the health care system as well. And $101 billion will buy a lot of lobbyists, right. So the more these companies get bigger, with the overpayments from Medicare Advantage, the harder it will be to change policies so they don't continue to be overpaid.

So it's hard to see this as a good thing, even if the estimates are not totally correct, although I think the work has been very carefully done.

So I think that it's hard to see those kinds of numbers, and the results of those kinds of numbers in terms of the changes in the structure of the health care system and not feel anything but a sense of urgency, especially when this goes on year after year after year.

That's the main point I want to emphasize, and it is hard for me to take that in a kind of laconic way.

Just two other specific points. The 85 percent MLR was intended to be a guardrail, and there's lots that can be said pro and con to that. But it does clearly have the strong unintended consequence of giving health plans a real incentive to buy medical groups. So for better or for worse -- you know, it could be a good thing that they're buying medical groups, but it certainly does that. And I think that's stronger than its guardrail effect right now.

I will say, just anecdotally, that in the '90s I spent a lot of time doing a couple of hundred interviews with the leaders of medical groups in California, and health plan and hospital leaders as well. This is when California was kind of in the lead of the so-called capitated delegated models, where health plans and physician groups were working pretty closely together, especially to try to reduce costs. There wasn't that much emphasis on quality, frankly.

But when the local nonprofit HMOs basically, that were doing what was not called Medicare Advantage then but was, when they were working closely with the big medical groups and IPAs it worked pretty well. But when those local nonprofits start to get bought, like PacifiCare by I

think United, and so on -- they were all bought in a pretty short period of time -- the medical groups and universities said everything changed, and we really weren't working together to fulfill what could be the promise of what's now called MA. So I'll just leave that there.

And the last comment about prior authorization, again, conceptually there are advantages to it. You know, I'd avoid unnecessary MRI scans, blah-blah-blah. But there is some academic work on this. The cost to physician practices in money and also just interruption and annoyance for physicians is enormous, and that doesn't count the cost of patients, of having to wait, of uncertainty, of being afraid I'm not going to be able to get what I get.

So I could fill an hour -- and this isn't the time for it -- telling prior authorization stories that would just kind -- some would make you laugh and some would make your hair stand on end. So it's not a trivial issue, and it is expensive.

Okay. That's it. First, I did the balanced part, then the foaming-at-the-mouth part.

MS. KELLEY: Jonathan.

DR. JAFFERY: Yeah, thanks. We're way over time,

so I'll be really brief, and first just thank the staff and the leadership for all your tireless work to make this all happen. It's always a great chapter.

I was going to put some points around the last thing that Larry said, about sort of the downstream impact on the ecosystem that a lot of the MA practices that Larry, Scott, and others have talked about, or utilization management and prior authorization and denials.

You know, the fact is it's not really a bug of -- it's really sort of a feature of their approach. There's a tactic around keeping things in accounts payable longer. Medicare fee-for-service has to pay within 30 days, and if you don't you pay interest, but I don't think that's the same case here, if I'm not mistaken, and they do delay the payments and then, you know, 30, 60, 90 days extra, keeping millions of dollars in your coffers has its advantages.

And the last sort of specific thing I'd say about the impact, Larry talked in general. But health systems are now employing many, many people. Large systems will employ well over 100 people to deal just with the issue of prior auth and working on denials in a way that, you know, just has exponentially grown in the last decade. And those

are real non-value-added costs to the health care system across the board.

So again, thanks for really amazing work.

MS. KELLEY: I think that's the end of the queue.

DR. CHERNEW: Great. So, you know, we went long. It's an important topic. There's a lot to say. So I think it's fine to get everybody's views out on the table.

A few things. I appreciate all of the engagement from the Commissioners. To the staff, I think you did an exceptional job, and I think you heard that in many, many, many, many comments, so thank you for that. I know much time and effort and work you've done to bring us the material that we saw, and I very much appreciate that.

There is a lot of discussion here and some very common theme -- heterogeneity across plans and a bunch of things. As I said at the outset, we are going to continue to do this work. As Medicare Advantage grows this is more important. I think some of these topics are quite pressing, and so we'll continue to work through all of this.

Just so people know at home, our timing for turnaround, the timelines are brutally short, so we will do

what we can, given the timing that we have for this cycle. But this is going to come back next cycle, and we're going to continue to do that. And as always, and, in fact, one of the things that you saw in our previous reports, we had one method, we did another method, we compared the two methods, we compared it to outside literature. People have raised a lot of important things. We will continue to do that type of work to make sure that we can estimate the things we estimate as best we can.

So because we went long, and because the next topic is so important, we're going to skip the break and we're going to jump right through to Eric's presentation. So Eric.

[Pause.]

DR. CHERNEW: All right, everybody. We are back for more MA on MA Friday, and we're now going to talk about the topic of the benefit package and benefit standardization. We've been looking at this type of issue for a while.

Eric, take it away.

MR. ROLLINS: Thank you, and good morning.

For our last presentation, we're going to return

to the topic of standardized benefits and MA plans.

I'll start by reviewing the Commission's previous work on this issue, touch on some potential effects of standardization, and then present three policy options for your discussion.

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

Enrollment in Medicare Advantage has been growing steadily for many years. More than half of all beneficiaries with Part A and Part B coverage are now in MA plans. This year, as mentioned in the previous session, the average beneficiary has 43 plans available in their area, and that figure has more than doubled since 2018.

Comparing plans is an increasingly important part of the beneficiary experience, but health plans can differ in many respects, and researchers have found that when individuals are faced with many choices, they have more difficulty comparing plans and deciding which one best meets their needs.

The Commission has been interested in standardized benefits as a way to make it easier for

beneficiaries to understand their plan options.

The Commission began working on this topic during the 2022-2023 meeting cycle when we made two presentations and included an informational chapter in our June 2023 report. In that chapter, we reviewed the use of standardization in the Medigap and ACA markets, described the flexibility that MA plans have to develop their own cost-sharing rules for Part A and Part B services and to cover a wide range of supplemental benefits, and described the variation in MA benefits at the national level.

We then made another presentation on this topic in September, where we examined the factors that have contributed to the growth in the number of plans and the variation in MA benefits at the local market level.

