MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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10:47 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:47 a.m.]

VICE CHAIR NAVATHE: Welcome, everybody, to our MedPAC March public meeting. It is a sunny spring day here in Washington, D.C., so I hope it's a sunny spring day wherever you are watching from.

As you may have noticed, I am not Mike Chernew. Mike, unfortunately, is not able to attend today due to a medical circumstance, but he did want to share that he is doing well and will be back at the April meeting.

In light of Mike's absence, I would appreciate everybody's patience today. Thank you very much to Paul, Dana, and the staff for still working with me going forward here for the next couple of days.

We have a nice lineup of important topics. We are going to start with the rural workplan, and Brian and Jeff, I will turn to over to you.

MR. O'DONNELL: Good morning. In this session we will discuss a potential workplan for the upcoming year that focuses on issues surround rural beneficiaries' access to hospitals and clinicians. Before we start, we want to thank Katelyn Smalley who is leading our work on MA network

adequacy and Stuart Hammond, who worked on our MA encounter data analyses.

For the audience at home, you can download a PDF of the slides by clicking on the control panel on the right-hand side of your screen.

There are four parts to this presentation. First, we will review existing rural hospital and clinician payment policies. Second, we will highlight concerns that the Commission has raised regarding cost-sharing at some rural providers. Third, we will talk about the potential effects of the expansion of Medicare Advantage on rural providers and rural beneficiaries' access to care. And finally, we will wrap up the presentation by laying out potential research topics for the coming cycle and soliciting feedback from the Commission.

We will start by providing some background on current rural payment policies.

In 2012, the Commission published a chapter on rural payment policy and established four principles to target special payments to rural providers. First, payment adjusters should be targeted to providers that are necessary to preserve beneficiaries' access to care.

Second, payments should be focused on low-volume, isolated providers. We want to preserve access, not necessarily to all providers. For example, we would not want to preserve two critical access hospitals that are located in the same town when both are struggling with low patient volumes.

Third, the magnitude of the adjustment should be empirically justified. And fourth, payments should be structured in a way to maintain incentives for cost control. Existing programs have had mixed success adhering to these policies.

Fee-for-service Medicare makes three main types of special payments to hospitals. One type is higher prospective payment rates. Rates for sole community hospitals and Medicare-dependent hospitals are partially based on their historical costs.

Low-volume hospitals receive an add-on to their inpatient PPS rates. Hospitals can qualify as a sole community hospital or Medicare-dependent hospital and as a low-volume hospital. This means, for example, that a hospital can receive a special rate as a sole community hospital and then receive a 25 percent increase to that special rate based on the fact that they qualify as a low-

volume hospital.

Fee-for-service Medicare also makes cost-based payments to critical access hospitals. In a given year, hospitals receive preliminary payments based on their estimate of cost and then, after the year is over, cost report data are used to make payment adjustments so that hospitals receive approximately 100 percent of their Medicare costs.

The third type of special rural payments fee-for-service Medicare makes are fixed payments under the new Rural Emergency Hospital designation. Fee-for-service Medicare makes fixed monthly payments to help cover providers' fixed costs plus prospective rates per service. We discuss this new model in our March 2024 Report to the Congress.

In total, about 95 percent of rural hospitals get at least one of these types of enhanced payments from the fee-for-service patients. These are all fee-for-service programs, and it is not clear how often MA plans also make these additional payments.

The result of all these special fee-for-service Medicare payments is that rural IPPS hospitals tend to have

higher fee-for-service Medicare margins than urban hospitals. For example, the median rural IPPS hospital had a fee-for-service margin of -7.8 percent, compared to the median urban IPPS margin of -10.4 percent, and critical access hospitals have fee-for-service margins that are approximately zero. However, fee-for-service margins were low in both rural and urban IPPS hospitals. In part, due to these low margins, the Commission recommended, in our March report, for payments to be increased at 1.5 percent above current law in 2025, and for additional safety net payments to be made to hospitals serving high shares of low-income Medicare patients.

One additional point to draw from this table is that the distribution of rural and urban hospital margins largely overlaps. This indicates that hospital-specific factors have a bigger effect on profitability than rural or urban locations.

While rural hospitals tend to have higher fee-for-service margins, this table shows that rural IPPS hospitals tend to have lower all-payer margins than urban hospitals. Part of this could reflect payer mix. Rural hospitals tend to have higher Medicare shares, which tend

to have lower profit margins than commercially insured patients. The higher Medicare profits at rural providers are not enough to offset the lower, non-Medicare profits that in part reflects differences in payer mix.

The year 2022 was the low point for all-payer margins. Historically, rural all-payer margins tended to be above zero, but were still often 2 or 3 percentage points below urban all-payer margins.

Now we will switch to looking at existing programs to preserve rural access to clinicians. Medicare supports access to clinician care for rural beneficiaries in two main ways: through payment systems that are separate from the physician fee schedule and policies related to the physician fee schedule. Many of these policies are not targeted only to rural providers, but rural providers disproportionately benefit from them.

Three examples of fee schedule-based policies include CAH method II billing, a payment mechanism in which clinicians reassign their billing rights to CAHs and receive a 15 percent add-on to fee schedule rates; the HPSA bonus, for which clinicians receive a 10 percent quarterly bonus based on fee schedule billings; and GPCI floors,

which raise fee schedule payments in lower cost areas. Similar to the situation for rural hospital payments, clinicians can receive more than one of these special payment rates.

Fee-for-service Medicare also established separate payment systems that pay enhanced rates to clinicians that are focused on delivering primary care in rural or underserved areas, including the FQHC payment system and rural health clinic, or RHC, payment system. We focus on RHCs in the next slide.

Fee-for-service Medicare rates for RHCs vary by whether an RHC is provider-based or independent, and other factors. For provider-based RHCs, Medicare's payment rate per visit averaged $255 in 2020, and increased by the annual change in the Medicare Economic Index thereafter.

Medicare's payment rates for independent RHCs are lower, but are set to more than double by 2028. Looking at the table you can see that Medicare's payment rate per visit for independent RHCs is set to increase from $86 in 2020 to $190 in 2028. These rapid increases are likely to maintain or potentially increase access to clinician care in rural areas, and will result in fee-for-service Medicare

paying much higher rates for primary care in many rural areas than in urban areas. The Commission will monitor the effect of these rate increases as they are implemented.

While the critical access hospital and RHC payment systems both increase payments to providers, they also result in higher cost-sharing obligations for rural beneficiaries or their Medigap plans. For most outpatient services at critical access hospitals, the program pays 101 percent of costs minus beneficiary coinsurance. Beneficiary coinsurance is set at 20 percent of charges. Because charges, on average, are about 250 percent of costs, beneficiaries often pay cost-sharing equal to about 50 percent of the full payment to the hospital.

In the extreme case where charges are set high relative to costs, which happens at some hospitals for imaging services, the beneficiary may pay the full cost of the service. For example, if charges are set at 500 percent of costs, then the beneficiary coinsurance will be 20 percent of 500 percent, or 100 percent of costs. Over the next year we will be evaluating options to reform cost-sharing at CAHs.

Beneficiary coinsurance at RHCs is also based on

provider charges. However, the program payment differs from that at critical access hospitals. In the RHC case, the program pays 80 percent of the RHC rate, regardless of how much the beneficiary pays, and the beneficiary pays 20 percent of charges. This means that providers can increase their total payment for a service if they increase their charges.

Our preliminary look at RHC data indicates that beneficiaries or their Medigap plans are paying more than 20 percent of RHC rates, suggesting RHC charges exceed their payment rates. Over the next year we will also be looking at alternatives to this policy.

I will now turn it over to Jeff who will talk about the interactions of the growth of Medicare Advantage and rural payment policy.

DR. STENSLAND: So the biggest change in rural payment and delivery over the past two decades is the expansion of Medicare Advantage. What follows is some background on this expansion, and over the next year we plan to analyze its effects on rural providers.

The Commission supports the inclusion of private plans in the Medicare program. Currently, over 99 percent

of beneficiaries live in counties where they can choose Medicare Advantage, and increasingly rural and urban beneficiaries are choosing MA plans, as we see in the next graphic.

By 2023, 44 percent of rural beneficiaries and 54 percent of urban beneficiaries were enrolled in MA. You can see from the graphic that the rural-urban different in MA penetration has shrunk slightly. A question to be analyzed over the next year is how will this affect providers. The Commission will be discussing whether there needs to be any payment policy changes as MA becomes the dominant player in many markets.

During our beneficiary focus groups we asked beneficiaries why did they choose MA. Many said it was a lower-cost option, and they allowed them to have out-of-pocket maximum liability without having to buy a Medigap plan. They also appreciated receiving several extra benefits, such as dental coverage, hearing benefits, Part D drug coverage, often with no extra premium, and prepaid debit cards that can be used to purchase over-the-counter medicines or groceries.

In addition, to see more beneficiaries enroll in

MA we have seen a decline in beneficiaries shifting out of MA to fee-for-service, from 2018 to 2022, as we discussed in more detail in your paper. Some of the reluctance to switch from MA to fee-for-service may be the inability to obtain Medigap policies without being underwritten. But that has not changed in recent years, and does not explain the reduction in beneficiaries switching out of MA over the last couple of years.

What has changed over time is the growth in the extra benefits provide by MA plans. From 2018 to 2023, the average MA rebate that can be used to provide extra supplemental benefits increased from about $95 per month to over $190 per month, roughly doubling. When plans increase their extra benefits the share of beneficiaries leaving the plans may decrease.

Over the next cycle we plan to look at MA plan network adequacy in rural areas and evaluate whether the limited networks caused beneficiary travel times to differ between fee-for-service and MA. We will examine travel times for primary care, inpatient care, and the distance traveled to the pharmacy to get prescriptions filled when the beneficiary has Part D coverage. We want to know if

rural MA beneficiaries tend to travel longer for care or if MA plans actually encourage the use of local care. It is an empirical question.

A related question is whether MA patients are more likely to bypass their local hospital. This can be examined by looking at beneficiary ZIP codes and the ZIP codes of hospitals used by fee-for-service and MA beneficiaries.

Over the past year we have been interviewing rural providers about how MA growth has affected them. These providers tended to express frustration. They were frustrated with prior authorization, with MA plans sometimes paying less than the full rates they received from fee-for-service Medicare, and the extra effort and time it takes to be paid from MA compared to fee-for-service.

If we just listened to the hospital administrators, we would expect hospitals to have greater financial difficulty in areas with MA expansion. However, a recent study by Henke and colleagues suggested rural closer rates were lower in areas with MA growth. This is a correlation and not a causation, but nevertheless it is

surprising and needs to be analyzed further. Over the next year we plan to talk to MA plans, talk to more providers, and analyze the data to see if we can reconcile some of these findings.

We also want to see if the way care delivered within a hospital differs for fee-for-service and MA patients. For example, hospital administrators told us they had trouble discharging MA patients to post-acute care and that MA plans preferred patients to be classified as observation rather than inpatients. These are some questions we can look at with data we have already compiled.

We also plan to analyze differences across MA plans. Some MA plans are owned by health systems that also own hospitals. When a single entity owns the MA plan and the hospital the incentives are different. Therefore, we hope to interview employees of both integrated MA plans and independent MA plans. We can then evaluate whether there are qualitative and quantitative differences across these MA plans on how the beneficiaries are treated.

Now here is an example of the type of data we hope to examine over the next year. This slide compares

length of stay for MA and fee-for-service patients. When those two groups are admitted to the same hospital, with the same principal diagnosis, and the same MS-DRG severity level. The first row shows that MA patients tend to have about a half a day longer length of stay, on average.

Next, we look at two subsets of the data. The second row shows that for patients discharged to SNFs, the MA patient stays about one day longer. This is about 15 percent longer than the average patient discharged to a SNF. And this fits what discharge planners and hospital administrators have told us during our interviews, where they said it took more time to find a post-acute placement for MA patients.

The third row shows the discharge to home. Here it indicates that MA patients do not stay much longer than fee-for-service patients. The data we show here are for pooled data over a three-year period, but the results are similar when we look at each individual year.

Now what are the effects of these longer lengths of stay? From the hospital's perspective, the longer length of stay can increase their costs. In addition, the hospital may not receive any addition revenue if it's paid

on a DRG basis. There are also some implications for patients. As we discussed in your paper, many MA plans require beneficiaries to pay a per diem cost sharing for the hospital but not for SNF care. Therefore, the beneficiary cost-sharing liability could increase with a longer hospital stay.

To summarize our tentative workplan for the next cycle, we expect to quantify the effective charge-based cost-sharing on rural health clinics and critical access hospitals. This will set you up to discuss if cost-sharing reform is needed.

Second, we plan to look at some quantifiable differences in the way MA and fee-for-service care is delivered. For example, we can examine differences in inpatient length of stay and associated costs, differences in MA and fee-for-service payment rates using encounter data, differences in bypass rates to the local hospital for MA and fee-for-service patients, and a broader look at travel times for primary care, especially in those with rural health clinics.

After gathering data on the individual pieces we will try to examine the overall effect of MA growth on

these rural providers' finances.

So we are still at the planning stage, and I said, and we would like to hear your feedback. Are there some issues you would like us to add to our list of research questions? Also, we plan to interview stakeholders over the next year, including rural beneficiaries, rural providers, and representatives of MA plans. Are there other stakeholders you think we should talk to?

And now I will turn it back to Amol to open it up for questions and suggestions.

VICE CHAIR NAVATHE: Great. Thank you, Brian. Thank you, Jeff.

So supporting high quality and accessible health care in the rural areas obviously is a big priority for the Commission, I think as it is for the Medicare program. There is obviously some complexity here. There are a number of different programs that CMS has. There are also a number of different factors that are happening in rural settings that are extending beyond just what the Medicare program is doing.

We, as a Commission, have been doing work on

rural for a very long time, including a chapter in 2021, and then ongoing work for the REH, or the Rural Emergency Hospital program as well.

So I just wanted to quickly mention that this work here is really an opportunity for feedback. This is not going to be a chapter in the upcoming June report.

With that we will move to our standard Round 1, Round 2 structure. Dana, I will turn it over to you to run that.

MS. KELLEY: Okay. Lynn is first.

MS. BARR: Thank you so much for this great report and taking up this important work. I have about 12 Round 1 comments, so you guys can cut me off at any time, and then I'll go to Round 2 later. So here are my comments on the work we have so far.

The MA growth that you show since 2018, those charts I find are a little bit misleading because they're not showing the growth -- it's much worse than it looks in that graph. I think if you showed the growth rates in urban versus rural you will see that sometime crazy happened in 2018, and you don't really see it the way that data is presented. So if you could look at growth rate, I

think it will be much clearer to people that something big is happening.

Your plan to study negative correlation between MA penetration and hospital closures, you know, there are an awful lot of things to look at. That's a very heterogeneous situation with these hospital closures. There are a lot of reasons behind it. The volume is relatively low. And it's probably not true, but I doubt it's worth your time. So that would be my suggestion is to just pass on that piece of the research.

I'd like you to study the effect of the high prices that are set by cost-based reimbursement. You know, how does that affect supplemental payments, how does that affect MA benchmarks, and how does that affect community rating for Med Sup, and how does that affect insurance costs? Because I think when Medicare sets a price for a critical access hospital or rural health clinic everyone pays that price, generally. And you're going to do some more research and you're going to see what that variability is. But the commercial plans, every is like, you know, that's the price. So that's driving prices up for everyone and making health care extremely expensive, in my opinion.

I would love to see data, so if you could look at that, that would be very important.

I think the fundamental problem that people have had with the MedPAC analysis in the past has been the question of defining rural, and defining rural as everything that's not urban is diluting the data with lots of actors that aren't rural. You've got all the suburban folks in there, for example, right, everybody that's not urban.

So I would suggest that we study these hospitals based on the RUCA codes of the patients that are being seen. So rather than trying to do it by geography, which is very heterogenous, if you look at the patients that are being served by those facilities, you'll be able to striate, truly, what facilities are serving rural patients versus everyone else. And so we get way from the fact of critical access hospitals in resort communities where 90 percent of their business is commercial and out of network, they have a very different profile, but they're in the data with everyone else.

So once you get all of these outliers out of the data, I think that you're going to see a much more serious

situation in rural, and that we'll be able to better striate the data. So I would really appreciate it if you could look at it through that lens. And this may actually create a rural safety net index number based on RUCA codes. You know, what's the average RUCA code for this facility. And then you could add that to other formulas, and you could really start seeing what are truly rural providers that are really taking care of rural communities.

And let's see. Next is it appears the life expectancy in rural is highly related to the public health issues like smoking. And so what is the impact of not participating in quality programs that require smoking cessation? You know, rural health clinics are exempt from quality reporting, right. So here's this set of providers that doesn't do smoking cessation, doesn't do depression screening, doesn't do colorectal screening. These are all the basic quality measures that we all scoff at in the urban area but aren't even reported in the rural area. And our experience was that once we started reporting rural under the ACO model we found that our scores were much lower than any of the providers thought.

And so it's very important, I think, that we look

at that, and understand what role is public health playing in rural communities. Are they actively involved in these programs? Where is public health? Why is the vaccination rate a third of the rest of the country? Why is smoking so high? Why is obesity so high? These are all the things that are contributing to the life expectancy, so I think that we need to better understand those.

On page 10 you mentioned that rural hospital margins were slightly higher than urban. I would read that as slightly less negative as opposed to slightly higher, and "slightly" was the right word. But then in the next paragraph you said the all-payer margins was slightly lower, but the difference was like almost 3 percent. That's not slight. That's significantly lower. And again, if we can stratify these hospitals based on patient origin, we may get a much clearer picture of all this, because you have got a whole bunch of hospitals in the data that don't belong in the data.

I'm on point 7. I'm almost done. Going to the work on rural health clinics. So the policy on rural health clinics that was passed, that dramatically increased the prices of rural health clinics, was one that was done

basically without participation from the National Rural Health Association, many stakeholders, and it's a bad policy. It's a really bad policy. We're fixing these prices for primary care at ridiculous rates, and in my rural health clinic the rate is over $500. You said the average was $226. Well, you know, I'm twice that average in my community. So my coinsurance on that is $100. And so no I have lots of access, right. I can get an appointment any time I want.

So I think that we have to really look at this rural health clinic policy that's been passed, and we need to make comments on it because I think it's very bad for the beneficiaries, and it was done without any sort of transparency with stakeholders, that I am aware of.

Let's see. We're almost done. And then MA. We talked about the relative growth rates. I think, actually, you're going to get a better look at utilization. Is there a way to map in-network versus out-of-network providers? We probably don't have that data, do we. You're just going to look more at just drive-by. And that will be a good proxy for that, so I'm good with that.

I'm just trying to think of given the description

of how they reduced the network adequacy requirements it would appear to me there's absolutely no requirement to include a rural provider in that network. And I think if we could be more explicit about that and say that you can sign everybody up in your rural county and not have a single rural provider in that network, I think that would be very, very informative to policymakers and what they need to understand.

Cost-based reimbursement. You mentioned that 10 percent don't have Med Sup, but I think you should also mention that employer plans are not required to cover rural coinsurance that is in excess of the minimum. So everybody thinks everybody's got Med Sup. A third of Med Sup is employer based, and we had patients in our office every day complaining about the fact that they had to pay coinsurance even though they had it covered. So that excess coinsurance was coming out of their pocket, they were very angry, and then they moved on to other facilities, then raising the cost for everyone else.

The biggest problem with cost-based reimbursement, we talked about, is the coinsurance. So the coinsurance is higher because the price is higher, and

cost-based reimbursement sets the price in that rural community. So what other impacts of these high prices do we need to study? How does this affect drive-by? Is the coinsurance the problem or is the price the problem?

I want to make sure, as people are thinking about how to solve this issue, it is not by just saying, oh, they're just going to pay 20 percent coinsurance. High prices have many, many problems in today's world, with value-based care, et cetera, and so there's not a real discussion of the impact of prices, and prices, again, have impact way beyond just coinsurance. They also cover the cost of other insurance and other issues that we need to really think about. So how does Medicare pricing affect other payers, community rating, and overall cost.

When it comes to post-acute care, which is the rural swingbed program is a very important program. We didn't really mention that in the chapter. I want to ask the question, does Medicare lose money or save money when using swing beds in a critical access hospital. And I've done a very brief analysis I would like to share with you about that, that could argue the point that we lose money by driving patients out of swing beds. And I'd love to

have your take on that and see is it really good policy. Because right now we drive patients out of swing bed because of the high price. So again, these are how prices are affecting behavior, but not nobody is looking at cost. So price versus cost, and I think high prices are actually creating higher overall costs by driving patients out of these facilities.

When you're thinking about post-acute care and swing beds then I think that we also need to think about the impact of the proposed skilled nursing facility staffing policy and how that is going to affect rural patients and rural SNFs. We also need to look at the quality of skilled nursing facilities in rural, because the quality improvements organizations have been focused, almost solely, on trying to improve the quality of rural SNFs versus urban because their quality is so much worse, and they have these huge staffing problems. We have wonderful abilities to give them post-acute care in these cost-based reimbursed facilities that probably cost us less to do it, and we're spinning around in circles. So I think policymakers need a good view of what's happening in post-acute care in rural America.

Three more, I promise.

So what about quality reporting and quality, in general? We do not require quality reporting in critical access hospitals, and we do not require quality reporting in rural health clinics. And the life expectancy data tracks with when urban started doing quality reporting and rural didn't. There are other factors, but if we believe quality reporting is important, and I believe the Commission all agrees it does, I don't understand why we're excluding 20 percent of beneficiaries from the benefits of having quality reporting and having providers work on improving their quality.

You mentioned multiple times the CAH Medicare margin, you know, 101 percent, and the CAH Medicare margin is roughly zero. Sequestration reduced CAH reimbursement by 2 percent. Now, by the way, if you are cost-based reimbursed that was a permanent penalty that never went away. If you're the Defense Department you got budget increases, right. So that 2 percent was a one-time cut. This 2 percent sequestration against cost-based reimbursement, it goes on forever. So the CAH Medicare margin is at least -1 percent, and some would argue it's

less because it's only on allowed costs, and so it's not zero. It's -1, at least, due to sequestration.

And then my final comment is the average rural county this year, in 2025, will have 27 MA plans, and that's up from about 1 to 2 four or five years ago. So at a critical access hospital, now we would typically get maybe 1,000 assigned Medicare beneficiaries from a critical access hospital, so I've got 1,000 Medicare beneficiaries that I'm billing 27 plans for Medicare plus the match. And so this is not sustainable, and we need to solve that problem. Because I also have to do prior auth with 27 plans.

We don't have the staffing or the knowledge to hire the people to be able to be effective. We have no leverage in negotiations. It is just a really terrible place to be is to have all that power pointing at you, and you're only a small part of that. So if you could think about sort of what is the impact of a critical access hospital, and then how does that increase the cost to Medicare, because we're going to have to pay for the people to do all of this extra billing in our cost-based reimbursement.

Thank you.

VICE CHAIR NAVATHE: Thanks, Lynn, very much. I appreciate your enthusiasm. Not at all a comment on the substance and quality of your comments, but just a reminder to Commissioners that Round 1 is for clarifying questions as opposed to comments.

From your comments I wanted to actually pull out one of the clarifying question for Brian and Jeff. Lynn commented about using the RUCA codes and the definition of "rural." So I just thought it was maybe helpful here for us to reaffirm. I believe what we are using here are the definitions that the CMS program is using to designate rural hospital as opposed to looking at beneficiaries served or some other definition. I just wanted to make sure we clarify that.

DR. STENSLAND: Yeah, so we are using rural/urban. So the urban includes the metropolitan and the suburbs and everybody who commutes into the central area. So for D.C., urban can extend into West Virginia.

There are definitely different levels of rural, and in the past, we've looked at comparing rural adjacent to a metropolitan area, rural not adjacent, rural frontier.

That's one way to look at it. Another way to look at it is the RUCA codes, which is more of what the Rural Health Research Center does. And you can have this kind of agreeing of how rural you are.

We can look at that and talk to people about which way they prefer it to happen. There are some plusses and minuses. Sometime the continuous nature of it is nice, but then you have smaller sample size when you have more different RUCA gradations. But we'll be going through that in the fall and hopefully talking to Lynn and the rest of you. We can do it either way.

MR. O'DONNELL: Actually, can I say one more thing? You know, when they use the CMS designation, it does vary by program. So like internally, for our agency, there is a different definition of what is non-urbanized. So behind the scenes we are tracking. We have a category called "urban/rural health clinics." And so as odd as that might seem, we are tracking behind the scenes and we understand that there are different ways to slice it to get at the different policy questions.

MS. BARR: On that point, like when you're talking about RUCA you were talking about the RUCA for the

actual facility, right. All analysis that I'm aware of has always been facility based. And when we did the safety net index and looked at patients, we found a very different story. This is a patient-focused approach, so it's really the RUCA codes of the patients that tell us really where rural patients are being seen, and I think it will be as illuminating as the SNI.

VICE CHAIR NAVATHE: Understood. Well taken. Thanks, Lynn. Dana, we can go back to the queue, please.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks. Lynn, you're a tough act to follow, but these are hopefully clarifying questions.

Some of the space is very new to me, and I guess I was curious as to how beneficiary cost sharing was set at 20 percent of charges for outpatient services. Because it feels to me like there is this very -- and I think this is the main point -- it's an unlevel playing field for the beneficiary. So can you maybe help us with some of the history of how that got determined?

DR. STENSLAND: Well, this is before my time, but the way people used to talk about it was initially everybody was paid based on their cost. And at the time,

back in the '80s, the cost wasn't that much different from the charges. And they said when the patient is in the hospital, you know, when they're being discharged or finished with their visit, we know the charges. We don't really know the costs yet because the costs are going to have to be sent through the cost reporting system at the end of the year. So we're going to make them pay 20 percent of charges, which is something we know when they leave the hospital. And I think that was that rationale.

And then they moved the traditional hospitals to the prospect payment system, and at that point they started having 20 percent of charges, and then we said, no, that doesn't make sense because now the charges have grown so much above cost. Then they shifted that to 20 percent of the payment rate.

But when the critical access hospital statute was developed in 1997, they tied it back into the old way of doing it, 20 percent of charges. So whether that was an intentional for budgetary reasons or not, I don't know, but that's the timeline of how all this happened.

DR. DAMBERG: Thank you. That's really helpful. And then the following sentence, on page 2, says CAH

coinsurance varies widely from provider to provider. Can you help me understand that?

DR. STENSLAND: Right. So let's say I hit my head, I'm in the critical access hospital, and I'm going to get a CT scan. And the one hospital says their charge for the CT scan is $2,000. So I'm going to pay $400 in cost sharing, or 20 percent of that.

Some other person might go to a critical access hospital and they say their charge for a CT scan is $1,000. So now you're going to pay $200 of cost sharing at that critical access hospital.

And so the variability of the cost sharing just goes up and down with the variability of the charges, which is really quite dramatic. In some places they charge about their costs, more common in the Midwest. Sometimes they charge way mor than their costs, more common out in the West, kind of the California mindset.

DR. DAMBERG: Great. That's super helpful. And then my last question is, so it's clear we don't really have transparency in terms of whether MA plans are making additional payments. And is there any mechanism for requiring plans to do that?

DR. STENSLAND: There's no mechanism now. In theory, if the patient goes to a hospital and the MA plan is responsible for that payment -- let's say they hit their head on their steering wheel and they get taken to this critical access hospital -- and there's no contract with that hospital, in theory then the critical access hospital should be paid the full fee-for-service rate. Sometimes they tell us they've had some difficulty actually getting that full rate from the providers, and that's kind of if there's no contract in place.

And then there's the other case if they're actually negotiating a contract then it can go up or down, and more often they say it goes down, at least in our interviews, from fee-for-service rates. But that's something we hope to not limit our analysis just to these interviews with critical access hospitals but also look at the encounter data to see if we can confirm.

DR. DAMBERG: Great. And this starts to bleed into Round 2, but I don't know whether all-payer claims data would offer some opportunities in the future. Because I know they're looking to capture alternative payments made to providers in some of the states. So California is

moving pretty quickly in that direction.

MS. KELLEY: Brian.

DR. MILLER: Thank you. I enjoyed this chapter, as someone who did part of my training at a very rural place, struggling with rear-wheel drive car in blizzards, and one stoplight.

I liked Table 2 a lot, and had a couple of clarifying questions about Table 2. Under the column that denotes annual cost in billions, in 2022 dollars, is that the subsidy that the hospital facility gets based upon the categorization, or is that just the cost of the Medicare program, and are those values I just denoted the same or different?

DR. STENSLAND: This is the extra money the hospital would get, and those amounts are different. The amounts are different. The biggest difference you'll see is with critical access hospitals and on the outpatient side, because if the patient is paying 50 percent of the cost, they are paying a lot of the extra payment that that critical access hospital is getting for outpatient services.

DR. MILLER: So you're saying this measure is the

cost to the Medicare program, which directly is the same amount that the hospital is getting.

DR. STENSLAND: These numbers in the column are the sum of the extra money that the Medicare program is paying plus the extra money the beneficiary is paying in cost sharing.

DR. MILLER: Okay. We should probably clarify that. And then what might be also helpful to make this table clearer is to include the number of facilities that are eligible. Eight hundred million dollars doesn't seem like a lot of money in the Medicare program context, but if that's for 10 hospitals versus 1,000 hospitals, that's a pretty big difference, so we should include an N, the number of hospitals, and then a dollars per hospital.

Also looking at this table, we mentioned the 340B program. It's not quantified. We should quantify that because I know that is an important source for these facilities. And then we should also probably denote that tax-paying hospitals are disadvantaged. Because of these payment choices they are not eligible for 340B, despite paying taxes.

A couple of other questions. Is there a reason

why we did not include the role of nurse practitioners, physician assistants, and pharmacists? And I ask this as someone who practiced in a rural area, and I would say perhaps the clinicians were those practitioners and that we actually wouldn't have been able to operate the clinics and the hospitals without them.

MR. O'DONNELL: So we have discussed. We have looked before at the share of clinicians in rural areas that are NPs and PAs are higher. We've also talked before that the whole reason for the RHC program to exist was to allow NPs and PAs to bill and to provide care. So we consumer wrap that in as context going forward. But if there's a particular policy you want us to --

DR. MILLER: I think the fact is that we probably wouldn't really have much primary care in rural areas if we didn't have nurse practitioners or physician assistants, and then we'd actually probably have limited access to specialty care. Because in a rural setting, at least when I was there, and I'm still sure the model is the same, that often the clinic visits would be done by the nurse practitioner or the physician assistant. The inpatient hospital consult service would often be run by them, and

then the physician would be doing surgery and procedures. Obviously, they would see the patients.

But a lot of the non-procedural volume was done almost exclusively by nurse practitioners and physician assistants, such that a lot of these rural, small facilities would not have cardiology, gastroenterology, cardiac surgery, general surgery, plastic surgery, or dermatology, or probably much specialty care involved procedures if they didn't have nurse practitioners and physician assistants, and we should make that clear, especially noting my colleague's comments about incident-to billing in prior meetings.

And then, of course, pharmacists were extremely important for immunization in rural areas too, and with the recent pandemic we should denote that.

I agree with my colleague's comments about quality as an important lever, and also about administrative burdens, noting that we mentioned the average of 27 MA plans, which is an overwhelming amount of paperwork that makes me want to hide under the table, and there's a certain so I truly could hide.

With the aim of talking about solutions, maybe

there are policies or regulations that we could explore as part of this, what I hope will be a chapter in a future report, exploring the role of automation and artificial intelligence to decrease administrative burden for clinicians so that they can focus on treating patients rather than signing forms.

And then one other question I was curious, I didn't see discussion of an efficient hospital, and I know that's something that we talked about in the other hospital chapter. I think that's important to have that same concept and respect our precedents of policy framing here.

And then we also don't talk about access to novel products like CAR T or gene therapy or other sort of revolutionary treatments, and if we want to ensure health equity, we want rural beneficiaries to have access to those. And so we should find a way to measure and include that. Thank you.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, thank you. I just had a clarifying question around the special payments, the ones that you list out on Slide 5. Is that included in the MA benchmarks?

MR. O'DONNELL: Yes.

DR. RYU: Thank you.

MS. KELLEY: Larry.

DR. CASALINO: I just want to make sure I understand. The rural-urban categorization you guys used this time, is it correct then to say that suburban hospitals are included in the urban, not in the rural?

MR. O'DONNELL: Yes.

DR. CASALINO: That's correct. Okay. And then the second thing, would it useful and/or possible to take a look at cost sharing as a reason for bypass? So if I know I'm going to have to pay some huge amount of cost sharing if I go someplace that's 20 minutes away, but much less cost sharing if I go to a place an hour and a half away, am I bypassing because I think the second place is better or because a $200 cost share is a lot for me? I don't know if that's worth looking at, or if we could look at it. But it could be a major reason for bypass, especially for outpatient care probably.

MR. O'DONNELL: Yeah. So we'll know the cost sharing levels, and we'll know whether there's bypass. So we'll be able to tell if there's a correlation. I'm not

sure how causal we will be able to say it is, but we can look at those correlations.

DR. CASALINO: Great. That would be useful. And then the last point, I know MedPAC is about Medicare policy and its effects on Medicare beneficiaries, but as I said before, I think that it would be wrong to ignore unintended consequences of Medicare policies on other people. And paying based on charges, to the extent that we are doing that, can really, really hurt people who are not Medicare beneficiaries but who don't have insurance. Because the hospital charges whatever it wants, but if you don't have insurance that's what they expect you to pay, right? And so that's not a trivial point, even though it's not directly involving Medicare beneficiaries.

Are you guys' wrists tired yet?

[Laughter.]

DR. CASALINO: I don't think I've ever seen such a list of things.

MR. O'DONNELL: Can we wait until Round 2, after Lynn's done, to answer that question?

[Laughter.]

DR. CASALINO: If you're lucky there won't be

time for a Round 2.

MS. KELLEY: Amol, that's all we have for Round 1. Should we move to Round 2.

VICE CHAIR NAVATHE: Scott, did you have a Round 1? No. Okay. Great.

Well, we'll move right to Round 2. I just wanted to highlight for folks that we have just a little over 30 minutes left, and we have something like 12 or 14 Commissioners. So brevity, please, here. Dana?

MS. KELLEY: Lynn?

MS. BARR: Okay. I will be brief. In my opinion, the problem with cost-based reimbursement paid facilities is that cost equal price and that there is no quality reporting. And I think that needs to be the main focus of the analysis is how does cost equal price really screw everything up, and what can we do about the lack of quality reporting in these facilities and how that's hurting patients. I do believe that high prices drive patients away, so I am plus-plus-plus-plus-one on Larry's comment. High prices double cost sharing. High prices go to MA benchmarks. High prices increase the cost of insurance. And this is a burden to our poorest

beneficiaries, and I would like to see us recommend changes in our next cycle. Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: All right. I will say piling on a lot of plus-ones to what has already been covered, especially by Lynn. Thanks for those excellent comments in Round 1 and 2.

I am just going to say, I'm incredibly excited about this stream of work, and I do want to see this move forward. Most of my remarks are going to be specifically about things I'd like to see in the analysis and the workstream moving forward.

Jeff, you asked the question, is cost sharing reform needed. Absolutely. Like it is absolutely appalling that anyone is paying based on charges. Charges are made up, like inflated in ways that are unbelievable, and the fact that anybody is still paying based on charges, uninsured people too, but people with Medicare coverage, it's just unbelievable that this still happens. So that needs to be reformed urgently.

I think figuring out what it means for how these sites of care are paid by MA and also what does that mean

for cost sharing for MA beneficiaries is mission critical. Like we need to know that because MA is such an important coverage type for people in rural areas, and it's growing. So that, I think, is really key for the workstream.

Looking at the trends in charges and cost sharing, absolutely. That is critical to get policies changed, I think, to really be very clear about what's happening to people.

A couple of other things that I noted in your presentation. The driving time and distance and how that changed to allow for telehealth to count, I do really worry what that means for people in rural areas, like really rural areas, and their ability to actually do telehealth is still, I think, fairly compromised in some ways. So I think looking into that would be great.

I definitely appreciated the summary of the switching between MA and fee-for-service, or from fee-for-service to MA, in particular, and I really wanted to know why. Like we know that once people make insurance decisions, they don't like to revisit those decisions a lot, and it feels like a lot of switching in a space where we know that people aren't really actively looking to do

so. So why are people switching? And to any extent that we could talk to the beneficiaries who are switching, and maybe it's the people who are switching and trying to switch back, we know that also happens, that would be really helpful for this analysis, and for other studies, I think, of what's really going on. You know, are people getting outreach that is prompting them to switch, or is it just that they've decided the coverage doesn't work the way that they thought.

So again, incredibly enthusiastic about this workstream, and thank you so much for the excellent work.

MS. KELLEY: Tamara?

DR. KONETZKA: Yeah, thank you for this really interesting chapter. My first reaction when I read about the patient cost sharing and the coinsurance based on charges was, do people actually pay this? I think it would be interesting to know whether those charges are actually paid, to what extent do these result in sort of bad debt and uncompensated care, because that sort of, in turn, has consequences for the hospital.

But my second and overriding reaction was very similar to Stacie's, which is why is anybody paying based

on charges? It does seem like a ridiculous policy that was just based on historical accident, for which there's really no justification anymore. And there are bad incentives to increase those charges associated with it.

So I would really love to see an exploration around the policy option, to change that policy, and have it based on something that's more equivalent to what a coinsurance rate would be under PPS. And so, you know, there are always unintended consequences. It would be nice to just sort of lay out how this could be changed and what the consequences might be, and some analyses around that.