Over the course of these meetings, Commissioners have discussed a range of policy issues that would need to be addressed to standardize MA benefits. These discussions have produced a potential framework for standardization that reflects areas where the Commission reached some level of agreement in its previous discussions.

I'll now spend the next few minutes highlighting some key features of this potential framework for

standardization. There's more detail in your mailing materials, and I'm happy to discuss further on question.

First, standardized benefits would only be used in conventional MA plans, which are available to all beneficiaries who have Part A and Part B and live in the plan service area. These plans account for about 64 percent of overall MA enrollment. Employer-sponsored plans and special needs plans would not be affected.

Second, standardization would only be used for two aspects of plans' benefit designs, cost sharing for Part A and B services, and supplemental dental, vision, and hearing benefits. None of the other supplemental benefits that plans can offer could be standardized, reflecting the Commission's interest in balancing the goals of making it easier for beneficiaries to compare plans with giving plans flexibility to develop their own benefit design.

Third, insurers could offer plans that have the same standardized benefits but different types of provider networks, such as HMO versus PPO.

Fourth, many of the specific requirements for standardized benefits would be set in regulation to give policymakers greater flexibility to respond to changes in

the delivery of health care.

For Part A and B cost sharing, the Commission has focused on an approach similar to that used in the Medigap and ACA markets that would require plans to use a limited number of packages that specify the plan's out-of-pocket limit and cost-sharing amounts for all major services.

This table, which we have also used in our earlier presentations, provides some purely illustrative packages to give you a sense of how this approach would work.

In this example, there are three benefit packages: lower generosity, medium generosity, and higher generosity. The differences in these packages are readily apparent because the more generous packages have both lower out-of-pocket limits and lower cost sharing for many services. For the sake of simplicity, these packages show only certain Part A and B services, and the actual benefit packages would likely include a wider array of services than the subset shown here.

Dental, vision, and hearing benefits would be standardized in two ways. First, the Secretary would require all plans that elect to offer those benefits to

cover a uniform set of items and services.

Second, the Secretary would develop standard and high options for each benefit and specify their cost-sharing amounts and annual spending limits. Every conventional plan that offers dental, vision, or hearing benefits would be required to use these options.

This table, which we have also used in earlier presentations, provides a purely illustrative example of standard and high options for dental benefits. Both options would cover the same uniform set of services, but the high coverage would clearly be more generous, with lower cost sharing and a higher annual limit. There would be separate standard and high options for both vision and hearing benefits.

Shifting gears now, there's some uncertainty about the effects of standardization, partly because some key elements would be developed later by CMS and partly because the behavior of beneficiaries and plans can be difficult to predict.

We met with representatives from several individual insurers and trade associations for health plans to get their views on standardization. They expressed a

mix of support and opposition to the Commission's potential framework. None of them thought standardization would be administratively difficult to implement.

Our discussions focused on two issues. The first was the impact on MA enrollees. Several stakeholders said that standardization would make plan choices clearer and easier for beneficiaries to understand. Every stakeholder said that standardization would be disruptive for enrollees because plans would have to modify their benefit designs to meet the new requirements.

However, this disruption was viewed as a one-time event during the initial transition to standardized benefits, and it's worth keeping in mind that enrollees already experienced disruption in the current program when plans make year-to-year changes in their premiums, cost-sharing rules, and supplemental benefits.

The second issue was the impact of standardization on MA plan competition. While we have largely viewed standardization as a way to make it easier to compare plans, it could also promote greater price competition among MA plans, because it would be easier for beneficiaries to determine which plans have similar

benefits and identify the plan that charges a lower price in the form of a lower premium.

Several stakeholders agreed with this assessment that there would be more pressure on plans to use their rebates to reduce premiums. Several stakeholders also said that plans would have more incentive to differentiate themselves from their competitors using the supplemental benefits that aren't standardized.

So now we're going to talk about some policy options for standardizing MA benefits. We developed three policy options that focus on the issue of how many standardized plans an insurer could offer in the same county. The Commission has discussed this issue previously but did not reach a consensus.

Every option is based on the Commission's potential framework for standardization, which again reflects areas where the Commission reached some agreement in its previous discussions. In addition, Commissioners could also identify an alternative option during their discussion of these three options.

This slide briefly summarizes the common features of the three policy options. As I mentioned earlier, these

options would apply to conventional MA plans only, and employer plans and SNPs would not be affected. Two types of benefits would be standardized, cost sharing for Part A and B services, and supplemental dental, vision, and hearing benefits. The other supplemental benefits that MA plans can offer would not be standardized.

For Part A and B cost sharing, plans would use a small number of packages that specify the cost-sharing amounts for all major services. The dental, vision, and hearing benefits, plans that offer those benefits, would be required to cover a standard set of items and services, and all plans would use either a standard or high option for their coverage. Finally, insurers would be able to offer plans that had the same benefit package but different types of provider networks, and many of the specific requirements for standardized benefits would be set through regulation.

I'll start with a brief overview of the options and then discuss each of them in more detail. As you can see in the first line of this table, Option 1 would not limit the number of plans an insurer could offer, while the other two options would limit the number of plans.

However, as you can see in the second line of the

table, Options 2 and 3 would use different types of limits. Option 2 would use a limit that is based on the different standardized packages of Part A and B cost sharing and the different network types, while Option 3 would put a hard overall cap on the number of plans.

Just as a reminder, these limits would apply to conventional plans only. Employer-sponsored plans and special needs plans would not be affected.

Option 1 is the least prescriptive option because insurers could offer as many plans as they wanted in a county as they can now. However, those plans would be easier to compare than current plans because they would have standardized Part A and B cost sharing and standardized dental, vision, and hearing benefits. Under this option, an insurer could offer multiple plans that have the same Part A and B cost sharing and the same network type. Those plans could still differ in other respects, such as their supplemental benefits or drug formularies.

For example, using our illustrative cost-sharing package, an insurer could offer multiple plans in the same county that use the higher generosity package of cost

sharing and have an HMO network.

Under Option 2, an insurer could offer one plan for each combination of cost-sharing package and network type. The maximum number of plans that an insurer could offer in a county would depend on the number of cost-sharing packages and the number of different network types that plans could use.

For example, if there were three cost-sharing packages, like the illustrative packages on slide 4, and two network types, HMO and PPO, then an insurer could offer up to six plans in the same county. Under this scenario, an insurer could offer just one plan that had the lower generosity package and a PPO network. If the insurer wanted to offer a second plan with the same cost-sharing package, that plan would need to be an HMO product.

Similarly, if the insurer wanted to offer another PPO product, that plan would need to use either the medium or higher generosity cost-sharing package.

Insurers could not offer multiple plans that have the same benefit package and network type. This approach would be similar to the approaches that CMS and some states have used to standardize plans offered through the ACA's

health insurance exchanges. Insurers might choose not to offer plans with every allowable combination of cost-sharing package and network type.

Option 3 would also limit the number of plans that an insurer could offer in a given county but do so through a different mechanism. Under this option, there would be an overall cap on the number of plans that an insurer could offer. We have proposed using three plans as the limit, but policymakers could use a higher or lower figure.

Aside from the overall cap, this option is similar to Option 1. Insurers would decide which standardized package of Part A and Part B cost sharing and which network type to use in each plan. As long as insurers comply with the overall cap, they could offer multiple plans with the same cost-sharing package and network type.

Putting an overall cap on the number of plans each insurer can offer would be similar to the approach that CMS uses to regulate the standalone prescription drug plans, where insurers are prohibited from offering more than three PDPs in the same market.

We chose a limit of three plans after examining how the number of plans that insurers offer in the same county changed between 2018, the last year when MA's meaningful differences' requirement was in effect in 2023.

As you can see on this table, in 2018, insurers offered a median of two plans in the same county and offered five or more plans in only about 10 percent of the counties they served. By 2023, the median number of plans had doubled to four plans, and insurers offered five or more plans in about 25 percent of the counties they served.

A limit of three plans would be lower than the number of plans that insurers offered in most counties in 2023 but higher than the number of plans that insurers offered in most counties in 2018 under the meaningful differences' requirement.

Under a three-plan limit, with an average of eight insurers now offering plans in each county, the average beneficiary would likely still have access to about 20 plans, assuming that some insurers might not offer a full complement of three plans.

About 95 percent of all beneficiaries live in counties where at least four insurers offer MA plans, and

they would likely have access to at least 10 plans.

These options make tradeoffs between two key outcomes. One, making it easier for beneficiaries to understand their plan choices; and two, giving MA insurers flexibility to develop their own plan benefit designs.

This table summarizes these tradeoffs. For beneficiaries, the three options would affect both the number of available plans and the level of differentiation among each insurer's plans.

Option 1 would have the smallest impact since it would not limit the number of plans an insurer could offer in the same county, and insurers could still offer multiple plans with similar benefits.

Option 2 would likely lead to some reduction in the number of plans, although the magnitude would depend to some extent on the number of distinct cost-sharing packages and network types. Option 2 would also produce the most differentiation among an insurer's plans, since each plan would have a different cost-sharing package, a different network type, or both.

Option 3 likely would lead to the largest reduction in the number of plans but would do less than

Option 2 to require insurers to differentiate their plan offerings.

As for MA insurers, the three options would affect their ability to offer multiple plans in the same county and to offer plans with similar benefits. The options would have effects that are essentially the inverse of the effects on beneficiaries.

Option 1 would give insurers the most flexibility since it would not limit the number of plans, they could offer in the same county or their ability to offer multiple plans with similar benefits.

Option 2 would put some limits on an insurer's ability to offer multiple plans and would force insurers to differentiate their plans based on their Part A and B cost sharing and network type.

Option 3 would likely do the most to limit insurer's ability to offer multiple plans in the same county but would also give insurers more latitude than Option 2 to offer plans with similar benefits.

That brings us to the discussion. We'd like to get your reactions to the three options that we presented today and that you see summarized here on this slide.

As part of this discussion, we'd like to know both if there are options that you particularly like, if there are options that you particularly dislike. We'd also like to know if there are other options that you think should be considered.

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

DR. CHERNEW: Eric, thanks.

I won't belabor this because we're short on time, and I am going to try and keep us a little more disciplined than usual.

I will say there's two related issues here. One of them is standardization of benefits in each package. The other one is the number of plans or what to do with the broad number of plans.

But, with that said, I think, Brian, you are the first person in the queue.

DR. MILLER: Yeah. This is a quick Round 1 question.

On page 43, we note that the average -- it's 43 -- the average beneficiary has 43 plans with eight insurers. In the MA status report this morning, we noted market

consolidation. So my question is, do we think it's a competitive market or not? We're not being consistent across the programs.

We also don't have a discussion how decreased choice and competition leads to increased prices and decreased nonprice competition. So our policy would be decreasing competition in the MA marketplace. This is, to me, ironic. I'm a huge fan of increased competition, and I note that the Biden Executive Order on health care specifically mentions -- or on competition specifically singles out health plan on hospital markets. We should be looking at increasing competition.

And the current administration also, for the first time in the history of the entire Department of HHS, has appointed a chief competition officer. So I think we should be looking at ways to increase competition, not decrease it. And so we should figure out in our chapter whether we think MA markets are consolidated or not and whether we want increased competition or not, and it's unclear to me from this document.

Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Quick question. I don't know if this is a lack of misunderstanding by me, Eric, or deliberate. That's what I'm trying to find out.

So in Table 4 in the written materials we received, but also, I think in one of your slides. when you show the three policy options, you say it's, select for Option 2, one plan for combination of Part A/B cost sharing, and network type. It doesn't mention anything about vision, hearing, and dental there. Is that just an oversight, or did you deliberately exclude the vision, dental, hearing?

MR. ROLLINS: I think that is a policy question that the Commissioners could discuss. I think the thinking that went into the paper was that insurers would have one plan for a combination of Part A/B cost sharing and network type. They could add whatever configuration of dental, vision, hearing to that one plan that they wanted to.

Again, they would -- under the sort of illustrative options that I've discussed earlier, they would have to use the standard and high options. But for that one plan, for their low generosity PPO product, one insurer might decide I'm going to have high dental,

standard vision, standard hearing. And another insurer for the exact same Part A/B cost sharing package and network type could say I'm going to have standard dental, but I'm going to have really -- I'm going to have the high options for vision and hearing. So there would be one plan. They could add whatever combination of dental, vision, and hearing they wanted to have to that one plan.