And then I say, similarly, this was a little tangential to the chapter but it did come up, and that was the fact that in switching from MA to fee-for-service that beneficiaries no longer have guaranteed issue of a Medigap policy. That also seems mostly historical accident. I assume the original intention was so that people wouldn't sort of wait until they're sick to be able to spend money on a Medigap policy. But I think that this consequence of not being able to switch or not finding enough horrible Medigap policies is probably out of alignment with that original intention. So I'd love to see some exploration of

policy options to change that, and what would happen if we sort of restored guaranteed issue for people switching from Medicare Advantage.

In terms of the Medicare Advantage stuff, I was really interested in that Henke study that you mentioned in the chapter, so I looked it up. It's a pretty simple fixed effect study. This is the study that found a negative correlation between MA penetration and hospital closures. It's just a fixed-effect analysis so that changes in MA penetration over time were correlated with changes in the probability of a hospital closure.

I think the obvious issue there is that MA penetration isn't sort of exhausting us, right. They go into certain markets, maybe sort of include certain hospitals in their network that are financially stable. So I guess I wouldn't worry that that study is sort of in contradiction to what people are worried about, and I think there really is a worry that we're implementing all these policies to sort of subsidize rural providers and make sure they stay in operation, and that, in turn, sort of creates some slack for MA insurers to just sort of negotiate lower prices. So we're just sort of shifting money around.

So I think it is still important to sort of monitor the health of providers over time and not spend too much time worrying about that one study. So I think we want to continue to monitor some profit margins, closures, and uncompensated care, in particular.

I was also worried, as Lynn was, about access to post-acute care. Again, this is part of the sort of coinsurance issue off of charges for swing beds, which is really high and perhaps unaffordable. I would say for this analysis I would really love to see us continue to monitor access to post-acute care in rural areas and especially to try to look at some patient outcomes. Because if there's one thing we know about post-acute care is that it's very unevenly used and there's still a lot of lack of clarity around the effectiveness of post-acute care. So less use is not necessarily bad, but it may be if it's just due to high prices, so I'd really like to see some more work around patient outcomes in rural areas, in terms of post-acute care and access to post-acute care.

And I'll stop there. Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thank you. I hope that this becomes

its own chapter in the next cycle, given that 60,800,000 Americans live in rural areas. I realize that they are not all Medicare benes, but we should respect their right to choose a different place that's not an urban city, and make sure that our system supports that.

I loved Table 2, so I apologize for being a little obsessive about it. But as I was thinking about it, and thinking about Lynn's comments about administrative burden, from plans, it's hard to run a hospital to knowing you have to do lots of paperwork. We all get excited to get up in the morning and go to the office and do paperwork. That's what gets us out of bed. I know it gets me right up before the quadruple-shot espresso.

So I was looking at the list of the categories -- sole community hospital, Medicare-dependent hospital, critical access hospital, rural emergency hospital, rural health clinic, 340B -- and my head started to spin. It's hard to keep track of what is doing what and what is measuring what.

I wonder, and would posit that perhaps two things we should think about, because we all care about rural health. Can we think about simplifying these categories?

Because I counted seven categories, I think. That's a lot. And if you're a clinic or a hospital you don't have a lot of financial resources and you don't have a lot of admin staff, figuring out how to meet the conditions for any of those programs could be pretty overwhelming. So could we think about a way to target our support for rural facilities and rural care in a more administratively efficient fashion.

And also long lens comments. If we were doing that, and we are doing that, we should measure quality, because we want to know what value we're getting for the beneficiaries. I think that could make it a lot easier to run a rural facility. Obviously quality measurement needs a lot of improvement. That doesn't mean that we shouldn't do it.

A couple of other thoughts. I looked at the MA veterans fee-for-service switching data a little bit differently than my colleague. I was interested that a lot of people switched in rather than switching out. But I'm still concerned about the equality of fee-for-service and MA, and I think how consumer we get there.

One way to get there, which we have not explored

as a Commission but we should think about is the competitive benchmark inclusive of fee-for-service, which would mean that we do things like apply risk adjustment payments to the fee-for-service plan, apply a quality rating system and bonus payments -- not the current one but a one -- to the fee-for-service plan in addition to the MA plan. Because it's really weird to have a market that's half of Medicare that gets all these additional payments and then have fee-for-service sitting there by itself and not having equal opportunity to get those payments, and then for prices for those plans for beneficiaries to not compete. Because in some areas fee-for-service might be a much better plan for benes, and if that's the case we should have them on an equal playing field.

I think, one other thing, hitting the nurse practitioner, physician assistant, Pharm.D. box, which is a favorite one for me, the reason that I'm interested in that is because rural areas have fewer resources, and when we have fewer resources, you have to innovate. And so we should spend time talking about what that innovation looks like, both with the types of clinicians that are using the delivery system, because the rural delivery system with its

different staffing and operational model, especially things like swing beds, could be a great model for urban and suburban areas, like we should learn from that and apply that throughout the rest of the Medicare program.

And then we should also, as Lynn has said in other sessions, focus on solving problems, not just pointing them out. And so I think about in addition to rural facilities, where you solve some of the staffing problems -- they still have barriers, but having solved it by using a different workforce -- and we think about technology as a way to automate, because some components of care are augment components of care. There was a recent study that showed that if primary care docs did everything they were supposed to they'd work 27 hours a day, which is, I mean, not sustainable. So can we use technology and automation, and is there a way we can pay for that, and should, say, a tech company be a Part B provider in order to do that, as an example.

So I think that those are things that we should explore in this chapter, and I look forward to seeing it as part of next year's formal workstream. Thank you.

MS. KELLEY: Cheryl?

DR. DAMBERG: Thanks very much. This is great work. I think it's a great start to developing a robust agenda, so thank you to the staff for getting us started on this discussion.

I do want to plus-one on much of what the other Commissioners have said, particularly Lynn, so I'm going to try not to repeat those comments.

You know, as I noted, the growth in MA I think presents us with new challenges related to some of these additional payments and what's going on in that space. So I think the more we can learn, you know, that will help us understand the extent to which these rural providers are sort of at risk.

I wholeheartedly support interviews or any other mechanism for making data transparent on how providers are paid on the MA side. That would be great.

I also think this issue of cost sharing and the need for reform is critically important, and Tamara mentioned the issue of bad debt. But I think it would be helpful to really spotlight, for the average beneficiary or beneficiaries in different groups, what their cost sharing exposure is. If you compare them, sort of between their

urban counterparts to really spotlight for people who are going to read this report what these differentials are and potential for bankruptcies. We know that's a critical issue underlying bankruptcy in the United States.

I mentioned the APCD data. It may not be kind of ready for prime time right now, but I think this will probably not be the last time we touch this issue, and I would certainly put this on your radar to think about whether some of the information you need could be found in some of these APCD databases.

Plus-one on what Tamara said about post-acute care. I had a question about the 340B dollars and how those are being used and the lack of transparency on that front. I think it would be helpful to see if we could dig a bit deeper there and to provide greater transparency in terms of what the hospital is actually paying and what they are charging people for those drugs, because I suspect that's not what we would want to be happening in that space. And the question is what are the reform options.

And then I think just overarching, this is a multidimensional examination, and I think one of the things that may help us as well as the future readers of this

chapter is trying to put some kind of framework around this, because there are so many different things we are talking about. We are talking about cost sharing and prices and quality of care, so I do support trying to get a better sense of what's going on in quality. But also the role that I think Lynn mentioned about public health, particularly in rural communities. And I recognize we probably can't tackle it all, but it might help to start framing this and then prioritizing where we look.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much. I really appreciate this work and the comments of the Commissioners, so I will try to be brief.

My first thought when I was reading this was that Table 2 is brilliant. I thought it was really, really helpful taxonomy. I've worked in rural and frontier areas most of my life, and it's always seemed like a bit of a soup. You know, I knew they were all out there so I really appreciate that.

My only slight suggestion there would be an asterisk to define "necessary provider," because people won't know what that is.

Lynn brought up the issue of the definitions of "rural," and I think that's extremely important. And I think a short box, kind of describing the pros and cons of the two methods would be very, very helpful. Many years ago I did my dissertation looking at barriers to delivery of home health services in rural areas by population density, and it was a remarkably different world depending on if you were in a frontier county or whatever, and the definitions really matter. So I think just clarifying that and then why we're going for what we're going would be helpful.

On page 23, it talks about physicians reporting that they were considering out of network so people in MA plans would bypass. I thought that was really important, and the magnitude of that wasn't clear to me, I think understanding how often that happens. The document says that we don't know how often beneficiaries pick the network before they pick an MA plan, but I assume they are like most and don't or can't. So I think if we can have some idea of the magnitude of that, that would be important.

You asked who else we should be looking at, other stakeholders, and you've talked to clinicians, which I

assume includes nurse practitioners, PAs, and physicians -- and thank you, Dr. Miller, for highlighting the important work they do -- and administrators. But I would also be very interested in the experience of the staff. The staff in these settings really are specialists because they're generalists, and at least whether they're physical therapists, nurses, whatever, they may be working the swing bed one day and the emergency department another, and that is quite a world to span.

It leads to the issues of quality, and not counting quality reporting I think is absolutely essential. But it's also important we get the right metrics and it doesn't just end up being reporting burden.

One of the things that I'm particularly concerned about, as a nurse, is how many procedures that are really low volume are done, because that is a very uncomfortable experience to be involved in something you don't do very much. So if we can get some handle on that.

I want to give a plus-one, plus-one on the post-acute thing that was mentioned by a number of people, Lynn and Tamara. And I just have to say that I'm really thinking about skilled nursing facilities a lot right now,

with what's been in the news about the mandatory staffing ratios and the kerfuffle around that. But I also know that the nursing staff and staff mix is the air traffic controllers. They are the safety in that environment. And if we didn't have enough air traffic controllers, would we still fly and just say, well, it's too much of a burden on the airline industry? So I really think we should think about that, whether it's in the quality reporting or what.

And then just this week I think I read that 30 percent of Medicare Advantage beneficiaries do not use any of the supplemental benefits. I couldn't find it right now. I'd be curious if we know that for rural beneficiaries.

And finally, cost sharing reform. Yes, yes, yes. That is extremely important.

So thank you all for your comments. I appreciate it. And thank you for this work.

MS. KELLEY: Greg.

MR. POULSEN: Thank you. I would pile on with saying great work. Thanks to you all for all the things that you've done. Like a lot of our colleagues here I've spent a lot of time in rural health care, but I still

learned a lot. So great work and great comments by the Commissioners that preceded me here.

I'm particularly grateful for your recognition that there is huge variation among the rural MA plans. I think that is a big deal in their performance, and it's likely to do varied, at least partially based on their different structures and incentives.

The variation in the two I highlighted supported I think supports the idea that there may be a potential change in rural health care that could be a really powerful incentive to do things in a more effective way. And I think we might have a model that we could look at that I don't think we've considered yet in rural areas and that's been the emerging CMMI CMS AHEAD Model, which is a hospital-based global payment approach that I know some of you are familiar with. While this model faces some really difficult challenges in most settings, I think it's intriguing as a concept for rural health care.

As I've mentioned here in the past, my own organization has had some extremely positive results in capitation-based payment in rural communities, especially isolated rural communities. The potentially wonderful

thing about that concept, as a model at least, is that it brings together multiple payers into a common payment approach and a prepayment approach, which is really important given the fixed cost nature of most rural communities.

This could be, I think, exciting in rural areas, but unfortunately the AHEAD Model, as it now exists, is state based, and there's really no capability to apply it explicitly or specifically for rural communities. But that doesn't mean that we couldn't consider such a concept more broadly as a recommendation, going forward.

Almost by definition, rural communities, especially isolated rural communities, are single provider in nature, and creating consistency in prepayment could create a remarkable health ecosystem where, again, as I mentioned, costs are largely fixed, and we could see a differential way of thinking about health care.

I think I could speak way longer than would be respectful on why I think this virtuous payment approach would be good for government, good for providers, good for private payers, and most importantly, good for beneficiaries. But as we think about a mechanism that

could really be a swing-for-the-fences kind of an approach we may have a leg up because of the work, again, as I mentioned, the work on AHEAD has had to deal with a lot of really complicated issues that they have now had to dig into and figure out. And I think that could give us some steps forward in potentially a different model that might really do something dramatically more effective in rural communities than we've experienced before. And given the new technologies that are available, I think we have the potential to experience a growth and really a regeneration of capabilities in rural communities that could make health care there very, very attractive financially as well as clinically.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks so much for the chapter. This would also add a plus-one to many of the comments that have already be made. These are some more granular comments about the chapter. But I am excited that we are working on -- it's not a chapter -- the work, the workstream, excuse me, but I do hope it becomes a chapter also.

So there is something on page 16 that says "while

Medigap plans are often more expensive than MA," and I have a problem with that. Often, yes, and that's technical true. However, if the person is not very healthy, goes in and out of the hospital, has to have PT/OT, you pay every time, go to rehab, if you can find local rehab, you see specialists -- you know, the maximum out-of-pocket for many Medicare Advantage plans, the max that the government sets in 2024 is $8,850. Of course, plans can have it lower than that.

In North Carolina, I was just looking at the Medicare Advantage plans, the maximum out-of-pockets, roughly around $3,500 to $4,000, something like that. But if I have a supplement, and on average we help people with supplements, say a 75-year-old, paying $200 a month in North Carolina -- I'm in an urban, you know, Durham -- that's $2,400. Plus you've got to pay your Part B deductible, so $2,600.

So if you're a sick person and you have to use a lot of services you save a lot of money by being in original Medicare and having a supplement. So I just want to point that out. So Medicare Advantage plans are not always less expensive.

So what I'd really like to think about is what are the costs of supplements in rural versus urban communities, and how is that disadvantaging some people in rural communities. And who owns those Medigap policies? And if you're a company that sells Medigap and Medicare Advantage, do you have an incentive to raise our Medigap prices to try to shift people over to the Medicare Advantage plans that you also own? I'm just curious if we have any ideas if that is happening.

Medical loss ratios with Medicare Supp plans, I think it's 65 percent, where we know with other insurance it's 80 to 85 percent. Is that true? Who decides that? And then to Larry's point.

DR. CASALINO: Gina, you just asked Jeff Stensland a question that he doesn't know the answer to. This is a first in my experience.

[Laughter.]

MS. UPCHURCH: I don't know. I may be wrong, but I think that is true.

And to Larry's point, when he says are people bypassing some of these rural hospitals or whatever because of the cost sharing, my question, they don't really know

the cost sharing because it's a percentage, that you know after the visit. So they're blindly, or they're hearing their neighbor say maybe it costs more or something, but it is not known to them up front if it's based on cost, is my understanding.

And I've got to say something about pharmacy. So 340B pricing, you know, if it's intended, I know in some rural communities they probably, if the FQHC or the rural health center doesn't have an in-house pharmacy, I'm wondering if they contract it out, which is probably a very good thing for those pharmacies because they are slammed by DIR fees. Rural pharmacies, in particular, have been hurt by direct and indirect remuneration fees and have been closing. So do they have impact to pharmacy in rural communities, and 340B contracting, is that a way to help those communities keep those pharmacies in tow?

And lastly, I am just concerned about network adequacy as we move forward in rural settings. You know, we've heard of people that, while on paper they have home health agency as an example, that's in network with a Medicare Advantage plan. When you call to actually get that home health nurse come see you, they say you're too

far, you live too far. So is that allowed? I mean, can that happen, because we've heard it some. Is that supposed to happen, and what can you do about it as an individual consumer if you are being told that even though that company is in your Medicare Advantage network but it's not actually servicing you. Thanks.

MS. KELLEY: Jaewon.

DR. RYU: Thanks. I just have three comments. First of all, at a high level I'm disappointed I won't be here to see this work come to fruition. It's a really important issue, and I'm glad we're tackling it.

Comment one had to do with the interplay between MA and rural. It gets to the question I asked as well. It just seem like, I think that's just one example of something that needs to be further explored, so I'm glad that's part of the workplan. That example, you know, if it's in the MA benchmark and yet plans aren't really passing that along, that just seems to defeat the whole purpose of what those special programs are there for, setting aside whether those special programs are indeed the right kinds of ways to further bolster or make rural health care more sustainable.

Number two, I think the copay issue absolutely needs to be a part of the workplan. I think it's poorly understood, to Gina's and others' points, and maybe something that people aren't even as aware of. So bringing light to that would be good.

The third, slightly longer comment, and this has come up before in terms of some of our payment adequacy discussions, but I think when we look at either hospital or even clinic -- and we have explored this a little bit on the ambulatory side when we did the last round of rural work -- but I think we have to get down to the granularity of types of services.

When we look at facilities and hospitals, and when we do that for adequacy discussions, we do that through the lens of simply are they open or did they close. There is a pretty wide gulf between an open hospital and a closed hospital, where services erode and essentially die on the vine. That dying on the vine process I think needs to be better understood, and it could even be, I think in the chapter it was on the bottom of page 5, into page 6, you list some of those critical services. And if there's a way to get better line of sight into whether those services

and programs continue to exist, even while these hospitals are open, I think that would be really informative.

For example, if the hospitals are open doesn't necessarily mean all is well. It doesn't mean that services are intact. It doesn't mean health needs are being met if some critical programs are not there. And so further fleshing that out, it would be great if that was part of the work, as well.

MS. KELLEY: Kenny.

MR. KAN: Outstanding chapter. I am very enthusiastic. I definitely want to encourage us to further explore the interplay of MA and rural health.

I'm definitely not a fan of charge-based pricing and would really encourage us to explore several things. Number one, given charge-based pricing, I'm really concerned about potential skipped or deferral of care, you know, Medicare beneficiaries. So I definitely agree with Jaewon. We should really explore more the whole copay/coinsurance dynamic. I

t's actually very complicated. With copay you will probably lower the out-of-pocket cost of the beneficiaries. It would shift costs over to MA. But yet,

at the same time, you also get what's called induced utilization, that probably didn't exist before. Some of that will be good utilization in terms of preventive care. Some probably will be unnecessary utilization, possibly. We don't know, so if we could look at that.

But yet at the same time, by having the copay model in there you help to inject predictability in terms of how you think about hospital finances. So could we actually look at that and blow that out, in the way that Greg was actually talking about, the AHEAD Model, inserting some kind of a capitation-based model. Because the key here is predictability of cost for the entire system. If we can maybe look at that as a pilot or some kind of accounting footprint and see how that actually works out, and then further extrapolate that, I think that could be very informative.

And that was it. Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. A great job in laying out this chapter in a way that allows for really productive discussion and solicitation of feedback, so that's definitely much appreciated.

I think for me what was most striking about the chapter is this patchwork of programs that is in place to make sure that we actually have a rural health care system. And because of that fragmentation there is a lot of complexity around it, which speaks to the whole issue around Medicare being programmatically complex and difficult to wrap your mind around.

In that same vein, we also tend to think about these different specialty areas, like rural health care, in bite-sized chunks, sometimes at the expense of other work that we're doing, or other recommendations that we may have. And so one of the things that I noticed was missing in the chapter is all the work that we've done around the safety net index. And I really do wonder if the safety net index was law what the impact would be on these various programs that are keeping rural health functional, and whether those programs may need to have adjustments based on the SNI or whether our SNI model actually needs to be adjusted in the context of those programs.

So if I were to put something on the wish list of many other items that the Commissioners have suggested it would be an analysis of what the SNI would look like in the

context of all these other payment programs that exist in the rural space.

But really, thanks for teeing this up very nicely.

MS. KELLEY: Scott.

DR. SARRAN: Yeah, great work, guys. Two series of comments. I will be very brief. The first is a series of strong plus-ones to other Commissioners' comments. Looking at the location of hospitals versus location of people they serve, beneficiaries they serve I think is important, for example. I think about a rural hospital that is the catchment area for a ski resort. They may have an extremely lucrative orthopedic service line doing emergent data in a network totally different than what we're trying to prop up and support here.

Swing beds. When I think about it, sort of a visual of the acuity of a beneficiary versus the capability of a provider with beds, there's a sweet spot there at the less than critical care and the greater than a rural SNF could provide, that is probably the lower end of inpatient acuity, the higher end of skilled acuity. We should not do things that discourage rural hospitals from serving that

niche, that sort of combined niche. So I really think that is worth looking at.

Quality reporting. We have to. I mean, we're making, in essence, a series of public policy and recommendations around propping up rural entities. We need to understand whether we can do that at an acceptable quality level, not just an acceptable cost level.

Greg's comments about population health, wow. If there's a home run to be hit in this space it's down that dimension because there are a variety, as you were point out, sort of structural reasons why this might make really wonderful sense.

And the beneficiary cost sharing, it is so perverse. It's not just wrong. It drives people away. It's such a perverse thing.

An MA comment. The issue, I think, with MA is in urban and suburban, with hospital consolidation, et cetera, it is a relatively even playing field on a good day between providers and large MA plans. It is grossly an unequal playing field with rural providers. So I think our mindset should be putting out potential solutions around leveling, what would enable a better leveling of that playing field.

For example, on the [audio disruption] solution, but there are things that we could think about such as any willing provider type regs for rural providers willing to accept their fully loaded fee-for-service rates, limiting MA plans' ability to do PAs for inpatient acute, perhaps, and for the first five days of skilled. I mean, there would a series of several others. The point is I think we should start looking at potential solution sets that would level the playing field.

Two minutes and 53 seconds, I just want to say.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, again, great chapter. Just a few quick comments. One is I just wanted to -- it has only come up once so I want to echo Stacie's thing about in looking at quality, trying to look at areas like cancer care, where there are reasons to believe that it might be worse in rural areas, in general, and even worse in rural areas where the person is an MA enrollee, but we don't know that.

Second, I just want to say I think Robert's comment about relationship of safety net index to this is really smart and would bear some more thinking.

The second comment, I don't know if there's any data or anything published on this, but my impression is that most Medicare beneficiaries don't really have a clue when they choose MA, or if they decide they want to initially, or if they decide they want to switch out of MA, that they don't have a clue about the consequences of that, which basically are prohibitive in most cases, unless you're a very, very healthy person.

So first of all, I'd like to know if there is any literature on that, and secondly, when you guys are out talking to beneficiaries or anybody else who might have some experience with this, I'd like to know more about the extent to which beneficiaries do have a clue. And there might be some thought given to if they don't have a clue, how they could be given a clue. Obviously, someone like Gina will give them a clue, but most benes don't talk to people like Gina.

Third and next to last comment is, it is striking, if these extra payments go into the MA benchmark but MA doesn't make those payments themselves, doesn't have to make those payments themselves, that is MA usually free-riding on the fee-for-service system. And I think some

discussion of that might be useful, because that's a fairly big deal. These payments are not small.

And the last comment is, I think in the last year or the year before, a so-called provider-based clinic, it was like $255 for an office visit and $85 for an independent clinic. Two comments about that. One is it took me a little while to figure out that by provider based we meant hospital based, I think. I don't know if provider based is the standard terminology, but it's poor terminology, and you might pay some attention to that in the chapter.

And then the last point about that is that $255 versus $85, it's amazing that there are any independent rural health clinics. It may not be a good thing for all the doctors in rural areas to work for hospitals. It could be a good thing. I'm not making the argument one way or the other. But the difference in price is so great, and it's going to decrease but it's still going to be very large. A little bit more comment about that and the consequence, which I assume is most clinicians working for hospitals, not in independent clinics, might be discussed a little bit, as well.

MS. KELLEY: Jonathan.

DR. CASALINO: I want to know if I was quicker than Scott.

MS. KELLEY: I was not timing. Sorry.

DR. JAFFERY: We will guess no.

VICE CHAIR NAVATHE: We have an empty Vice Chair. The Vice Chair does the recording. So poorly done, Vice Chair.

DR. JAFFERY: I will try and be brief, because I think we are over time already. So first off, this is a great chapter, and I think really several things, really new information, and in particular this notion about copays being based on charges. I really appreciate, Jeff, you walking us through the history. It helps us understand how we got here and how it wasn't completely irrational at the time, but I think it's unconscionable if Congress and others, you know, perpetuate that. This can and should be fixed.

I just wanted to share a little bit of data, that I'm happy to share more offline with you guys. The AAMC's Research and Action Institute published an issue brief back in the fall looking at some of the use of services, both in

primary care and specialty care, in rural versus urban. And there have been some comments that we've made along the way today and in previous conversations that make sense, but I'm not sure they're 100 percent based in the data.

And so, you know, essentially, if you look at the number of visits to primary care physicians in urban and rural areas for Medicare beneficiaries, they are pretty similar. And we talked about nurse practitioners and PAs kind of filling the gap, and they do fill the gap a lot but they are almost exactly the same. There was a number of visits that rural and urban Medicare beneficiaries is what was found, and there are actually more family medicine docs per capita.

And I think one other really interesting finding was that rural beneficiaries were more likely to have a usual source of care, and perhaps that relates to access to urgent that is greater in urban settings.

Now clearly rural populations have worse health status overall -- we know that -- higher poverty rates, lower education levels. But I think the big thing that was found here was this differential in specialty care access, and Jaewon mentioned the closures. And we talked a lot

about hospital closures, but think he spoke well to the fact that it's not always a hospital closing. They're closing a service line. And lots of interesting data about that, as well, put forth about how much the median distance that rural residents had to travel after that closure.

I mean, it already can be more challenging to get somewhere if you live in a rural area. We expect that. I mean, people choose to live in rural areas probably because they want to not be in those more crowded spaces. But, you know, it's not a slight difference. And the change that happened after these closures, you know, we're talking about going from 3.5 miles to get to general inpatient care up to almost 25 miles, 24 miles. So it's really, really significant, especially if you have to undergo some significant and repeated chronic care, like radiation therapy or certainly emergent care.

Again, I'm happy to share that offline, but I thought those were important elements in the conversation, as well. Thanks.

VICE CHAIR NAVATHE: Brian, I think you had something, on the point, that you wanted to add.

DR. MILLER: Yeah, I had an on-point response to

Scott. I agree that managed care can be a burden to rural providers, but multiple Commissioners have commented how rural markets often have monopolies or near monopolies for hospitals or clinics. And so I think that the problem might be slightly different. The problem might be if you are out of network as a rural facility you have trouble getting the fee-for-service rate, which is what the regs say that you're supposed to get, and so that could be an area for exploration, if that does or does not happen and how to fix that, which would be a good regulatory policy intervention to ensure access.

I do think, though, that the market dynamics are perhaps a bit different. So if the hospital is super and the delivery system is consolidated and there is only one delivery system, functionally what that means, actually, is that even your multibillion-dollar, monstrous plan showing up in the black suburban corporate jet or whatever could actually be held hostage by the small rural hospital, which chooses to go out of network and not accept the rates and get the fee-for-service rate. That's a consumer protection that's really important for the beneficiaries to assure that if they don't have that in-network facility that they

can still get care there at a fee-for-service rate.

So I don't think it's necessarily the market dynamics of consolidation of plans, because the consolidation is usually more on the hospital side or the clinic side in rural areas, but making sure that that consumer protection works so that benes actually get access to care and don't get pushed under the bus financially. Thank you.

VICE CHAIR NAVATHE: Dana, is that the end of the Round 2 queue? Okay, great.

So Brian and Jeff, thank you so much. I definitely echo the comments from the other Commissioners about the great work. Commissioners, thank you so much. It is very clear there is a lot of enthusiasm for the work.

I was planning, actually, on doing a little recap, a wrap-up, and then I started to make a list, and then the list was going on to three pages. So suffice it to say that I think there is a lot of enthusiasm for the cost sharing work. There is a lot of enthusiasm for the MA interaction. There is also a lot of enthusiasm for a lot more than just those, and also there are nuances within those topics.

So I think that's very good feedback. I think one of the things that we'll have to chew on here is just scope and bandwidth. Obviously, we can't do everything everyone suggested in the next cycle, so I think that's something that we'll be processing as we go. But thank you so much for the very thoughtful comments. I think it's clear that you all put a lot of effort into the comments that you shared.

So we will wrap up here. For those listening at home, we want to hear from you, as well. Please send your comments in at meetingcomments@medpac.gov, or you can do it also through our website at medpac.gov/meeting.

We will reconvene at 1:30 Eastern today, so just about an hour, and we'll start with Medicare Advantage encounter data. Thank you, everyone.

[Whereupon, at 12:28 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION

[1:32 p.m.]

VICE CHAIR NAVATHE: Welcome back, everyone, for the afternoon session. We will be starting with Andy Johnson and Stuart Hammond, who will be talking about Medicare counter data.

DR. JOHNSON: Good afternoon, this presentation updates our assessment of the completeness of MA encounter data and other sources of information about MA enrollees' use of health care services. The audience can download a PDF version of these slides in the handout section of the control panel on the right side of your screen. The material presented today will be included in a June report chapter, along with a comparison of MA encounter data and plan bids that we will present in April.

I will begin today's presentation with an overview of the MA encounter data, its uses, incentives for submitting the data, and the Commission's prior recommendation to improve encounter data completeness. Then I'll turn it over to Stuart to discuss our comparison of MA encounter data with other sources of MA utilization information, including an assessment of completeness across

contracts. Finally, we will discuss the implications of the findings for policymakers and researchers.

MA encounter data began with the Balanced Budget Act of 1997, which required the collection of encounter data for inpatient hospital services and permitted the Secretary to collect encounter data for other services. However, those efforts were abandoned after plans claimed that submission of the data would be an excessive burden. In 2008, CMS resumed the collection of detailed encounter data for all Medicare services and stated its intention to use the data for risk adjustment and other purposes.

Encounter data collection began in 2012. CMS phased in the use of encounter data as a source of diagnostic information for MA risk scores from 2015 to 2022, and encounter data have been the sole source of MA diagnoses since then.

Detailed encounter data are essential for oversight of the care provided to the more than half of Medicare beneficiaries who are enrolled in MA. Without valid and reliable data, there is limited understanding of how payments to plans correspond with service use, quality of care, and the provision of extra benefits that MA plans

offer.

In addition, administering the MA program requires the use of disparate data sources, including many single-purpose data submissions from plans and providers. Complete encounter data could assist or even replace various data collection efforts and would ensure that the program relies on data that are internally consistent and conform to program rules.

Finally, plans have the flexibility to implement utilization management practices, use value-based insurance design, and beneficiary incentive programs. Encounter data have the potential to inform how these techniques are employed and help improve Medicare policies more broadly.

One other potential use of complete encounter data is to assess the use of certain services by MA enrollees. In recent years, researchers have begun to compare utilization rates between MA and fee-for-service. However, we note that there are important differences between MA encounter data and fee-for-service claims.

In fee-for-service Medicare, claim submission is required for payment, so providers have a strong incentive to submit claims and provide all needed information for

payment. Fee-for-service claims files include all final adjudicated claims and therefore are generally considered a complete record of Medicare-covered services provided to beneficiaries covered under fee-for-service Medicare.

In MA, plans are required to submit encounter records to CMS for all items and services provided to enrollees, but that submission process is separate from plans' payment adjudication with providers. CMS performs front-end checks to verify the quality of the data, but there is no formal assessment of whether all encounters were submitted.

Although information about MA enrollees' use of services has value, we should be cautious about assessments made solely using MA encounter data.

Through reports and presentations since 2019, MedPAC has found the data to be incomplete, and the current incentives to submit encounter data have only resulted in incremental improvement.

The use of encounter data to calculate MA risk scores provides some incentive to submit records of inpatient and outpatient hospital and physician services when those records identify a diagnosis that is not

identified on another record during the same calendar year. There is less incentive to submit records for other settings that are not used for risk adjustment.

CMS provides feedback to plans regarding their encounter submissions, but only about the number of submissions per enrollee by service category. Plans are given report cards that compare their submissions to regional and national averages, but these report cards do not contain comparisons with external data sources.

CMS also does not assess the consistency of information reported through plans' encounter data with other data that plans submit, such as HEDIS quality data, bid data, and medical loss ratio data.

Since 2019, CMS has sent performance reports to MA organizations evaluating each contract's submission of encounter records based on certain metrics. Noncompliance with these metrics could initiate a process of escalating CMS actions, including outreach to plans, technical assistance, warning letters, and corrective action plans.

A couple metrics focus on whether an MA contract has successfully submitted any encounter records for each of the six health care settings.

This table shows that since 2015, the share of MA contracts successfully submitting a record for each setting has improved, but a small number of contracts did not submit any records for skilled nursing, home health, or durable medical equipment in 2020.

In 2023, CMS added four metrics that evaluate the internal consistency of the data, assessing whether facility and professional encounter records match for inpatient stays and emergency department visits, whether enrollees with an end-stage renal disease diagnosis had an encounter record for dialysis services, and whether enrollees with three or more chronic conditions had any encounter records at all.

Although these metrics are a step in the right direction, the Commission has compared encounter data for 2014 through 2019, to other sources of information about MA enrollee inpatient stays, skilled nursing users, and home health users, and dialysis users, and found that encounter data are incomplete and improving only incrementally.

To accelerate the pace of that improvement, in 2019, the Commission recommended additional steps to increase encounter data completeness and accuracy.

The recommendation directed the Secretary to establish thresholds for the completeness and accuracy of MA encounter data, evaluate MA organizations' submitted data, and provide feedback to plans on completeness metrics. In addition, a payment withhold would be applied, and CMS would provide refunds to MA organizations that meet encounter data completeness thresholds.

Finally, the Commission also recommended establishing a mechanism for direct submission of provider claims to Medicare Administrative Contractors. One provision was that, if program-wide thresholds were not met, the recommendation would require all MA organizations to submit claims via the administrative contractors.

I'll now turn it over to Stuart to present our updated assessment of encounter data completeness.

MR. HAMMOND: Thank you, Andy.

We compared MA encounter data with four other datasets that contain information about MA enrollees' use of services: the Medicare Provider Analysis and Review file, or MedPAR, for inpatient stays; the Dialysis risk-adjustment indicator, for dialysis services; the Minimum Data Set, or MDS, for skilled nursing stays; and the

Outcome and Assessment Information Set, or OASIS, for home health services.

Providers are required to submit these data directly to CMS, without any processing by MA plans. For each comparison, we assessed the number of MA enrollees who had a service record in either source. For inpatient services, we also evaluated whether specific hospital stays were reported in both the MedPAR and encounter data. We restricted our analyses to encounters for HMO and PPO plans, as submission requirements for other plan-types varies. We excluded chart reviews from our analysis.

Some of the external data sources we used in our comparisons are themselves incomplete, which limits how comprehensively we can assess the MA encounter data. To reflect this, we present the share of records that appear in both the encounter data and the external data source, as well as the share appearing in one source but not the other. Each data source provides evidence of services that were provided to MA enrollees.

The figure on the left illustrates how we present our findings throughout the presentation. The orange segment of the bar represents the share of MA enrollees who

used that service and for whom a record was present in both data sources. The other segments represent the share of MA service users who had a record in only one of the two sources: dark blue for those appearing only in the comparator data and light blue for those appearing only in the encounter data.

There are some limitations to our analysis. For example, encounter data can include records for services where the claim was denied. In addition, encounter data might not include services provided out of a plan's network for which a plan did not receive a claim.

This figure shows an overview of our results. Each bar represents a comparison between MA encounter data and another data source in a year between 2017 and 2021.

Across the four service categories, most beneficiaries who used a service had a record in both data sources. However, in all four service categories, we found some MA enrollees with records reported in only one of the two sources. This suggests that both sources are incomplete.

These data are consistent with our previous assessments of the MA encounter data. The share of MA

enrollees with an inpatient hospital record in both data sources and the share with a dialysis record in both data sources has been relatively steady since 2017. In the skilled nursing and home health data, the share of MA enrollees appearing in both the encounter data and the comparator data has improved since 2017.

I'll now provide more detail on each comparison, starting with inpatient hospital services.

The Medicare Provider and Analysis Review file, or MedPAR, contains information about inpatient hospital stays for both MA and fee-for-service enrollees. Hospitals submit "information-only" claims to CMS when treating MA enrollees. CMS uses the information to calculate DSH and Graduate Medical Education payment amounts.

We found that 88 percent of MA enrollees who were hospitalized in 2021, i.e., those with a record in either file, could be identified in both data sources. This share is slightly higher than the share in 2017, and has been relatively consistent over the last three years.

Some beneficiaries appeared in only the encounter or MedPAR data, with a larger share appearing only in the encounter data. These findings suggest that both sources

are missing data for some MA enrollees. The presence of encounter records with no matching MedPAR record is unsurprising, given that non-teaching hospitals and those that do not receive DSH payments have little incentive to submit information for MA enrollees.

In addition to checking whether MA hospital users had records in both sources, we also attempted to match records for specific hospitalizations between the two files, using the dates of service listed on each record.

We found that just over 80 percent of MA hospitalizations were present in both data sources in each year of our analysis. The share was relatively consistent between 2017 and 2021. In 2021, 13 percent of hospitalizations appeared only in the encounter data, and 6 percent appeared only in the MedPAR data, suggesting some records are missing from each file.

In a sensitivity analysis, we were able to match an additional 3 percent of 2021 records by linking records with overlapping dates of services, rather than requiring an exact match. We plan to continue refining how we link records between the two data sources. However, given our finding that not all beneficiaries are reported in both

files, it is unlikely that improving our method will demonstrate either file to be complete.

The next three slides present beneficiary-level comparisons, starting with a comparison of sources pertaining to MA enrollees' use of dialysis services.

Providers treating Medicare beneficiaries with end-stage renal disease submit a medical evidence form to CMS when a patient begins dialysis treatment. These data are used to risk adjust payments to MA plans for enrollees with ESRD.

We compared those data to the outpatient encounter data and assessed whether each beneficiary's identification number could be found in both data sources. We found that 89 percent of MA enrollees with ESRD who received dialysis could be identified in both files in 2020. The share was relatively consistent across the years we assessed. This is equivalent to the percentage of fee-for-service beneficiaries with the dialysis indicator who also had a fee-for-service dialysis claim.