Another option would be that for a given combination of Part A/B cost sharing and network type, you could have sort of branching options of this one has -- that within that base, I could offer one that has high dental. I could offer one that has standard dental. That would be another option. That would lead to probably more choices on the market.

DR. CHERNEW: So thank you for that, Eric.

Just quickly, Larry, these are illustrative options. Our recommendation is not going to -- any answer Eric gave you is not going to be explicitly in the recommendation. We can discuss it. It's more to -- it's just complicated to get a whole range of things down.

My general view is if that was your hangup on versions of that, it would probably be flexibility for CMS

to address that in a range of ways. We're going to illustrate the type of tradeoffs that there are.

DR. CASALINO: The reason I bring it up, Mike, is not that I have a particular point of view on it, but that it seems to me that is an inescapable extra parameter, right?

DR. CHERNEW: Yeah. Right.

DR. CASALINO: And so that in this table and --

DR. CHERNEW: Totally.

DR. CASALINO: -- and ending where this kind of comes up, I think it might be a mistake not to make it clear, because that would exponentially increase the number of plans. And people need to understand that, I think.

DR. CHERNEW: Absolutely.

And I think Amol is next.

DR. CASALINO: If I could just add one other thing, Mike. I just want to point out that I think, again, the way things are framed here, I'm afraid that we could, as a Commission, wind up spending all our time on a number of plans, which is important, but I think talking about should A and B be standardized and should vision, dental, hearing be standardized, not just in terms of high and low

option or whatever but also in terms of should the benefits that are offered in vision, dental, and hearing, apart from the cost sharing, be standardized.

DR. CHERNEW: Exactly. So when we get to Round 2, I would like the discussion to be, one -- and I said this -- standardizing within the things, and there's a number of ways you could worry about a separate issue, which is the number of plans. One of them is you could pre-specify the combination of those standardized things. That's basically Option 2. The other one is you could just limit the number of plans. That's Option 3.

The parameters to how many things that got picked would probably be outside of any recommendation, but those are the issues on the table. You're correct to point that out.

I'm sorry for rushing.

Amol.

DR. NAVATHE: I'll try to be very brief, so hopefully, two quick questions.

One, I just wanted to clarify while we're talking about Part A, Part B benefit standardization, A and B benefit standardization, we're not talking anything about

the rebates that plans can offer for either Part B and Part D, correct? The premiums.

MR. ROLLINS: For Part B premium reductions, no.

DR. NAVATHE: Okay. Great.

MR. ROLLINS: The options, the illustrative options -- again, these are illustrative -- would just focus on the cost sharing that enrollees would pay when they obtain those services. It would not affect a plan's ability to offer -- use some of their rebates to offer a buydown of the Part B premium.

DR. NAVATHE: Great. Thank you, Eric.

Second question is, as we're talking about standardization here, standardization -- I guess just to clarify, at what level are we talking about standardization? Are we saying that this would happen at the national level, or is this at a regional or local market-type level where MA plans are actually competing and currently have variation?

MR. ROLLINS: I think that is an issue that the Commissioners can discuss. You could envision a couple of different options.

I think the version that's laid out in the paper

is you would have sort of a range of cost-sharing packages that plans could use, and that would partly be a way to address geographic variation and rebate levels and plan benefit offerings.

I wouldn't necessarily expect that in every single part of the country, you would see all of those cost-sharing packages used. You might see some are more common in a high rebate area and others more common in sort of low to mid-rate rebate areas.

DR. NAVATHE: Great. Okay. So I'm just interpreting that. That means that if that is the case, although we currently can see geographically that there are differences in the benefits offered, that might minimize the amount of differences between the standardized plans and what's actually locally happening, if that's the direction we went with.

MR. ROLLINS: I think it would, to some extent, change the way it looks.

So, for example, in a very high rebate area like South Florida, you might see that basically all of the plans use the high generosity package. Whereas, if you look in a low rebate area, maybe what's on the market is

maybe some of the lower generosity plans and maybe a few medium generosity plans.

So I think you would still see some geographic variation in the benefits that plans offer. You would kind of just be using these sort of bins of these standardized packages that you would look at.

DR. NAVATHE: Great. Thanks, Eric.

DR. CASALINO: If I may? But would the dollar amounts vary geographically?

MR. ROLLINS: Again, that's something the Commission can discuss. In sort of the option laid out in the paper, no. Option 2, like the medium generosity package, you would pay -- I forget the actual dollar amount. Say it's $30 to see a specialist. That would be the copay in, no matter what part of the country plan was using that benefit package.

MS. KELLEY: I think that's it for Round 1.

So we can move to Round 2, and I have Kenny first.

MR. KAN: I acknowledge the MA benefit choice conundrum and appreciate the chapter. Great work.

This is a very complicated issue, as suggested by

Eric's answer to Larry's simple question: How many options?

While we have done a lot of good analysis, which is well intentioned, I'm very nervous that we as a Commission don't fully grasp the hugely disruptive impact on the MA beneficiary experience. This is way more than a one-time event.

I'm very worried about the disruption, unintended consequences, and consolidation concerns of the three proposed policy options.

Medigap-like benefit standardization, which represents 15 to 20 percent of total cost, may work in fee-for-service due to nationwide standardized cost sharing, but highly unlikely to work in MA, 100 percent of the cost, in 3,300 counties or 32 million MA beneficiaries. There is a huge amount of cost-sharing variation.

California beneficiaries, as Cheryl was saying, have an average maximum out-of-pocket of approximately $2,500, while New York is almost triple that at $7,200. I'm very nervous that while well intended, applying benefit standardization would create significant unintended consequences, including changes in care access and

treatment patterns.

Imagine if your $10 specialist copay that you usually use to monitor your diabetic care goes to $40. What does that mean for care patterns? Resulting in a significantly worse-off MA beneficiary experience.