Next, we compared data sources pertaining to MA enrollees' use of skilled nursing care.

Skilled nursing facilities are required to report

information about patients' health status to CMS using an assessment tool called the Minimum Data Set, or MDS. We compared data for MA enrollees who had an MDS assessment with enrollees who had a SNF encounter data record. We excluded MA enrollees who were eligible for full Medicaid benefits to avoid counting assessments of enrollees receiving non-Medicare-covered services. We found that the share of MA enrollees appearing in both data sources appears to have improved over time, rising from two-thirds in 2017 to 81 percent in 2021.

In 2021, 15 percent of MA SNF users were found only in the MDS data. While this may indicate missing encounter records, it is also possible that we included some MDS assessments of MA enrollees receiving services not covered under Medicare. We would not expect there to be an encounter record for such services. This would mean that our assessment of agreement between the two sources is too low. We are continuing to refine our methods for linking SNF assessments with specific MA encounters.

Next, we compared data sources pertaining to MA enrollees' use of home health services.

Home health agencies are required to submit an

assessment of patients' health status for all Medicare beneficiaries at the start of a home health episode and at several points thereafter. The assessment data are available to researchers in a dataset called the Outcome and Assessment Information Set, or OASIS.

We compared MA enrollees who had OASIS assessments with MA enrollees who had home health encounter records. From 2017 to 2020, many beneficiaries appeared only in the home health encounter records and were missing from the OASIS data. However, the share of MA enrollees appearing in both sources improved significantly over the period, increasing from 49 to 84 percent by 2021.

The change appears to have been driven by an increase in the number of beneficiaries with an OASIS assessment record. A smaller share of beneficiaries could be found only in the OASIS data, suggesting, again, that neither source is complete.

Researchers have used the data sources we discussed in this presentation to assess MA enrollees' use of services and compare with use among fee-for-service enrollees. Your reading material includes a list of 24 studies published between 2016 and 2024, that used the

MedPAR, OASIS, or MDS data without supplementing the data with information from MA encounter data. One of the studies did conduct a sensitivity analysis using the encounter data instead of the MedPAR but did not combine the two sources. Several studies restricted their analysis of inpatient hospital stays to DSH or teaching hospitals to reduce the effects of missing MedPAR records, and several studies supplemented the data with HEDIS quality data but not encounter data.

Given our finding that the MedPAR, OASIS, MDS, and MA encounter data are all missing records for some MA enrollees, we are concerned that such studies may be affected by missing data. We cannot draw conclusions from comparisons of MA and fee-for-service, in which the data for MA enrollees are not as complete as those for fee-for-service enrollees. This concern is particularly acute for studies that relied solely on the OASIS data, given our finding that many MA enrollees receiving home health services were recorded only in the encounter data.

Other researchers have attempted to account for missing data by selecting encounter data only from MA contracts that have comparatively high match rates with

other datasets. For example, Jung and colleagues selected MA contracts for which at least 90 percent of inpatient stays were reported in the encounter data, and for which the difference between HEDIS and encounter data was less than 10 percent for select services. This method has been adopted by several other researchers.

We assessed the completeness of MA encounter data within and across MA contracts using a set of comparisons like those described in the earlier slides. We began by grouping MA contracts according to the percentage of hospital stays recorded in the MedPAR for which we found a matching encounter record. We're going to focus on the top row of the table; the other two rows are shown for reference. The top row shows information for the 311 MA contracts that had encounter records for at least 90 percent of MedPAR records. Among these contracts, the average match rate was 97 percent, the lowest match rate with the MedPAR for a contract in this group was 90 percent, and the highest match-rate was nearly 100 percent.

Moving across the columns, we find wide ranges of encounter data completeness across service sectors, even among the contracts with comparatively better overlap with

the MedPAR. For example, the match rates for home health and SNF users in these contracts averaged 88 percent and 84 percent respectively, but ranged from 1 percent to nearly 100 percent.

Given these findings, we urge caution for policymakers and researchers using encounter data to examine MA enrollees' use of services. Relatively high completeness with respect to one service category is not a marker of complete data across all service categories. This issue is particularly important for studies using encounter data from service categories that do not have a viable external data source with which to validate the completeness of the data.

We urge researchers to use similar caution when examining MA utilization using other sources of data we discussed today. Our results show that several of the provider-submitted data sources are missing records for MA enrollees. For studying these service categories, using a combination of the encounter data and the provider-submitted data is one way to reduce the impact of missing data on the findings, although we cannot determine if this approach fully resolves the issue.

Overall, we find that encounter data and other sources of information about MA enrollees' use of services are incomplete but have generally improved since 2017. Even in their current state, it may be possible to leverage the encounter data when examining patterns of service use by combining the encounter data with other data sources.

We note that for the majority of physician and outpatient hospital services, there is no comprehensive independent data source on MA enrollees that is available for comparison with the encounter data. We used the dialysis risk-adjustment indicator to assess outpatient encounter data, but this represents a small fraction of outpatient services.

Consistent with our 2019 recommendation, CMS could do more to more to validate these data and hold plans accountable for incomplete encounter submissions. We, along with other researchers, have found that data completeness increases when data submission is tied to payment. This supports our recommendation to apply a payment withhold to increase incentive to submit complete and accurate data.

For Commissioner discussion, we welcome your

questions about the analysis, thoughts on the current state of the encounter data, suggestions for future analysis, and other feedback you may have.

With that, I'll turn it back over to Amol.

VICE CHAIR NAVATHE: Thank you, Stuart and Andy, for a very nice and concise presentation. The Commission, as Andy and Stuart have highlighted, has been doing a continuous workstream of work on the encounter data over time, as it has improved and then, perhaps, plateaued somewhat recently, although we see some improvements in the SNF side. So in some sense this is an update to analysis that's been ongoing

Encounter data are clearly very important because we tend to know a lot, as a health policy community, about what happens on the fee-for-service side of the program because of the claims, and the encounter data can be a really valuable resource from that perspective, to better understand what happens in MA.

Nonetheless, I think a couple of things to highlight. One, as part of this work we're not making any new policy recommendations, but this work will be a chapter in the June report.

With that I will turn it over to Dana to run the Round 1 queue.

MS. KELLEY: All right. Tamara?

DR. KONETZKA: Great. This is so important, so thank you for your meticulous work on trying to figure this out.

Yeah, I'm going to save most of my SNF and home health comments for Round 2. My Round 1 question is just about the MedPAR comparison. I just want to make sure I understand completely, so tell me if this is wrong or not.

Hospitals directly report the data that goes into MedPAR, right, and this is required of all hospitals, but the hospitals that have the greatest incentive to comply are those that are DSH hospitals or have graduate medical education, right? So those other hospitals that have less of an incentive to report this, they're still supposed to, and some of them do, but it's just less complete, probably. Right?

MR. HAMMOND: That's correct.

DR. KONETZKA: Okay. And so I guess the follow-up to that is then that's sort of a known problem, that if you want to just focus on certain hospitals, you can be

fairly certain of getting a much better match, for example, if you just used the DSH and teaching hospitals, et cetera, and sort of, at least in a sensitivity analysis or something, just counted those other hospitals, you might get close to 100 percent?

MR. HAMMOND: So I don't think that we have the numbers to say whether it's close to 100 percent, but there is a good 2023 paper by Phil Cotterill that breaks this down by facility type and compares those. So we're happy to send that to you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks very much. I love this work, and I think anyone who wants these encounter data out there will get a lot of good information here.

So I had a couple of questions. The encounter data are not adjudicated, and is that because of the source of where the data comes from? So I'm trying to understand why the flow would be different on the MA side versus the fee-for-service side.

DR. JOHNSON: There are some claims adjudicated data in the encounter data, but I think because it is a rolling process of submissions, that plans can submit and

then they can replace and send a new one, and sometimes it's not known whether or not the claims adjudication process is as complete when a plan submits its record of encounters. So it is a rolling process, but it is a mix of final adjudicated encounters, or on the other side, where the plan and the provider have a claim that is adjudicated, and other records.

DR. DAMBERG: So when CMS tells people to use the fee-for-service data, they have a period by which the claims are adjudicated. And so is there something parallel on the encounter data side? So like if you waited, I don't know, 15 months post submission you would mostly have adjudicated encounters?

DR. JOHNSON: There is a deadline that the plans have to submit encounter records. I think we know a little less about what the deadlines are between a plan and a provider and whether or not those claims adjudication process and negotiations are ongoing beyond that deadline or because of data lags that don't get submitted by the CMS reporting deadline.

DR. DAMBERG: Okay. I have two other quick questions, in reference to the 2019 recommendations to try

to induce plans to more completely report. But was there any consideration given to other uses of the encounter data to try to enhance that inducement, such as for quality reporting?

DR. JOHNSON: We've talked about that some, and generally supported all uses of the encounter data. Well, not all uses, but uses that would encourage additional or incentivize greater submission of encounter records, and that would include some plan quality reporting. Also, there was some information in a recent proposed rule about reporting utilization numbers for individual providers and including MA utilization numbers along with fee-for-service utilization numbers. That was not part of the recommendation, but we have at various points commented on individual policies to use encounter data.

DR. DAMBERG: Yeah, because I do think there are opportunities to use the information for quality reporting, and I think that would strengthen the incentives for complete reporting.

The other, and last, question that I have is, so there is some percentage in each of these different sectors that there's a lack of concordance, and I think you know

there is missing data. The issue with missing data is, is it missing at random or is there something systematic? And I wonder if you've had an opportunity to take the areas where there's not overlap and see if it is certain types of claims that are not getting submitted through encounter, and what does that tell us about being able to use this data?

DR. JOHNSON: I think that's an excellent suggestion for future analysis. One of the issues that we've seen in prior updates is that the data we are continuing to approve, when we had looked at older years, and now we see more of a plateau. So I think there probably will be more value in digging into where there is remaining incompleteness or lack of overlapping information.

MS. KELLEY: Brian.

DR. MILLER: Thank you for this. I think we can call this the bible for encounter data. I just had a simple question about this. Was this a statutorily mandated book of work?

DR. JOHNSON: No, it was not.

DR. MILLER: Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. And I realize you are the messenger in all this really kind of difficult problem that we've talked about for a while. What I will say is that the way this was presented, I think I have more clarity than I did in the first year when this was initially presented. So I have some R1 questions, more than usual.

We have sort of two different buckets of data. We have claims data, which I think I understand that process. You know, a lot of it is automated with the EMR, it's electronically pulled in. There are coders in the background that adjudicate, validate it, push it out to the payer, and basically it gets processed for payment.

Then there is this other animal, which is the encounter data, where the MA programs are expected to complete it, but it's not like a requirement the same way it is around claim data, is kind of the way I understand it.

And so these are two different systems that don't talk to each other. Correct?

DR. JOHNSON: I think the extent to which they

talk to one another might vary by plan, but in general you are right, that there is a plan data process going on with their providers and a plan to CMS records submission that are separate.

DR. CHERRY: Yeah, and I think I'm talking about mainly sort of maybe not the CMS level. So the claims data doesn't get pulled into the encounter data. There's no automation around that, right?

DR. JOHNSON: That's right.

DR. CHERRY: Okay. At the same time a lot of the claims data is also part of the encounter data, right. There's a big overlap there, if I'm reading the chapter correctly?

DR. JOHNSON: Are we talking about the fee-for-service claims data, or the claim when a provider sends a bill to an MA plan?

DR. CHERRY: Well, on the MA side there is encounter data, so the question is how much of an overlap is there with the counter data compared to the claims data that's done through the provider?

DR. JOHNSON: On the MA side.

DR. CHERRY: Yeah, on the MA side.

DR. JOHNSON: There should be complete overlap. That is the goal. But I think because there are these two separate streams, or at least there are two different parts to the data processing, where the claims adjudication is happening with the plan and the provider, and that may not align perfectly with the information that is submitted to the encounter record. So it's through CMS, that encounter record.

DR. CHERRY: So it's fair to say on the MA side that there a few items of encounter data that's just on the encounter data but not on the claims data, that's used for things like -- perhaps it's used for risk assessment scores or doing disproportionate share percentages, right. So there is a small number of items.

DR. JOHNSON: So there is another component to this. I think I'm understanding the question. When a provider treats, say for a hospital, treats an MA enrollee, they submit two copies of the claim. One is the information-only claim, or sometimes called a shadow claim. It goes straight to the Medicare administrative contractors. That is who does the fee-for-service claims processing. So they get a copy of that, and that ends up

in the MedPAR claims file for MA enrollees. And the other copy goes to the plan and goes this through whole process of being adjudicated for payment, and the plan formats that into an encounter record that gets submitted to CMS.

So it is the provider to CMS claims data for MA enrollees that is in the MedPAR being compared with its other route, which is a copy of the claim went to the plan and then to CMS, and there is a decent amount of overlap that's in the MedPAR-to-encounter data comparison.

DR. CHERRY: Okay. And so even though the data is virtually the same, once undergoing a validation process the other one is not.

DR. JOHNSON: I think they have separate validation processes, one that the Medicare administrative contractors would implement and the other that the CMS's encounter data group would be implementing as their front-end quality checks that they do.

DR. CHERRY: So I have one final question. It's kind of like an R1.5 question. Why do we have two different data forms, one for data, one for encounter, if they're basically the same?

DR. JOHNSON: My reading between the lines,

because I was not doing the Medicare policy back in the days when [inaudible] MedPAR information. But I think in order to implement the DSH payment processes and the graduate medical education policies before encounter data were available, they needed some stream of information to make those calculations on. And so collecting the claims data from the hospital, through the Medicare administrative contractors, was one of the purposes. There may be other reasons out of necessity. But in the absence of encounter data I think there were -- and there are other instances of this too, where other data was submitted in order to implement certain policies. Now that the encounter data is available, as it becomes more complete, there are more uses and greater incentives that could be.

DR. CHERRY: That makes sense in an era before EMRs, before data integration, you know, these pathways were set up separate and not integrated. And so, hence, you have one that has complete data and the other one that has incomplete data, and the systems aren't really integrated into one system. Okay. Thanks.

MS. KELLEY: Larry.

DR. CASALINO: I think this is very timely

because, as you know, with Medicare Advantage data becoming much more available to researchers now and the program being so big, it is of great interest, this area, to researchers. And I think Brian is right when he said this is going to be like the bible, and Cheryl, it would be very, very useful information to any team that wants to do good research. So it should help us learn a lot more about the MA program.

Two quick questions. Could we look at Slide, I think it's 7, the first table, for a second? It may be on the presentation slides. All right, anyways.

So this is share of contracts so maybe at least one record for all service categories. So pretty impressive increase from 8 percent to 90 percent. How useful is knowing that they submitted at least one record? I mean, should there be some kind of sensitivity analysis, or should this be the sensitivity analysis, picking some larger number for how many records got submitted in all service categories? Because at least one seems like a pretty low bar, to put it mildly.

DR. JOHNSON: It is, and I think this was some work that we had looked at starting with the first time

that we ever addressed the encounter data, and in part it was to put into context some of the challenges that the plans were dealing with at the time, which is setting up their encounter data systems, getting them tested and to end by CMS, and being able to submit an encounter record with all of the fields formatted properly as sort of a first pass at being able to even assess completeness.

So meant that in this context, which is as a first pass, all the plans have to had passed that test before we really even consider are they submitting complete encounter records.

DR. CASALINO: Yeah. If it's not too much work I would strongly suggest that we pick some larger number and also present that, especially if we are doing to in the chapter. Because otherwise I think people think, oh, 96 percent, there's no problem, right.

And my other comment is, and this is very similar to what Cheryl said, just prefacing that by saying I think some context might be useful. I mean, people can decide this for themselves, but some comment from you guys might be useful. How important are the limits in data capture? So if 90 percent of the encounters are in both, let's say

only 10 percent seem to be missing in one way or another, some people may say that's only 10 percent.

So there are two kinds of caveats to that, that might be worth some discussion. One is, is 10 percent a big number? If you're reducing the admissions by 10 percent really, as opposed to the 10 percent missing, that would be kind of useful to know. So 10 percent might be a big or a little number, depending on how you think about it. Some discussion of that might be useful.

Then my other comment was Cheryl said if the data is missing like random, then 10 percent might not be that much of a problem at all. If it's systematically missing, for certain types of plans, for certain types of providers, for certain types of beneficiaries, for certain types of services, then it is important. And I don't know if we have, or could have in the future, anything useful to say about that, but I think it would make the work the researchers do much more accurate, I think, and also help policymakers understand that, you know, 5 or 10 percent is not necessarily a small number in the context of what the data could be used for.

DR. JOHNSON: That's exactly what we were

thinking. I don't think we have a lot more to say, but that when effect sizes are in the single digits and the missing-ness is also in the single digits, we've got to be concerned about whether or not your measuring is missing this versus actual --

[Inaudible comment.]

DR. JOHNSON: No, just highlight some of the papers that are beginning to use. I think we will be digging into some of the paper more, and I'm sure Stuart will be doing a lot of analysis on figuring out where those missing --

MS. KELLEY: Gina.

MS. UPCHURCH: It's one of my new favorite words, missing-ness, and generification is another one that's just come up recently. But anyway.

My research thoughts are nothing like the folks around the table, but two things in the footnotes I just have questions about, so I could understand a little bit more.

At the bottom of page 6 it says, "Insurers and providers have, in certain instances, provided researchers with access to claims data for MA enrollees. The

Commission does not have access to such data." How is that possible? I mean, did they just get paid for it, and we're just not paying?

DR. JOHNSON: So I think our meaning there is that some companies have made their data available to researchers, and we have not gone through that process. And so it is not published in a systematic, regular way, to CMS and made publicly available to researchers. So we have not saw it, nor do we have that data.

MS. UPCHURCH: You don't have any side deals to get the data. Okay. All right.

So the next question is just on the next page, at the bottom. So encounter data can include records for services where the claim was denied, as plans are required to submit records for all items and services provided to the enrollees. But if it was denied it wasn't provided to the enrollee. So should that say that that were provided or ordered and denied? Are you really getting denials?

DR. JOHNSON: Denial there, in the way that we have used it, is that there is no payment from the plan to the provider for that service. So the service may have been rendered, but not necessarily paid for.

MS. UPCHURCH: Okay. The denial of payment, okay. Not denial for not getting service.

DR. JOHNSON: Not like the prior authorization.

MS. UPCHURCH: Okay. Thank you for clarifying. Thank you.

MS. KELLEY: Scott.

DR. SARRAN: A question more for Amol. Did you say we're not going to be making any recommendation coming out of this work today?

VICE CHAIR NAVATHE: That's correct. So we have standing recommendations. I think they're from 2019. So those standing recommendations are there. As part of this work, this will be a chapter, but we're not making new recommendations as part of the work.

DR. SARRAN: What if we want to?

[Laughter.]

VICE CHAIR NAVATHE: No worries. So in your Round 2 comments, please express your comments.

MS. KELLEY: That's all I have for Round 1, unless I missed anyone. Should we go to Round 2? Okay. Tamara.

DR. KONETZKA: Great. So these comments focused

on the SNF and the home health analysis. I mean, my first reaction when I saw those charts was just surprise because I think of MDS and OASIS as being pretty complete, and we've used them for years, really, to identify SNF and home health use among MA enrollees even.

And in part I think I was surprised because MDS data are not just used for payment but also for care planning, for quality measures, and then those quality measures, in turn, sort of allow facilities to participate in certain demonstrations. They give that data to hospitals that are referring to them. I mean, those MDS data are used for a lot of things, so they have a lot of incentives to fill out the MDS for every single patient, and for SNFs it's required of every resident in the facility, even if they're not on Medicare or Medicaid, right. So it should be pretty complete.

And I spent time in nursing homes interviewing those MDS coordinators who filled these things out, and if nothing else they seemed very clear on the legal and regulatory implications of not filling these things out correctly for every resident.

And so I drilled down into that a little bit

more, and I think there might be some reasons or things we might want to look at a little bit differently in the analysis that would reassure me about the completeness of some of those data.

The OASIS, there are exceptions. There are people who don't actually need an OASIS. It's not quite as mandatory across the facility as the MDS is.

So a couple of things. One is that I'll note that every time we we've tried to match MDS to fee-for-service claims we also don't get 100 percent. And so I think in all of these, if we're going to use something as the gold standard and we see that there is a mismatch between the MDS and the encounter data, I think one comparison should be to fee-for-service, because there are natural frictions and reasons why we might not see an MDS assessment, for example, and that affects how we might think about this denominator, for anybody who has either an MDS or an encounter claim.

And so, yeah, before we sort of say that it's insufficient encounter data, I think we need to set a sort of barometer or a benchmark for the amount of friction we also see in fee-for-service data, and I would say the same

thing across some of these other sectors, as well.

The second thing, so for beneficiaries who have an encounter record but not an MDS or an OASIS assessment, I guess going to back to this sort of missing at random, I would really like to know who those people are, and I'm guessing it might be, you know, even though everybody is supposed to get an assessment, they have a certain number of days in order to do it. So maybe it's going to be like very short stays, very short home health or SNF stays. And it would be good to know that if those are the ones that were missing out of the MDS, or it might be certain SNFs. It might be very small SNFs who don't use these data for as many things and therefore might have less of an incentive or something.

And again, both of those things might happen with fee-for-service beneficiaries too.

So in SNF they are all supposed to have an MDS assessment, but this may not actually be about MA.

On the flip side, for beneficiaries who have an MDS or OASIS assessment but no encounter record, so I understand your motivation for just omitting duals from the analysis because clearly, they might be there for a long

stay, and therefore you wouldn't see the encounter record because it's not a Medicare-funded short stay.

But I think this just omitting duals is a really blunt tool for a couple of reasons. First, duals, of course, in nursing homes are pretty important, the non-trivial, non-random portion of SNF users. So when we think about a denominator that excludes them, I'm not sure who we're talking about, so I don't know what this overall statistic about the completeness of the data means when we've excluded duals from nursing homes or home health.

And the second, as you noted in the chapter, there are some non-duals who might also have nursing home stays that aren't short-term, post-acute stays, funded by Medicare. And so that muddies the water even more.

And so I guess I have a couple of suggestions about that, or a couple of alternatives you could look into. One is you could try some more standard methods to separate short-stay and long-stay populations. You can use the type of assessment in MDS and the frequency of assessment to try to get at that. In all of the quality measures that CMS publishes they have denominators kind of defined. They have an algorithm for defining short-stay

and long-stay populations, and so that might be a better way to get at the right sort of MDS denominator.

Yeah, and then like I said, doing the same thing with fee-for-service to see whether or not this just frictions or missing encounter data.

So overall, when I looked at the MDS and the OASIS comparison at first, I found it kind of frightening, and then after I started thinking about some of these analyses I was like, this may not actually be so bad. We may be pretty safe kind of using MDS and OASIS, and keep trying to improve the encounter data.

Sorry. I left a little bit more sanguine than we started. Thanks.

VICE CHAIR NAVATHE: Just as quick point there, I think, Tamara, you make a good general point, which I think is helpful for everybody in the context of interpretation here, which is there may be some factors that are at play that would naturally result, even if every actor here were doing perfect reporting, is still less than 100 percent match, and that's what you're highlighting here. And that could happen because they have secondary coverage with sort of coverage from another insurer, that could happen if they

are doing this outside of their coverage or outside of network. There are a whole bunch of reasons why that could be, and you outlined a bunch of them. But I just wanted to elevate that point because I think it is helpful for context.

MS. KELLEY: Stacie.

DR. DUSETZINA: Great. Thank you so much, and thanks for this fantastic work. I also think this is going to be something that is just critical for researchers, students, everyone who wants to start using the data here. So a lot of my comments are going to be based on things that I'm hoping you're able to either look into or maybe make a comment about it, at the very least, for those researchers who are trying to extent into this space, especially on files that aren't included explicitly in your analysis.

One of the things, when Robert was asking his clarifying question it made it pretty clear to me, a flow diagram here would go a really long way to talk about how fee-for-service claims are going through, how encounter data are going through, and why we would end up with such differences. And I think it would help to orient the

chapter for people being like, what is this about, who are outside of this space. So I'd encourage something like that just to get everybody on the same page about why we have differences in this historically.

I also think, when looking at the figure, of like what percent were missing, I felt a little bit better about it than I thought I was going to do, so I guess my bar was pretty low for how much matching we would have, and I was like, oh, that's not that bad.

But very much to Cheryl and to Larry's points, the big thing I had flagged was missing, and is it random or is it not random, and is there some way to be able to point out if it's not random is there a way to figure out who's missing and why, so that if you're doing a comparison among those, where we have better information, you could exclude that same group on the fee-for-service side if you're doing an apples-to-apples comparison as best you can.

I also really just wanted to know, are there any lessons learned from these files that we could extend to other services where we don't have this kind of gold standard? Because, you know, I appreciate that Tamara is

like, these are my files; I am ready for this, and I'm like, what about the Part B drugs? What about all the other services we don't really have that gold standard, and is there anything that we could add to at least opine about, you know, these files are fairly similar in the way that we think about they're processed in the same way. Or the way that plans or systems would be receiving that information might be the same so do we think we can draw any parallels to help give people a sense of what they might be able to do, knowing that we're just never going to have that gold standards.

I'm very excited about this work, and thank you guys for the great effort put in here and moving this work forward.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks. So I also was sort of struck by the figure, I guess it's X-1, in the document, because I sort of felt the level of completeness or the percent that was from the external source only seemed pretty small in several of these settings. So I was like, hey, let's run with it. Looks pretty good.

But I realized there is a lot of heterogeneity

and completeness across plans, and I know one of the recommendations was to share information back with the plans to try to improve their completeness. But I think it would still be helpful for us to understand how much heterogeneity still exists and whether some of that problem has been solved for.

And I really appreciated Tamara's comments about there are reasons why we would expect to see some of these differences, and trying to unpack some of the processes of what goes on between the provider submitting data to the plan and the plan sort of processing that data, and then moving up the food chain to CMS.

In work that I did in the past on the commercial side providers would hand off data to the plans. This was in the HMO capitated environment. And plans had different cleaning algorithms that they used, and would reject different percentages. So one plan might accept sort of all of it, and the next plan would reject half of it.

So I think there is a lot of variability and probably more information that could be learned there that would help us understand variations that we see across these plans and their interactions with providers.

You know, I've been doing some work in another space where we've been interviewing Medicare Advantage plans to try to understand differences, and this kind of pertains to the next topic we're going to talk about related to quality reporting and use of encounter data for quality measurement. And those conversations with plans have been particularly illuminating to try to understand reasons for differences. And I think if the Commission has resources it would benefit from talking to MAOs about why you're seeing some of these differences. And perhaps you look at plans who have very large discrepancies to understand what's going on with those plans.

MS. KELLEY: Brian.

DR. MILLER: Thank you. As I said, I consider this space to be the bible for encounter data. That aside, I have some comments not related to this, details of this excellent work, but of this work overall.

As many of you know, I was an FDA product reviewer, which is a lot of fun, and you have something called the filing meeting, where the company came in and they said, you have all your data, you submitted your clinical trial study protocols, you sent your datasets, et

cetera, et cetera. And the agency had a certain amount of time to review that and make a decision to accept the filing of the new drug application, or it could be a premarket tobacco application, or it could be a PMA for advice. And if you didn't have the data, you reserve your refusal to file, like the agency would decline your application. It's aggressive but it worked, so you got the complete application.

Now, the complete application still is not perfect. You're making decisions about items, since we're in the Medicare space, drugs, devices, et cetera. And your data is imperfect and you make a decision about the effect and impact, the safety and efficacy of that drug or device, and you're making an approval or clearance decision.

You could imagine an issue like encounter data simply with a performance metric tied to either a payment penalty or, if you wanted to be really aggressive, inability to participate in the marketplace the following year if you don't improve.

So that would be a very simple way to solve this encounter data problem, looking at our actual data in the encounter data. I think it was page 20 and page 10 had

some great tables and facts which showed how we are around 90 percent complete. Could it be better? Should it be better? Absolutely. Is that terrible? No, that's pretty darn good.

So, you know, as an academic and a policy analyst I'm like this is a great chapter, but I'm here not as an academic. I'm here as a Commissioner, to look out for Medicare beneficiaries and taxpayers.

And so we have lots of other Medicare program policy issues that we haven't addressed -- I-SNPs, care for the institution lives, elderly, the role of nurse practitioners, pharmacists, and physician assistants, concerns and questions about vertical integration in Medicare Advantage, lots of important policy issue that Congress doesn't really have another independent body to turn to.

So I guess my question is, why is this not just a letter from MedPAC to CMS? Why are we spending staff time, the time of 17 Commissioners, all the other staff sitting here with us, instead of just sending a letter to CMS recommending a regulatory intervention and then devoting this time, after having said hey, you should just have a

penalty or something similar or simple, to other pressing program policy issues, given the limited time that we have on our agenda for voluntary items.

So I think that this work is important, but I would think that it would, as a strategic organizational strategy we would just send a letter rather than devote a chapter, and we are now an hour into a discussion on the details of, frankly, it's something that matters most to researchers but doesn't really matter much to the Medicare beneficiary. Thank you.

MS. KELLEY: Greg.

MR. POULSEN: Well, you know, I appreciate the nice summary that we received in this chapter, and as usual the work was clear and excellent. And I broadly agree with both the implicit and explicit goals that we have put out. I think that this kind of research is incredibly important if we want to push things forward and have additional insight going into the future as we set out policy, so I get that.

I did want to call out a couple of potential implications where I think my perspective might differ a little bit from some of my colleagues, but only at the

limit. I'm particularly nervous to say this sitting next to Cheryl, but maybe a little less nervous after her report or her discussion regarding the historic HMO variation on this point, because I think that's kind of to the point that I was coming to as well.

Like many of you, I depend on and see the value of clean data for analytics and policy definition and implications, and I'm clearly sympathetic to the benefit that we could get from additional data. In this instance, however, I think there is a reason to think that the goals of getting 100 percent complete encounter data may be mitigated by other factors, and I think none of us are really expecting that we get to 100 percent, but we may want to look for ways to get close but maybe be satisfied when we get close.

First, the most successful MA plans -- success, in this case, being defined by enhanced outcomes for beneficiaries at lower total cost -- are increasingly paying providers on a basis other than fee-for-service. The extreme is full capitation paid to provider organizations, and when this happens, we can see dramatic improvements in things like prior authorization issues and

claims denial challenges, which we talked about earlier, which is a good thing for beneficiaries.

However, since providers aren't claims processors, at their expertise level anyway, they may not be submitting bills in any traditional sense of the word to plans. And there's reasoning for providing certain types of encounter data that makes this incredibly challenging if we try and look for them as the encounter data source.

Second, one of the ways that providers enhance care and lower cost is by providing services that don't fall into traditional fee-for-service payment categories. Things like nutrition, housing, safety, transportation, and others confound the tracking that we may seek here.

Another example that has become a staple, to me anyway, is unbilled telehealth services. This service is free in my organization to everybody and has no billing code associated with it. And in some instances, there can't be a billing code associated with it or even a patient associated because it's intentionally anonymous, and that provides value in and of itself. It may substitute for other services that would have a billing code, and we would make a mistake when we accumulate

encounter data to assume that the coded services inexplicably disappeared, and yet the billing system, or any other encounter system, wouldn't necessarily capture the alternative data.

The chapter very nicely notes that reporting has become more inclusive in recent years, and to Brian's point has become, I think beyond what probably our predecessor expected we'd be in this time frame, and notes that this is a good thing. I certainly agree.

The implicitness is that we would like to move to capture more encounter data. I also agree. But we need to just be a bit cautious, in my view. While I love data as much as the next person and I think that this is an area where the perfect may be an enemy to the good, however, I think it may make sense to simply recognize that in the world of value-based payment there will be patterns that traditional encounter data will not, and possibly cannot, capture perfectly.

So again, I'm broadly supportive of gathering additional data where we can for reasonable incremental expense, and by incremental expense I don't mean just to the government but to the providers of that data. But I

certainly would also encourage a recognition that there may be some data that would have cost that exceeds the incremental value to gather. And as alternative payment approaches increase in number our sensitivity to this issue, I think, should also increase, because we're going to find more and more services that provider are actually producing, for which there isn't an obvious encounter data element gathered. Thanks.

MS. KELLEY: Lynn.

MS. BARR: Thanks for this great work. I really appreciate it. I'm concerned that we don't have the outpatient physician data, because we don't really know where we are on that. And, you know, like you noticed the reaction when we publish data like on home health and how they improved. And I doubt we're in a similar situation, but it concerns me.

I want to give a plus-one on Cheryl, on let's understand the missing data. But I also agree with Greg and others that, damn, if I got 90 percent of the data I could do almost anything with it, you know. So it's a lot cleaner than what I'm used to looking at.

But I guess what concerns me is right now we're

doing shadow billing for the inpatient, which means our providers have to bill twice. They have to send a claim to both the MA plan and they have to send a claim to the MAC. Is that correct?

DR. JOHNSON: I think it's basically the same claim, but there is an intermediary to splits it off and sends it to both.

MS. BARR: Who is that intermediary? Is it the MAC that does that?

DR. JOHNSON: No. There are other data warehouses, or claims warehouses that sort of sit in the middle.

MS. BARR: So they could pay somebody. It's an expense. So it's an expense.

So I guess what I'm trying to get at is I've been thinking a lot about shadow billing for outpatient services lately. Isn't that a coincidence? But as we're trying to think about what is happening in rural, right, and as we think about how we might change those payment models, we need to understand what's happening with MA that we really have no visibility into today. And we're dealing with really small numbers. We need that data.

You know, when you're talking about low-volume providers and you're wiping out half their data, now we know nothing about them, right. And so we need to have a complete dataset for our Medicare beneficiaries, and I would just like to, you know, if there's a shadow billing mechanism in the world for inpatient there needs to be a shadow billing mechanism in the world for outpatient. But I would argue that this should be at the expense of Medicare and not the providers, and not an additional burden to them, so that we would have a good line of sight into what's happening with our low-volume providers, which right now, you know, you miss half the data, it's almost impossible to interpret. So I would love to see that. Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Great work, guys. Although I agree with Brian that this work doesn't necessarily immediately directly impact beneficiaries, and I certainly agree with Greg that as you move, or as many plans move more towards completely capitating providers, there are going to be encounters that occur outside of those traditionally measurable via claims, I still think that this is

important. Just to remind us all, we are talking about a program that is getting close to being half a trillion dollars a year in cost and a program that we think is paid versus fee-for-service basis on an apples-to-apples basis, something north of $50 billion too much, right, or $50 billion more than the equivalent patients would cost in fee-for-service.

So those kinds of orders of magnitude just require, I think, an appropriate level of scrutiny that I do not believe is adequately enabled by completeness in the, call it, 90 percent rage.

I completely understand, Tamara, you raised some great points about we'll never hit 100 percent, that when you really dig into the process flows -- and I've done that at different points in time -- you'll never get to 100 percent, but 90 percent, that's too low. We should be able to 97, 98, something like that. So that's my first comment.

My second comment is basically while I'm not trying to introduce a new recommendation, but really as I looked at what we said in 2019, I think it's still there. I look at the 2019 recommendation that we came out with and

I think it highlights two truisms. One is you get what you paid for, and the other is if you're not happy with your current results, change the process.

So I think we should do both. First, for sure we should get what we pay for, which is hold the plans financially more accountable, sticks and, you know, positive incentives, whatever. So there should be a tightened link, a tighter link between plan performance in this dimension and plan payment, and I think that is reasonably easy to do. CMS has all sorts of ways to do that. It will be resisted, of course, by plans, but I think again it's in the public's interest to pursue that.

And the other is that whole thing that if we're not happy with the results we're getting, look at a different process, and Lynn, I think this ties in somewhat to where you are going. We should, I think, encourage a continued deeper dive into looking at a change in process where MA providers submit their claims first to the MAC, and it's routed from there to the plan.

Among other reasons for doing that might be included that that might, as we talk subsequently about plan quality data, and we talk again about plan risk

adjustment payments, that might help facilitate work on those two dimensions as well, and then, Brian, we're in a place where we're going from something that isn't necessarily the most important body of work to a collected set of bodies of work that I think we'd all agree are hugely important. So I think a deeper dive into, hey, what would that look like, what could that look like, makes a lot of sense.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. I do think we sometimes spend a disproportionate amount of time talking about incomplete encounter data, and I think there is probably good reason for it is because historically this Commission has looked at quality data, and one of the major limitations in terms of having robust quality data is incomplete data in the encounter data. So it's not the only limitation, but it tends to be one of the major ones, so this issue keeps coming back.

I will say that if I had stay within sort of the limits of the request here I think one of the things that would enhance the chapter is that if the claims data across different sectors is pretty much the same data as the

encounter data, it would really help within the chapter to have a visual sort of workflow process map of understanding how this data is adjudicated, you know, through the claims process, and what happens to it, with the encounter data, to the understand where the deficiencies in the workflow may be occurring. Because if we had that current state then we can work towards solutions.

You know, my bias in all of this is that I think what that workflow diagram would probably show is redundant, duplicative services that don't necessarily take advantage of the integrated IT technology that exists today. And so we have these two different workstreams, that we are trying to get data from one system when, in fact, we probably just need to blow it up and just have one integrated system that is really linked to the claims data. That would probably solve the problem, but I don't want to oversimplify it either, because it's nice to see the complete workflow and understand that in its entirety and in its context.

I think, you know, based on the 2019 recommendations, simply asking CMS to tell the plans to do better is probably not going to work unless we create a

better system with them that allows them to reduce redundant work and allow for us to get the data that's really essential.

But thanks for the great work.

MS. KELLEY: Lynn, did you have a response to Scott?