Please allow me to explain further on why I believe that the lemon is not worth the squeeze. First, disruption. There will be massive disruption. The BlueCross BlueShield Association ensures 40 percent of Americans. The BCBSA engaged Oliver Wyman to independently and objectively analyze how standardization of A/B plan designs could impact choices currently available to 32 million MA beneficiaries in 3,300 counties based on designs on page 5 and findings that were recently shared with MedPAC.

Here are the key findings. All of MA's 32 million benefit enrollees would face changes to their current plans. The vast majority, 93 percent, would likely need to switch to new coverage. Seventy percent of beneficiaries would be forced to choose a plan with higher premiums or fewer supplemental benefits. The remainder will be required to choose a plan with leaner benefits,

resulting in higher A/B cost sharing for those members when they access care.

Beneficiaries in states like California, with a 2,500 average MOOP, and Texas would experience the largest increases in cost sharing, while those in states like New York, with an average 7,200 MOOP, and Washington, would face the biggest premium increases and/or decreases to their supplemental benefit offerings.

Unintended consequences. In addition to massive disruption, imprudent benefit standardization will lead to undesirable consequences.

Let me let you in on a secret. Most MA plans try very hard to keep benefits the same every year to avoid confusion for the beneficiaries. We want a seamless beneficiary experience.

So to dampen the challenges posed by benefit standardization, MA plans are likely to change their formularies, size of your networks, value-based care, stricter prior auth requirements. This can lead to even more disruption, less standardization, and reduce transparency for 32 million beneficiaries.

So at the end of the day, let's ask the question:

Is the lemon worth the squeeze? I would argue not, as this results in a worse beneficiary experience and increased administrative costs for the health plans.

While the idea of benefit standardization is well intentioned, we need to be very, very careful not to unintentionally cause MA plans to reduce the size of the networks, tighten formulary, and restrict the prior auth. Otherwise, have we gained anything if we end up trading increased benefit standardization or significantly less standardization in other key holistic aspects of the MA beneficiary experience?

Another unintended consequence of benefit standardization is increased consolidation as the big players with scale win. As I mentioned earlier, MA is not a monolithic, homogeneous entity, which is comprised -- but is comprised of a heterogeneous landscape of MA plans, which include the big national players, provider-sponsored plans, and many small nonprofit community-rooted plans. Let us be aware of unintended consequences. Overly restrictive benefit standardization leads to a race to the bottom on price and discourages innovation.

In addition, this would actually increase the

admin burden for the industry, especially for small plans which lack scale. As a result, more local nonprofit small plans could drop out as they are saddled with higher administrative burden and an inability to differentiate themselves. When this happens, the big plans win.

If we proceed to recommend imprudent benefit standardization, I'm very nervous that we'll be on the wrong side of consolidation.

So instead of the three options, I strongly encourage us to consider a less invasive Option 4 for the June chapter, which could include restoring meaningful difference, raising the low enrollment threshold, and improving Medicare Plan Finder to help Medicare beneficiaries make better choices.

In the next '24-'25 cycle, perhaps we could look at a modified Option 1, which hopefully will better address disruption, unintended consequences, and consolidation concerns.

Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Okay. I'll try to speak quickly.

Thank you for this work, and I support continued

exploration and consideration of how to simplify the choice process for the consumer.

We know that consumers are making suboptimal choice. The current choice environment places high cognitive burden on individuals to try to sort through all of this information, and that simplification could actually improve competition. And I think we're operating in a market right now where the distinctions that plans are putting forward in the market often are without meaning. So I think it's tricky because I too support competition, but I'm not convinced that currently the market is operating with full information for the consumer in a way that they can digest and act on.

So while I agree that Plan Finder can be improved, I think there's so many different dimensions they're being asked to consider and so many different choices that it really is untenable.

So I appreciate the three approaches that were put forth. Obviously, they need additional exploration. I sort of am more in favor of Option 2 than Option 1, since Option 1 would continue to have too many options in the marketplace. So that would not be my preferred choice.

I struggle with some of the innovation concerns that have been raised. On one hand, I'm not convinced that it would actually stifle innovation, but on the other hand, I think we might want to take some time and consider where innovation might be affected and whether there's anything in terms of the design of this that could be done to help mitigate that.

Regarding the disruption, clearly, this is not trivial. Ways of dealing with that could be to phase it in, but I would say, given a lot of the work that I've done talking to Medicare beneficiaries on an annual basis, they are required to go back and check their plans because so many things change. And a substantial portion of them are switching each year to deal with that, so again, anything to simplify that choice process for the consumer.

And I would encourage MedPAC to look at the experience where this has already been done, such as the insurance exchanges, to see what the effects have been, both positive and potentially negative.

MS. KELLEY: Okay. Thank you.

I have a comment from Greg, which I will read. Greg likes the idea of limiting to a number of plans -- of

limiting the number of plans per carrier. He's somewhat concerned that carriers could game this by using subsidiaries, and the chapter -- the paper addresses this concern by identifying parent organizations.

We need to reinforce the need for such a mechanism. Such a proliferation of carriers would be even more confused -- since a proliferation of carriers would be even more confusing than a proliferation of plans.

With that said, Greg believes we gain far more by limiting the number of plans than by creating benefit standardization within plans. Benefit design can be integral to the way a plan accomplishes its care goals; for example, cost sharing for specialist visits, home care, virtual visits, et cetera, maybe independent of generosity and maybe part of the fabric of the care model.

For this reason, he thinks that standardized benefits should not be a baseline and then constrain plan numbers. Rather, he thinks we should constrain the number of plan offerings and then very cautiously, if at all, consider standardizing benefits.

With a limited number of plans -- three or four feels like the sweet spot -- each carrier would be

incentivized to create plan designs that they believe will be broadly marketable, cost effective, and clinically cohesive, ss opposed to the current incentive to create a spectrum of niche products. This would likely lead to greater benefit consistency, but he thinks it would be a mistake to predetermine or impose what that benefit design should be. And real innovation in areas like hospital at home, reimagined care teams, teleservices, and AI monitoring could be stifled by forced benefit designs.

Greg believes that restraining the number of plans offered by each carrier while retaining the ability of plans to have benefit flexibility will not only benefit beneficiaries but would also level the playing field between the largest carriers and others and would reduce the current momentum toward consolidation and national market concentration.

Now I have Tamara next.

DR. KONETZKA: Thanks for this great work.

I can be really brief because I think Cheryl -- I pretty much agree with everything that Cheryl said.

I strongly support continued exploration of standardization. I think, sure, there are some potential

unintended consequences and things we'll want to monitor, but I think the status quo is also untenable, and the trends in the status quo are untenable. And so I think those tradeoffs, in my opinion, will be worth it for a couple of key reasons.

I think the innovation that everybody talks about, sometimes it's true innovation, but a lot of times it's not. I think there are some really, sort of trivial differences between plans that just make it much more complicated for people who are sorting through 25 different plans.

I think that there will be some disruption, but as many others have noted and the chapter noted, there's disruption every year anyway. Plans change, and I think the disruption will be well worth it in the long run.

I think that I would like to see us -- we haven't -- I'm sure it's out there. We haven't talked about it a lot in this chapter or in these discussions, but I think it's important to go back to the consumer literature that's been done, or I'm not sure how much has been done, but to really make sure that we're offering choices on the things that are most important to consumers. Clearly, consumers

care about HMO versus PPO. So we would never want to not allow those different choices for similar plans, and clearly, people care about cost sharing and the overall price.

And so I think you know as we think about how to standardize plans, we should you know rely on the consumer literature or on new research in that area to try to figure out where we need to maintain differentiation and what can be collapsed.

So overall, I'm strongly in support of this direction. I've sort of wavered between Options 2 and 3. I think it's really important for consumers. As somebody who does this for my mother every year, I think that the number of choices is overwhelming. If anybody can sort through this, I should be able to, right, or one of us should be able to, and that the number of choices is overwhelming. I know that personally, I'll kick out 75 percent of the plans because they don't adhere to a certain key criteria, right? So I think we need to stick to those key criteria and try to move toward the option that eliminates the trivial differences to make it easier.

Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thank you.

I am surprised to find this on the agenda today, as the Chair had previously assured me after our fall discussion that this work would take a while and not get to policy options or a recommendation this cycle. Yet here we are, acting as if the sky is falling.

I'm concerned and curious about what are the policies and processes for Commissioner issues getting on the agenda at MedPAC, it does not seem clear.

The discussion and draft here seem premature and incomplete. We need to be deliberative. As my colleague, Kenny, has noted, we are disrupting a $400 billion-a-year marketplace with 32 million beneficiaries, and in that vein, I think that the staff need to include and respond to the Blue Cross Blue Shield Association report.

I'm also concerned, as I said, that the chapter did not scope the problem fully. I see three references, so it is unclear how I sort opinion from evidence if we are to be an evidence-based organization.

If we want to transform this into an evidence-based decision we need to engage the marketing research

community, as I mentioned at the prior meeting, where my comments were not integrated. There are over 500 business schools with marketing departments that do research on how consumers make choices. Some examples include, in the elderly population, 804,000 Americans over the age of 66 bought homes last year, and 27 percent of car buyers were over the age of 65. Sometimes these choices are assisted by an intermediary who is the salesperson for the company, and sometimes it's a broker paid by the consumer.

We also need to look at other marketplaces, such as the ACA, FEHB, ESI, and BHA. We need to look at a broad set of options, including changing the filter through which beneficiaries make choices, changing the learned intermediary through broker regulation, which the Biden administration is doing, and I support, shift counselors, further customization to promote specialized plans by marketing, disease, geography, or some other feature. And because we have not taken this robust research and broad scoping, our record is incomplete and our analysis is flawed and focused on arriving at a predetermined conclusion.

Two articles from across the political spectrum I

have found on consumer choice are by Lisa Grabert in Inquiry. She is a noted Republican health policy analyst, and Sarah Rosenbloom, who is a noted Democratic health policy analyst, who also wrote about improving the Medicare Plan Finder.

So in summary, I think that standardization is a poison disguised as candy. Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks. And Eric, thanks so much for your work on this. I am very pro-standardization of Medicare Advantage plans.

As I noted earlier, even as a shift counselor with years of experience I struggle to differentiate HMO from HMO POS, HMO with a 12-month travel benefit from a PPO, Medicare Advantage that's called private fee-for-service plan. It's too much.

I believe standardization and fewer options would be welcomed by beneficiaries and those of us trying to help them. This standardization would create more transparency, and I believe that, in turn, would create more competition. We are asking plan sponsors to give us your top goods, that could be more easily be compared by consumers.

Again, I think the beds may improve, primarily for A and B benefits and dental, vision, and hearing, maybe less so for the extra add-ons, but at least they're there because they'll all want to have high ratings.

It is true that the Plan Finder can be improved. I sometimes wonder if it's been beta tested before they release it, especially a few years ago.

However, in addition to mastering the Plan Finder we have to create, as a SHIP site, every year stacks of cheat sheets comparing A and B cost sharing, dental, vision, hearing, and then all the extra benefits. Each county has to do this to be effective. The standardization would help us all be better counselors.

I want to understand Greg's comments. However, a little bit more about -- he used hospital home as an example. But as far as I'm concerned, the health system drives that decision versus the plan sponsor. But I do want to understand Greg's comments more.

I am concerned about the market disruption, building on Tamara's point. Every year there is disruption. A barrage of advertising, phone calls that confuse beneficiaries. We say you should pay attention,

every year, but it seems like cruel and unusual punishment. However, we insist that older adults and adults with disabilities who are least able to access to technology and have the highest medical needs go shopping every year, even though they don't have a crystal ball to know what they need for the coming year.

Instead of so many plans going away, we could encourage plan sponsors working with CMS to crosswalk to better benefits, on average, and not crosswalk plans to more limited benefits. And a reminder that if a Medicare Advantage plan is terminated, this is welcome news for people in states that restrict guarantee issue rights. A plan termination generates a guarantee issue right in those states.

One note of caution. I think we do need to better understand potential concentration and those related concerns.

But thank you for the great work, and I really support standardization, and I like Option 3.

MS. KELLEY: Stacie.

DR. DUSETZINA: I just want to echo my plus-one on Cheryl's, Tamara's, and Gina's comments on trying to

simplify this for the beneficiary. I don't know what the exact right number of plans are, and it does seem there are some key considerations that we have to take into account, but I don't think we make it easy for people to know what they're picking, what it includes, and even as Gina said, helping people navigate that system is very difficult.