MS. BARR: You know, I just wanted to plus-one on, of course, using the MAC as a single data source. I think we're all kind of saying the same thing here. Why are we doing this? Why are we reporting the same data multiple times, in multiple sources, and trying to put them together? Just have one source of data.

And particularly for the rural providers, because up until very recently they only had to deal with the MAC and maybe one MA plan, maybe two. Again, there are 27 MA plans per county, in rural counties, next year, right. And so now they have to build 27 different entities. I don't think this is what we had in mind. And it would be so much easier to have a clearinghouse deal with all this than have it do that.

And I will take this a step further, that almost all Americans are going to become eligible for Medicare or

Medicaid at some point in their life, and we could use the MACs to be a clearinghouse for all claims data, so when they do come into our plans, we have a history. And I'd rather have a claims history on a patient that went back to the beginning of their life than anything I could have in an EMR, right, because it will be incomplete.

MS. KELLEY: Brian?

DR. MILLER: Thank you. Yeah, so as I said I obviously support more complete and more accurate data. I just think that there's a huge assumption we're all making, which I think Greg hit on, which is that if we have more accurate and more complete data than we do that we will get different results and make different decisions. I don't think that's true. I think that there are a lot of health services research out there that shows small effects that we could make different econometric decisions about how the analysis is done and get a slightly different effect.

And in fact, a lot of health services research is not very useful to policymakers, but I think we should be very cognizant of trying to -- and again, I personally support more complete, more accurate data, but I think we should be cognizant of the fact that we are, again,

spending the time of, you know, a huge Medicare policy program brain in terms of the Commissioners and the staff on an issue that probably would be best addressed with a letter in response to like an annual rule about Medicare Advantage, as opposed to a chapter. I think it's good work. I just think from a titration of effort perspective we're not using our time strategically, noting that it sounds like our appropriation was not extended yet.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I'll be very brief. I just wanted to get on the record with a few comments and reflections. Thank you for this work.

In terms of the data being close or close enough, I was somewhat reassured by those of you that were deeply in analytic space, that you're feeling better about it, because looking at it I couldn't be sure. At the same time, I think it really is important to disaggregate the missing data to see if there's any patterns that really tell us something. I think that's really important.

And I do think the data has ripple effects on beneficiaries and taxpayers. Because it does shape all kinds of things. So it's not an esoteric exercise.

I strongly agree with using MAC. I mean, it just seems like this is time. Maybe that's a new recommendation. Maybe it can be dovetailed to the 2019. But that just is so logical. And I'm sure it's more complicated than it looks to be on the surface.

But to just underscore, I think Scott said performance and payment need to align, and I think we all agree with that.

So those are my thoughts. Thank you.

MS. KELLEY: Kenny.

MR. KAN: Thank for the excellent chapter. I'm a data geek, and obviously I'm broadly supportive of the overall recommendation to try to capture as much data as possible. However, I'm also a pragmatic realist and believe that perhaps after a set of thresholds, say 80 percent, like what Brian, Tamara, and Greg said, we could be seeing a point of diminishing returns, for various reasons, why this is probably going to top out at some percentage, in my opinion. One, I think encounter data will not be friendly to capitation in heavy states like California and Florida. You have multiple plans' data-cleaning algorithms. You have a data process flows, like

what Robert suggested.

So I have one recommendation to the Commission be to really come up with something that's like a scalable cloud model where everyone populates this, it's flexible, and then you use AI, and then you prepopulate an ideal world and common data submission. Then maybe we could like really sort of like look at. Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. You know, I agree that at a certain point it wouldn't be worth staff or Commissioner time to try to get fewer points of missing data. But I don't think we've reached that point yet. And I think to me the main thing that's missing -- well, let me back up for a second. I think creating this so-called bible for research is about how we can understand Medicare and Medicare Advantage encounter data is really important, because there is going to be a lot of research coming out over the next 5 years, and it's going to have an effect, right. I mean, if there's research saying, oh, wow, Medicare Advantage has 10 percent, 15 percent fewer ambulatory care-admissions, that's going to have some traction, right.

So what you guys are doing is very, very important, I think. It's not just going to have an academic effect for researchers to get a few more papers published.

So I just wanted to kind of give a real-world example, although it may be not true in the real world, but it kind of shows what's at stake. Let's say that there's 10 percent of what we would call ambulatory care sensitive, potentially preventable hospitalizations that are in the MedPAR file but not in the encounter file. If we didn't know that was the case, we might use the encounter data to say, ha, look, Medicare Advantage is very good at reducing ambulatory care-sensitive admissions compared to fee-for-service.

But if those 10 percent that happen to be missing in the encounter data are predominantly, or there are a lot of them that are ambulatory-sensitive admissions, then that would be an importantly erroneous conclusion. So that's why I think a number of us are saying I think the next step, and maybe only the last step that needs to be taken, in my opinion, is to try to understand more about what data is missing. And if it's truly random, that's fine, but if

it's certain kinds of services, certain kinds of plans, certain kinds of providers, then all the research could be wrong, even if the percentage missing looks pretty small. Again, 10 percent missing, at random we don't care that much. Ten percent missing systematically is going to lead to wrong conclusions.

MS. KELLEY: That's all I have for Round 2.

VICE CHAIR NAVATHE: Great. So thanks, everyone, for a robust discussion. I think we covered a lot of different ground in terms of some people feeling reassured, some people feeling a little bit less assured, and a variety of opinions. But a lot of great analytic suggestions as well, which we'll definitely take forward. As mentioned earlier, this will be a chapter in the June report.

And why don't we take a quick break here. Why don't we take a 10-minute break, and we'll reconvene at 3:02 Eastern to start our next sessions. Thanks.

[Recess.]

VICE CHAIR NAVATHE: All right. Welcome back. We are going to now be doing a session on Medicare Advantage quality, some preliminary work, and Ledia, I

believe you are kicking it off. Great.

MS. TABOR: Good afternoon. The audience can download a PDF version of these slides in the handout section on the right side of the screen.

This presentation reviews some preliminary analysis of Medicare Advantage quality. This work will not be a part of the June 2024 Report to the Congress. Today, we are seeking the Commissioners' feedback on these analyses and other potential work around MA quality that we can consider for future Commission cycles.

We would like to thank Andy Johnson, Stuart Hammond, and Pamina Mejia for their contributions to this work.

To start today's presentation, I will present background on MA quality and the Commission's prior recommendations for MA quality. I'll then review results from an evaluation of MA quality using a measure of ambulatory care-sensitive hospitalizations.

Then, Katelyn will present a review of recent literature comparing MA and fee-for-service quality and methodological issues with MA and fee-for-service comparisons. Then we look forward to your discussion of

these analysis and direction for future work.

Over half of beneficiaries are enrolled in MA, a model where plans have greater incentives than fee-for-service providers to deliver efficient care. It is important to monitor MA plan performance and quality in order to provide beneficiaries with good information for decision-making, ensure that beneficiaries have access to high-quality care, and reward high-quality and drive quality improvement

However, the Commission has determined that the current system for MA quality measurement and reporting is flawed, so we cannot provide an accurate assessment of MA quality using CMS's current data.

Medicare currently uses over 100 MA quality measures. CMS collects MA quality measure results on a contract-wide basis, which are used to determine a star rating for all plans under the contract which can reflect many diverse health care markets.

For example, the largest MA contract, with 2.6 million enrollees has enrollees in almost every state, with over 1,000 enrollees in each of 46 states, and also a large number of enrollees in many states, with over 20,000

enrollees in each of 30 states. Because of this issue, in three separate reports the Commission has recommended that MA quality should be evaluated at the local market area level.

The Commission has also reviewed the MA quality bonus program, or QBP, which is based on the star ratings, and has determined that it is costly and not a good basis for judging quality. The program accounts for at least $15 billion in MA payments annually.

As described 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, some of which are based on small sample, and not being able to compare fee-for-service in a local market. In our June 2020 report, the Commission recommended replacing the quality bonus program with a value incentive program that would address its flaws.

As we think about what analysis MedPAC can do to evaluate MA quality, we need to acknowledge some limitations in our ability to calculate MA quality at the local market area level.

First, as described on previous slides, MA plan sponsors report quality data at the contract level. Some MA quality measures are based on administrative data but there are some "hybrid" and survey measures for which MA organizations can or must use data collected from a sample of enrollee medical records or enrollee surveys. When organizations report data for hybrid or survey measures, these samples are generally too small for us to generate reliable estimates at the market-area level.

Second, although we have encounter data that MA organizations report to CMS, we are unable to validate whether the data are complete for some types of encounters, as Stuart and Andy just spoke about.

Now let's discuss our preliminary analysis evaluating MA quality using a measure of ambulatory care-sensitive hospitalizations.

Even with the flaws in current MA quality assessment, we know that it important for the program to evaluate MA quality. We started with calculating one outcome measure, risk-adjusted ACS hospitalization rates, which we can calculate with currently available encounter and administrative data.

We acknowledge that this measure should be used in conjunction with other measures to comprehensively evaluate quality in the MA program.

This work is preliminary and not for publication at this time. We plan to do more analysis of MA quality in upcoming cycles and look forward to your feedback today.

The Commission used a measure of ACS hospitalizations in our illustrative modeling of the MA value incentive program in 2020. Within a population of interest, we calculate the rates of hospitalizations, which includes both inpatient and observations stays, that are tied to certain ambulatory care-sensitive acute and chronic conditions. In determining the final measure result we take into account beneficiary-level clinical risk factors such as age, sex, and clinical comorbidities.

Conceptually, an ACS hospitalization could have been prevented with timely, appropriate, high-quality care. MA plans have the potential to influence rates through tools such as network design, managing access to certain services, and taking a role in case management.

We used 2021 MA encounter data supplemented with MA inpatient data reported in the MedPAR file. This is

important for calculating more complete results because of the limitations with the encounter data.

We calculated risk-adjusted ACS hospitalization rates for various units of analysis including across market areas, which is consistent with the Commission's recommendations, within market area by parent organization, by MA enrollee characteristics, and by MA organization and plan characteristics. Let's review the results now.

The distribution of risk-adjusted rates of ACS hospitalizations per 1,000 MA enrollees varied widely across market areas. As we walk through these results, keep in mind that lower rates are better.

The market area at the 90th percentile of ACS hospitalizations had a rate of 41.7 per 1,000 MA enrollees, which was almost twice the better-performing market area at the 10th percentile that had a rate of 22.4 per 1,000 MA enrollees. The considerable variation in risk-adjusted ACS hospitalization rates across market areas suggests some relatively high performers that could be rewarded as well as opportunities to improve the quality of care in some markets.

This figure illustrates the distribution of ACS

hospitalizations across MA parent organizations within three sample markets, markets that had ACS hospitalization rates near the 25th, 50th and 75th percentiles relative to all markets in the country. We saw variation across organizations operating in the same market area.

I'll walk though one of sample markets, the market with a rate at the 75th percentile of performance on the right-hand side of the slide, which is the lowest-performing market area example. Each vertical bar represents one parent organization. The average risk-adjusted ACS hospitalization rate for the market area at the 75th percentile was 35.4 ACS hospitalizations per 1,000 MA enrollees, which is the black line. There were 10 parent organizations in that market area. The worst-performing organization had a rate of 47.9 ACS hospitalizations per 1,000 MA enrollees, which is almost double the best-performing organization with a rate of 24.5 ACS hospitalizations per 1,000 MA enrollees.

This figure also shows that there is between market variation. The best performing organization in the market at the 75th percentile had a rate that was more than 1.5 higher than the best performing organization within the

market area at the 25th percentile.

Now I'll review ACS hospitalization results by groups of MA enrollees. On the left side of the screen, across the age/eligibility group, MA enrollees 65 years and older and originally disabled, the orange bar, had the highest, or worst, rate of risk-adjusted ACS hospitalizations, which was 1.1 times higher than the rate of the lowest group which was MA enrollees 65 years and older and not originally disabled, or the middle grey bar.

On the right-hand side of the slide, across the race/ethnicity categories, Black beneficiaries, the orange bar, had the highest rate of risk-adjusted ACS hospitalizations, which was 1.4 times higher than the rate of the lowest group, Asian/Pacific Islander enrollees, or the light gray bar.

Looking at the left-hand side of the slide, within the income status group, there was a small difference between the risk-adjusted ACS hospitalization rates. The risk-adjusted rate of ACS hospitalizations for MA enrollees receiving low-income subsidy, the dark bar, was higher than for those MA enrollees not receiving the LIS, the lighter bar, by a ratio of 1.1. Within the plan

type group on the right-hand side of the slide, the regional PPOs had slightly higher rates of ACS hospitalizations compared to HMO plans, with a ratio of 1.1.

There were little to no difference within some groups of our analysis of risk-adjusted rates of ACS hospitalizations for MA enrollees.

These include calculations for beneficiaries residing in urban and rural areas, beneficiaries enrolled in non-profit and for-profit MA organizations, provider sponsored and non-sponsored organizations, and within restricted-availability plans.

I'll now turn it over to Katelyn.

DR. SMALLEY: Thanks, Ledia. The Commission has long maintained that in addition to comparing quality across MA plans comparisons of quality between MA and fee-for-service are needed, both for beneficiaries to be able to make informed coverage and enrollment decisions and for Medicare to monitor the value that MA plans bring to the program. These comparisons are challenging, however, for several reasons.

As we reported in our March 2023 Report to the

Congress, previous systematic reviews of these studies found wide heterogeneity in terms of the study population, design, and other attributes, and findings were mixed. Some studies found that MA outperformed fee-for-service on the metrics they evaluated, others reported better quality or patient experience in fee-for-service, and others found no significant differences on the metrics they studied.

To extend this work, we conducted our own systematic review of the literature that has been published since those reviews were conducted in 2020. We searched for studies of quality of care in MA compared to fee-for-service that were published between the beginning of 2020 and the end of 2023. We reviewed peer-reviewed studies reporting original research. We included studies that compared performance on at least one quality measure, for MA enrollees compared to fee-for-service beneficiaries.

We excluded studies that reported MA and fee-for-service comparisons that were not directly related to quality, such as spending, enrollee characteristics, or enrollment trends. Studies of quality related to Part D, or of disparities in quality across subgroups of Medicare beneficiaries, were outside the scope of this review.

We reviewed quantitative studies of real-world data only. We did not review pilot studies or case studies, or randomized trials of medical interventions. While this review was informed by previous systematic reviews on the topic, we did not include those studies in the analysis.

We identified articles using the PubMed database. Our search returned 677 studies, published since 2020, for potential inclusion. We used the inclusion and exclusion criteria from the previous slide to determine the relevance of each study. 626 of these articles were removed from the analysis based on their title or abstract alone. We reviewed the full text of 51 articles, and excluded a further 15, noting the reasons why they did not match our inclusion criteria. Thirty-six articles remained for analysis.

Similarly to the findings of previous literature reviews, we observed substantial variation in terms of the specific populations studied, the quality measures evaluated, the data sources used, and the results reported.

The studies' inclusion criteria varied on several dimensions. Some studies focused on subsets of MA

enrollees, such as those in specific states, with particular diagnoses, or in specific MA plans. While it is important to understand how MA performs for groups with different needs and preferences, the findings of these studies may not be generalizable to the wider population, and comparing a subgroup of MA enrollees to a representative sample of fee-for-service beneficiaries will not compare like with like.

Methods for assigning a participant to MA or fee-for-service also varied, using for instance CMS enrollment files, claims, or self-reported survey data. In order to make accurate comparisons, we must have high confidence that a beneficiary's experience is attributed to the correct program.

The quality measures that studies reported also varied. Many studies reported multiple measures, and the most common types of metrics were preventive care, readmissions, mortality, and surgical complications. Within these measure types, many studies used multiple metrics or differed in how they defined their outcomes.

To observe these quality measures, studies used a variety of sources, including surveys, administrative data

like claims and encounters, state all-payer databases, proprietary data, and disease registries, or some combination. Data sources for MA enrollees and their fee-for-service comparators, such as MA encounters and fee-for-service claims, were not always directly comparable.

Within each measure category, findings were mixed. Some studies found that MA outperformed fee-for-service, some found that fee-for-service outperformed MA, and some were unable to conclude that one program was better than the other.

In studies reporting multiple outcomes, results did not consistently point to higher performance in one program than the other.

Despite the variability across these studies, all faced three methodological challenges that limit the reliability of their findings. In our assessment, some included studies were more successful than others at addressing these issues, but none were able to fully address the problems associated with data comparability and completeness, differences in coding intensity, and favorable selection.

For these reasons, we urge caution in

interpreting the findings of these studies as a signal of overall higher quality in either MA or fee-for-service.

As you heard in the previous session, MedPAC has long been concerned about the completeness and accuracy of MA encounter data. Part of our rationale for analyzing ACS hospitalizations in the first instance was because of the relative completeness of inpatient hospital encounter data, and the ability to supplement that data with MedPAR.

MedPAC has also raised concerns about the accuracy of post-acute care data sources. Since these assessments are not used for MA payment purposes, the completeness of the records may vary across MA plans, and between MA and fee-for-service.

Complete data is a particular concern for correct interpretation of differences in utilization rates. On the one hand, for services for which a lower rate of utilization, such as hospitalizations or emergency department use, indicates higher quality. Lower rates could either be attributed to efforts to improve care, like greater use of preventive care or better care coordination, or to unrecorded utilization. In these cases, MA plans might receive better quality scores on some measures due to

incomplete recordkeeping. On the other hand, for service types for which higher utilization indicates higher quality, such as preventive care, incomplete encounter records could understate service use in MA, and thus inflate the relative performance of fee-for-service on those metrics.

Supplementation of these data sources with other sources, like the MedPAR file, could reduce the risks of bias associated with incomplete data.

Medicare's payments to MA plans are adjusted to reflect a beneficiary's expected spending, which creates a greater incentive for MA plans than providers in fee-for-service to code diagnoses for Medicare beneficiaries. By contrast, fee-for-service payments are based more often on procedure codes. As described in the forthcoming March report, there is wide variation in the intensity of diagnostic coding across MA plans.

These differences in coding intensity have implications for quality comparisons that adjust for health status using diagnoses, because differences in outcomes may be due to either differences in the quality of care, differences in plan coding intensity, or to unobserved

differences in beneficiaries' underlying health status. In essence, differential coding intensity will result in comparing individuals who appear to have the same health status based on their risk score, when in fact one may be much sicker than the other. For an outcome measure like ACS hospitalizations, differences in coding intensity could result in comparing beneficiaries at high risk of hospitalization with those at comparatively much lower risk.

MedPAC's approach to addressing coding intensity is to first address the underlying causes. In the forthcoming March report, we estimate that health risk assessments and chart reviews account for about half of the differences in coding intensity between MA and fee-for-service, because those mechanisms for submitting diagnoses are used less often, or not at all, in fee-for-service.