So I am in favor of moving towards standardized benefits. I don't know what the exact right number are, but I'm supportive of that direction. Thank you.

MS. KELLEY: Betty.

DR. RAMBUR: Further piling on this theme, thank you so much for this work. I'm very supportive of the direction.

I'm a big believer of let the buyer beware, but a poor choice in a water heater or a car simply doesn't have the same life-and-death consequences and ongoing financial echo to individuals and their families. So I think it's something you can compare this kind of choice.

I see information that's central to improving markets, and I see standardization as an important tool to enhance market competition, despite the initial disruption.

And I'm actually quite confident that the plans

could be innovative within standardization. I'm pretty confident. So that's why it's really important we think about the parameters and all of that.

I'm still thinking about Greg's comments. I want to think about that a bit more. But at the moment I like 3 the best, and then 2, and then 1 less.

I would just say in terms of information, this was sort of said, but some of the patients I work with, and not as a SHIP counselor, it's very difficult to even understand the difference between an HMO and a PPO, and there are huge consequences for that, especially with all the marketing.

So I'm very supportive of this direction. Thank you.

MS. KELLEY: I'll just read a brief comment from Lynn. She enthusiastically supports standardization of benefits. This will be very helpful for beneficiaries. She would also support moving MA selection to a healthcare.gov-like website, and either eliminate broker payments for Medicare or have fee-for-service pay broker fees as well. MedPAC needs to look at how these distort the market and reduce or eliminate market distortions.

And I have Scott next.

DR. SARRAN: First, thanks Eric. Excellent work.

With respect to Kenny's comments, the BCBSA and Oliver Wyman study, I spent a little bit of time reviewing it. It just fails, in my mind, to meet basic logic, and the whole sky is going to fall, I just think is not serving any of this discussion well at all.

That said, I think we should review thoroughly the Oliver Wyman work, between now and the next meeting.

I think the reasons in favor of standardization are so darn strong, and just to quickly recap them. Today -- and other folks have commented on this -- the lack of and the asymmetry of useful information is, first of all, it's not consistent with free markets. Free markets depend on symmetry and access to useful information.

Second, it distracts beneficiaries from making decisions on what's really important, such as network, network access, Part D benefit, true access to needed care, et cetera.

Third, it makes it near impossible to, as taxpayers, determine how our money is being spent, and that's a huge problem.

And it actually moves plans away from focusing on innovations in care delivery, which is where we need innovation.

In terms of the options, I could live with any of them. I'm super impressed that we came up with three excellent ones. I would vote, if I had to vote, 2, 3, then 1. I like the maximum differentiation that's engendered by Option 2, but I think they all represent good work and a significant move forward.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Eric. Great work, as usual. I'll try to be punchy in my comments to keep them as brief as possible.

First, I support standardization really as a means to improve competition. I will just note that as trained as a market economist I certainly believe that competition is important and I think standardization can definitely support that.

So a couple of other points. That being said, I think there is meaningful variation. I think Tamara said that. I think there is some innovation that's good. There's some variation that probably is not necessarily as

pro-beneficiary benefit. And so I think we should be thoughtful about the sort of balance between the two things.

I think previously, Eric, you had done some work that showed the variation in the different benefits and the cost sharing and how there was kind of clustering in certain areas, and that's, in part, how you sort of came up with the template that you suggested, the policy options that you suggested.

I think it would be really helpful to bring back some of that analysis together with this, because I think otherwise it does feel potentially very disruptive if we don't really know how much of a difference there is, and I think showing some of that correlation or commonality, the fact that most beneficiaries are actually clustering around some particular types of benefits and there is, therefore, a lot of variation, but that could be small variation, that's not necessarily that meaningful.

Accordingly, I agree -- and I don't remember who it was of the Commissioners -- but I think bringing back something like a meaningful difference could also be quite helpful in this. And that might also allow some

flexibility in terms of the number of plans. And I think, again, recognizing that there is some good innovation, maybe and some less meaningful innovation.

I could also envision that we could have a kind of stepwise way that this rolls out. We start out with an Option 1, see how many different plans there are. If there is a plethora of plans despite a meaningful difference kind of criterion, then I think one could worry about, or consider potentially restricting in the future. But it seems like without knowing this kind of innovation tradeoff it seems like we could be thoughtful about that, or at least even consider sequential approaches.

The other part that I think came out of the discussion today, I think that was actually quite helpful, is as I think about at what level the standardization should or could happen to minimize disruption. I think disruption certainly is something that we don't want. One-time disruption is obviously better than long-term disruption. But nonetheless, I think if there could be some regional standardization that would meaningfully impact this kind of disruption concept, I think that's something that would be worth, at least analytically,

exploring, to see kind of what that would look like.

But again, to recap, I'm very support of the standardization work as a way to support more competition, and out of the options presented I guess I would favor Option 1. Thanks.

MS. KELLEY: Jonathan.

DR. JAFFERY: Yeah, thanks. Eric, great chapter. Great work. I'm really happy that we are continuing along this path like we started earlier and we said we would continue in this cycle.

You know, I echo a lot of what my fellow Commissioners -- Betty, Amol, Scott made some great points, among others. I'm very supportive of standardization, and my sort of, you know, true north on this is the beneficiary, and I think Gina summed this up not only today but in multiple conversations we've had. You know, we've seen data around what happens when people have choices. We all have personal experiences trying to decide on things where it's much easier to make decisions. And of course health care market is completely unlike any other one and so it's just exponentially more complicated.

So I am strongly in favor of standardization. I

think this notion of stifling innovation is a bit of a distraction, because what you're talking about here, and you've been very clear about it in our previous discussions, is focusing on areas where standardization is clear and makes sense. And nobody is innovating about whether a beneficiary needs 2 or 6 or 12 teeth cleanings a year, which is some of the examples we saw last time. People want to be able to get dental benefits and vision and hearing like they expect that will actually cover their needs. They're not getting that now and they don't know it because there's so much.

So innovation really is in these other spaces, and so I think this actually does encourage innovation in that way.

So I'm strongly in favor of standardization. My preferences would be starting with Option 3, because I think that will help the beneficiaries be able to choose and understand things the most. Next would be 2, for reasons others have said, and I could live with 1, but that would be my approach. Thank you.

MS. KELLEY: Larry.

DR. CASALINO: I'm very enthusiastic about

continuing with this work. I'm not enthusiastic about necessarily moving really fast. It's a very important issue, but as Kenny said, I would really, really, really hate to get this wrong, and we could, I think. Kenny's points did make me worry a little bit. So I don't see a need to rush it.

And in particular, Greg's proposal is very interesting to me, and I'd like to see more work on that. I mean, restricting the number of plans as opposed to the other three options, restricting the number of plans without declining benefit packages, I think that wouldn't stifle innovation, for sure, and plans could innovate all they want. But they can't offer 20 plans.

Let's not pretend that the differentiation that plans offer is necessarily primarily to try to appeal to consumer preferences. I mean, there is that, for sure, but there is also for sure, let's think very hard about which plans will make us the most money, by basically getting us the kinds of beneficiaries we want, and the way we can price it, and so on.

And I also think that restricting the number of plans that a plan could offer would help the small plans,

because the big plans can come in and they can crush, with many, many options. And they also are much better at figuring out, I'm sure, where can we make money, in ways that don't necessarily reflect consumer preferences.

So when I say I don't want to rush, I think if you asked me what do I mean by that, maybe some more exploration of the kind of concerns that Kenny brought up but also more consideration of Greg's idea.

That said, I just have two other things to say, and people have said this in various ways. Competition only works well when the product is well-defined, right. So to the extent that we can make the product well-defined, then we'll have more competition, not less. Otherwise, competition doesn't work because people don't really know what they're buying.

And my last point, which is related to that, I may be misunderstanding but I think Part A and B are Part A and B. The kind of lifestyle supplemental benefits we're not really addressing. But there is the dental, vision, hearing, and I think, at least off the top of my head, I think there is a place for requiring standardization there. But what the package is for sure I'm less concerned about

standardizing the co-pays and out-of-pocket limits, and so on and so forth. That could be done easily enough.

But I think it's very hard for people, even for me -- oh God, do I have to look at what the dental, vision, hearing benefits are and try to compare those? That is very tough, I think. So I don't see any harm, if you want to offer dental, vision, hearing, high and low option, this is what you're going to offer, but these are the benefits you have to offer. That I can see standardizing. But trying to standardize other things may not be necessary. That's it.

MS. KELLEY: I believe we have reached the end of the queue, Mike.

DR. CHERNEW: All right. So this is a terrific conversation. Let me try and jump in and say a few things, some of which are reactions and some of which are sort of where we will go. And I will afterwards loop back with the staff and make some decisions on that. But a few things, just to make sure that people at home are clear.

When we talk about standardization, we're not talking about who has to offer this. There would be multiple levels of things that could offered, which came up

in the range of things. And that's what happened, for example, in Medigap and other places, and I think, to be clear, some version of that would be on the table, and we would not be saying yes, do this one option and this other option. So there would be a lot of wiggle room for CMS to do what they do. That's the first thing.

The second thing is, there's been a lot of discussion about when standardization increases or decreases competition. I think the important thing to understand is it changes the dimensions along which competition works. So if you could truly standardize everything -- which, by the way, we cannot -- it would force all of the competition to be on price. Because we can't standardize a bunch of different benefits -- the formulary, prior auth, networks, those are not going to be standardized -- we are changing the nature of competition in ways that we may like or we may dislike, but it is not, I think, an issue of competition sort of going up or down as opposed to nature of that way that competition will play out.

The other thing is, just to be clear, because there are so many issues that are going on when we go

around the table, I just want to specify sort of what they are. One is given carriers are offering a lot of plans that aren't that different, I think meaningful difference tries to address that.

Another issue is three plans that offer dental, but dental means something completely different for all three of the plans, and there are 52 dimensions of dental. And then someone says, "Do I want to this much for cleaning or this much for" -- I don't know enough about teeth, but anyway, whatever else it is. And I actually think some of those choices amongst the plans are almost random in a particular way. I would defer to Kenny. But it's very hard to know what you're buying when you're buying certain things if those things mean different across plans.

And again, I think we should look at meaningful difference, but I'm just trying to lay out the issues. Meaningful difference would not solve that apples-to-apples comparison on the vast number of things that are going on. Plan Compare might. Like you could think of, in a Plan Compare world, you might be able to solve that problem there. It might not, and we can have a discussion about that. But that's the difference in sort of

standardization. And, of course, none of that deals with the issue of just the number of plans. My general view is if there was a lot of standardization, having a lot of plans could be okay with permutations because you would know what each building block would be. But if there's not standardization, having a lot of plans is just super, super hard.

But again, I worry about the disruption that was raised, as an issue. I worry about the competition moving to a dimension that we actually like less than some of the other things with competition. On the other hand, I worry about beneficiaries getting a package of something that they didn't really know they wanted.

So what does seem to be clear, for many of you at least, is that the current choice environment is unbelievably burdensome, and we would like that choice environment to be better. It is not clear that we want that choice environment to better through standardization, although many of you have expressed strong support for that approach. And so that's sort of where I see where we are.

Eric, you have done an amazing amount of work to develop these options and these issues, and I think there's

a ton of appreciation for all of that. So, in particular, thank you for all of that. I think there's really strong appreciation for that.

To the folks at home who surely have interest on this point about what it would mean or not mean, please reach out at meetingcomments@medpac.gov. We really do listen to what is said and think about the comments and think about where we are going.

So that's where I see the standardization part. I think you could tell from this morning that Medicare Advantage more broadly is both an important program but in need of some reexamination because there are a number of issues there that I think where improvements might be made, and we will continue to look at that.

And we will certainly continue to try and understand how Medicare Advantage is affecting all other aspects of the Medicare program.

So with that said, I know a lot of people are hoping that it's not snowing wherever they're going. And some people have lost their flights already, so sorry. That was actually genuine.

But in any case, for those of you at home, thank

you for listening. For the staff yesterday as well, thank you for all you've done. And we will be back again in March, and I will be in touch. So again, thank you. Travel safe.

[Whereupon, at 12:23 p.m., the meeting was adjourned.]