At least one of the studies we reviewed removed these diagnoses when adjusting for beneficiary differences, but many other studies adjusted for health status using diagnostic information without considering the impacts of differences in coding intensity, either across MA plans or between MA and fee-for-service. This is why, in the

analysis Ledia described earlier, we calibrated an MA-only risk model that excluded data from HRAs and chart reviews. We will need to undertake further sensitivity analyses and make refinements to our model of ACS hospitalizations before attempting to compare rates in MA and fee-for-service.

The Commission maintains that preserving beneficiaries' choice to enroll in MA or fee-for-service is important. However, the beneficiaries who choose to enroll in MA likely differ in meaningful says from those who choose fee-for-service. This is not a problem per se, but it does complicate comparisons between the programs when those differences are unobservable and/or poorly understood.

In our June 2023 and March 2024 report we present evidence that MA enrollees represent a favorable selection of MA beneficiaries, in the sense that their spending is systematically lower than their risk scores would predict. This indicates that there are relevant differences between these populations that are not adequately accounted for in risk scores. We have concerns over how well the risk adjustment model performed in predicting MA spending, and

more work needs to be done to understand the implications of this for quality comparisons between MA and fee-for-service.

And now, we turn to your discussion. We are happy to answer any questions you may have. We would also appreciate your feedback on the analyses we presented today, as well as your ideas for future work on MA quality.

Thanks, and I'll hand it back to Amol.

VICE CHAIR NAVATHE: Thank you, Katelyn, and thank you, Ledia. Very nice presentation.

So I think Ledia mentioned this but I just wanted to reemphasize. This is very preliminary work. This is not going to be a chapter. This is really an opportunity for us to show you some of the active work and get feedback. This is general continuation of work that we are obviously doing on the Medicare Advantage program. And that the use of the ACS measure, for example, it was part of the value incentive program that was illustrative, so this is sort of a continuation of that work, as well. So several part here. I just wanted to highlight these because they are sort of a natural next step continuation and the like.

And I think as Katelyn and Ledia highlighted, it's obviously challenging to make perfect apples-to-apples comparisons here. The use of the ACS is within the MA program, so we're not doing any cross MA and fee-for-service comparisons using the ACS hospitalization data.

So with that context in place, Dana, I will turn it over to you to run the queue.

MS. KELLEY: Okay. I have Cheryl first for Round 1.

DR. DAMBERG: Thank you both for this work. It's a really hard area. I feel your pain.

I have two questions, just to make sure I'm on the same page with you. So on page 7, at the top, the sentence reads, "The Commission has determined that the QBP is overly complex, distributes financial rewards inequitably, and reports inaccurate information on quality." Could you say what you mean by the word "inaccurate"? I just want to make sure I'm interpreting it the same way that you mean it.

MS. TABOR: I think it's because of the contract-level reporting and not at the market-area level. So for example, the CAHPS patient experience measures are done at

the very large contract level as opposed to the market-area level. So the information that is in the star ratings, which the QBP is based on, is based on a sample of beneficiaries across a very large area, as opposed to what would be accurate for beneficiaries' decision-making.

DR. DAMBERG: So I think with that I would encourage you to better describe that, because I don't think the information is inaccurate at the level at which it's collected. But I think what the Commission has been signaling is to make the information more useful to beneficiaries and to aid in their selection, the information would need to be at a more granular level.

So my second question relates to Slide 4, and you provided a couple of examples that there are plans that are in 46 states. I was kind of curious. Are these employer plans? And kind of what do you know about the plans that have that profile?

MS. TABOR: So we can definitely add more detail to the paper on that, but I will say that that large example that I gave on Slide 4 is not [inaudible] plan.

MS. KELLEY: Tamara?

DR. KONETZKA: Yeah, one question. Yeah, thank

you. This is a really hard area and really interesting work.

Both of my questions are about the ACS analysis. First of all, when you calculated the expected hospitalization rate did you do that on the same sample that you then did the observed on?

DR. KONETZKA: Yes. I actually had that in a question from Amol earlier this morning. I realized that we can probably add like a text box or something to better explain how the calculation was done, so I'll just kind of start from scratch to answer the question.

So what we did, the first step was to determine the population. So we looked at beneficiaries who were enrolled in MA for 12 months, were alive for the 12 months, so we would have complete data, and that we also had complete data on. That was kind of the first step.

The next step is within that population we counted how many ambulatory care-sensitive hospitalization there were. And then as a third step, we used a regression model to calculate the expected, and that model had two steps within it, that determined for each beneficiary what is the probability that they would have ACS

hospitalization, and the second, what count of ACS hospitalizations they would have. That's the expected rate.

So then as the fourth step you take the observed over the expected and multiply it by the national observed rate, and that's the rates that were in this paper.

DR. KONETZKA: You might think about whether you want to do the expected, that first regression model in a different sample, or split the sample, so that you can get potentially less biased predictions above the effects of all those comorbidities. Anyway, something to think about.

The other related question was I was really struck by the pretty large organization level variation you found in these ACS hospitalizations, and yet the pretty moderate or small variation by patient type, by income, et cetera. And I'm wondering, I just want to make sure that's not an artifact of the risk adjustment model itself. So are the small, individual level differences small because you have adjusted for those in the predictions.

MS. TABOR: So we did that to the risk-adjusted model. Those just include beneficiary clinical factors, so it's age, sex, and HCCUs.

DR. KONETZKA: The age might be one of those where since you've adjusted for it you are not going to expect big differences. Correct?

MS. TABOR: Yeah, that's a good point. And we definitely plan on doing some more sensitivity analyses on these, but these are just kind of preliminary findings.

MS. KELLEY: Lynn.

MS. BARR: Thank you. What a hornet's nest. As we're thinking about MA quality reporting, can you help me understand how the MA plans can consistently get EMR data out of all of these providers? I mean, I don't really understand how that could possibly work. So like there would be inconsistency. Small providers won't report. Rural providers won't report. And so are they sampling but then people don't send the data in? I mean, how does this really work on those ambulatory measures, not the ACS but smoking cessation or things that are reported out of the EMR?

MS. TABOR: So like the HEDIS measures, which are currently a large portion of the stars, which include a lot of the preventative care and staying healthy measures that you mentioned, some of those are based purely on encounter

data, but MA plans calculate on their own encounter data, and some do require a chart review, like you said.

And I think plans are using a variety of ways to get those charts. It could be looking within the electronic medical records from providers. It could be looking at sending employees from the plan to go actually do the research. I think actually probably some of the Commissioners here could probably speak better to this, of how that chart review is actually done.

MS. BARR: Is there like bias in that process, like selection bias? Because again I'm thinking about my 27 plans in a rural county with 1,000 Medicare beneficiaries, and I have got 50 of them in each plan, right. So are my providers then reporting on 50 patients to 27 plans?

MS. TABOR: Not for purposes of quality measurement, no.

MS. BARR: But then how would they get the data?

MS. TABOR: So, sorry. Let me back up for a second. So I think for the current measures that do require chart review it is on a sample of patients, so not all.

MS. BARR: But can they choose who to sample, I guess is my question.

MS. TABOR: No.

MS. BARR: And what if the providers can't provide the data?

DR. DAMBERG: So when there's kind of two sets of -- like if you're thinking of HEDIS measures, there are some that require the plans to report on the universe, like mammography screening. So that's all coming out of like --

MS. BARR: That's claims data. Yeah. Blood pressure out of control, for example.

DR. DAMBERG: Right. So they're required to draw a random sample of 411 patients for that plan, for that contract.

MS. BARR: 411 out of 20,000 patients, like 411 out of --

DR. DAMBERG: Or out of a million.

MS. BARR: Okay, whatever the --

DR. DAMBERG: Yeah.

MS. BARR: So then it isn't that much of a burden because I'm going to call you and I'm going to say give me these three patients.

DR. DAMBERG: So the plans look at their data and what the providers have submitted, and then they will do additional going in to the providers' offices to try to round up whatever data they think is theirs, so that could be data out of patient registries, and so on.

MS. BARR: And would they also, so like if they don't like the results go in and look at the charts to say, oh, wait a second, surely you're missing this?

DR. DAMBERG: Yeah, they can do chart review.

MS. BARR: They can do chart reviews selectively. So none of that exists in fee-for-service. I'm just trying to figure out how are we ever going to get to apples-and-apples when we have two different systems.

DR. DAMBERG: Yeah, and it's highly variable depending on the measure, because you can imagine intermediate outcomes, like lab values. That has to come from lab data, right, and a lot of that stuff doesn't make its way into fee-for-service data, or encounter data for that matter.

MS. BARR: Thank you. Thanks, Cheryl.

MS. KELLEY: Brian.

DR. MILLER: Thank you. Having done a systematic

review I know how painful it is, so I appreciate your effort and evenings and weekends that have been sacrificed to do that.

A couple of sort of simple technical questions. On page 15, I liked the ACS hospitalization rates across market areas, and I read about the MedPAC market area, although I think that most of the people who are Commissioners, myself included, probably didn't know what the MedPAC market area is as a geographic unit. And I imagine most people reading this wouldn't know that. So could we add an additional analysis by county or census tract or something? County might make most sense, considering that's the bidding market for MA for competition.

My other question is, again, knowing the full pain of the systematic review, usually after you do one the joke is you never want to do one ever again because they are so much work. Can we, because we are a taxpayer-funded organization and this is, I think, some of the work that probably won't be repeated by others, can we post the Prisma flow chart diagram and the Excel spreadsheet of the article, sort of adjudication for a universe of what we've

included and what we haven't included? Not to question it, but that way other researchers who are working in this space and other policy analysts can see how our thinking was, and then that would also be, I think, a best practice for research transparency. Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you for this great work. I particularly like those tables at the end of the chapter. Super helpful to have it all in one place and the sources for the quality measures.

Just a couple of quick questions. When we talk about the contract level, if I'm an insurance company and I have an HMO, an HMO-POS, a regional PPO, and a D-SNP, are they all the same contract? So they would all have different contract number, but they would be over different areas.

DR. SMALLEY: That's correct. There could be multiple plans in the same contract but they have to be of the same type.

MS. UPCHURCH: Okay. That's right. That's right. So you could have one contract but two different PPO offerings. Okay. You just told me that. Okay. Thank

you. Or you put that in the paper. I had forgotten that.

The Table 4 with the regional PPOs, having a little bit higher ACS hospitalization, and I don't know if it's significant, but do you have any concerns about that or any reasons why? I know often PPOs can have higher cost sharing when it comes to primary care, specialty care. Is there any reason why there would be?

MS. TABOR: So the PPOs do have higher rates, which are like the worst rates compared to the HMOs. This just kind of fits in with other literature that's out there. We do plan to dive into this a bit more, but again, this gives us a look at what else is out there.

MS. UPCHURCH: Okay. And Tamara had me nervous because it sounds like we have controlled for a lot of things. And if you look at Table 3, what jumps out at me is race and ethnicity having -- I mean, I just assumed, honestly, that LIS status would have rural, urban. I thought there would be a differential. So it sounds like you've controlled for some of these things, like age. You've already controlled for it. That's why there's not a difference there. What about race? Did you control for race?

MS. TABOR: We did not control for race, and that's due to Commission's past principles, or current principles. The idea is that we don't want to mask disparities by adjusting away for them. So that's why we purposely did not include race in the risk adjustment model.

MS. UPCHURCH: How about the LIS and urban/rural?

MS. TABOR: The same premise also, is that that can mask disparities.

MS. UPCHURCH: Okay. Well, the only thing that really looks disparate is race and ethnicity. So do we have some ideas of that? I mean, obviously years of maybe less access or less trust in the system, I mean, that's not what this paper is about. But it just sort of jumps out as being a real problem, that you've got people of color that feel like their role is, you know, they have to go to the hospital versus potentially having preventive care or something else that would make that not happen. So I just think that's a red flag in my mind when I see something like that. Thank you.

MS. KELLEY: Kenny.

MR. KAN: Very insightful analysis. I know that

this is a preliminary analysis, but I really appreciate you, Ledia and Katelyn, you ladies do the extensive review.

So two Round 1 questions. Number one, I understand why you look at quality for a contract level quality measure that spans multiple geographies versus a local market area. But would it be possible maybe to throw up some of those contracts that span multiple geographies and focus on those that are a little bit more local market area focused and see if we can actually decipher trends from those contracts?

I mean, you may end up getting like 20 to 50 percent of your total beneficiaries, but they is for any patterns and observations, that would be helpful. So that would be one.

Number two, on the 36 studies that you studied, did all 36 use sort of like a propensity cohort analysis, where they actually measured the results of a targeted group, or was this a control group? And did I hear you right that basically all 36 are an apples-to-oranges comparison, depending on how they adjust for those three problems, those three issues that you mentioned in the slide deck?

DR. SMALLEY: So some of the studies that we looked at did a propensity score matching. Some of them used other matching techniques or other kind of instrumental variable, other methods to try and adjust for those unobservables. Some studies didn't use any of those advanced statistical techniques. And so we tried to look at the totality of the studies, recognizing that some of those techniques will get you further towards addressing those issues.

We have some concerns, especially around propensity score matching and its ability to address our concerns around coding intensity and favorable selection. The difference is that we can't pick up based on observables in the differences in population between MA and fee-for-service. That's why we're saying that recognizing that some of these -- there are strengths to some of these things, but we still have concerns about the totality of the studies that we looked at.

MR. KAN: Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, two comments, one very quick one, in violation of all Round 1 principles. I have to say

that one thing I'll take home from today that I won't forget is the 27 MA plans per rural county. I think that to exaggerate, when you have more plans that people in a county, we can probably assume that Congress has maybe overdone it a little in giving incentives for MA plans to locate in rural counties.

Okay. Put me on probation.

But you asked for other ideas about quality measures, and I think ambulatory care-sensitive issues are a good one because they should represent all kinds of things that could improve quality. For example, the kinds of things Greg likes to talk about that aren't billed but could be useful. Like free telehealth visits might keep someone out of the hospital. And there are flaws, and if Mike Chernew was here today, he could probably articulate them quite well, like they're related probably to the geographic areas' overall admission rates.

But, you know, I think ambulatory care-sensitive ED visits are interesting, and my guess is that they're even more sensitive to the quality of care than ambulatory care-sensitive admission. So they would be a good measure, and you do mention these in the document we have, that we

have contracts with RTI to measure ambulatory care-sensitive ED visits, but that we haven't included because there is no comparator like MedPAR to see how much of this is due to missing data.

There's really so much interplay between the encounter chapter and this. The admission data problem makes it, I think, really wrong to compare visits fee-for-service versus Medicare. But the kind of comparisons you did in this chapter, across market areas, across types of plans, and so on and so forth, still might be worth -- I mean, it is possible that some market areas or some types of plans have more incomplete ED visit data than others. So that problem won't go away. And, in fact, that could be a good illustration for either chapter of why the lack of a concrete illustration of why even a small amount of missing data could really matter to the result.

But it still might be worth taking a closer look at ED visits, if not now but sometime in the future.

And I'll just mention, to finish up, you guys are probably aware that there's the Billings NYU procedure. But then there's the Minnesota model for identifying probably potentially preventable ED visits. I don't know

how that relates to RTI, what RTI did, or what you guys are thinking about that. It's a pretty simple model, actually, attractive in some ways, I think the Minnesota model.

MS. TABOR: We'll take a look.

MS. KELLEY: That's all I have for Round 1. Should I go to Round 2? All right. I have Cheryl first.

DR. DAMBERG: Okay. A couple of thoughts. So I know you recognize, and Amol set the stage, that this is just one measure, and it's insufficient for really assessing quality. And I agree with that, and I think we have to keep trying to think hard about what we can do to expand the set, but I'll touch on that in a minute.

But this particular measure, you know, as you start to kind of look at within markets and thinking about doing this at a contract level, I mean, this measure, when it was originally conceived of by AHRQ was a community-based measure, and so the smaller units you try to measure with it, it starts getting very noisy. And I think that's something you allude to in the chapter.

And so I think, again, we're going to have to think harder about other measures that can be measured at the contractor and below, because I know the Commission is

really interested in going lower than that.

But one of the things, in looking at your results, that sort of came to mind and could potentially be follow-on analyses is how do these rates vary by the availability of primary care, either within the plan or area, or the amount of spending on primary care by the plans. Because I think that that is going to be a factor that's going to affect what we see in these rates, and the plans could vary substantially in that regard.

The point I made earlier in the encounter data session that we just had, you know, there's a clear connect to this quality measurement work, and I do believe that we need to take steps to assess quality using encounter data as a way to try to induce more complete data.

However, one of the things that I've been reminded of recently is that the quality measure specifications allow plans to use supplemental data, and we've done work comparing the encounter data versus what the plans submit. And we get a pretty high level of agreement on denominations, so who is eligible for those services, and where the disagreement comes in is whether they got the service or not, or the event.

And the use of supplemental data is really enhancing plans' ability to demonstrate that they provided the mammography, or whatever the service is. And this in part because the MCA QA specifications allow them to look at multiple lines of business. So somebody aging into Medicare, you know, if they were in the same plan when they were in the commercial aging into Medicare, the plan can look back and see whether somebody had that service. And just looking at encounter data alone doesn't allow us to observe that, which I think is sort of a challenge. So we may have to think about encounter data plus, if we really want to try to fully represent what the measure specifications ask for.

And then I think this issue of service areas and contiguous states versus states that are not, I seem to recall that once upon a time CMS required contracts to be defined by having contiguous areas, but then there was something that changed over time. So I think maybe that's worth asking about and whether there is some mechanism to shift back to having contiguous service areas when defining a contract.

MS. KELLEY: Tamara.

DR. KONETZKA: First of all, plus-one to Cheryl and others who have underscored the fact that we really need to monitor and assess quality and access in the MA population, and to do that we need the data. It might not tell us everything but we need the data to create these quality measures.

But my broader point is, I know that there are many conversations about the appropriate level to measure quality that happened in this Commission long before I was on it, so this may be a risky thing to say.

But I guess I would say that even as we acknowledge that consumers, beneficiaries really want information at a plan level and to be able to compare things locally, that doesn't mean there's not value in measuring quality at a bigger level. And the way I think about it is we might really want conceptual mapping between a certain quality measure that we might think is important and the production functions for that quality. Because there may be things that happen at a more regional level, or at a broader company level, or at a contract level. And if there are certain things -- screenings or preventive care or customer service -- that happen at that broader

level, then that may be the level at which we want to measure it.

And then as sort of a related point, I think it can be useful for consumers certainly to know what the plan quality is in their area. But if they're thinking about signing up for an Aetna plan or something it may be useful to know that broadly Aetna does well on certain things or not, right. Because it may be a new plan and they want to know what the history of performance in this company has been.

So I guess I don't want to sort of move toward measuring quality in a smaller and smaller level when conceptually the right levels may be different for different quality levels.

MS. KELLEY: Stacie.

DR. DUSETZINA: I was kind of hoping you wouldn't say my name next because I was trying to think through Tamara's comment, because I was going to go in the opposite direction on like where we should measure quality. So maybe I'll just make my comment and reflect a little bit on that.

I agree that it is important to think about what

question are we trying to answer with what exactly we are measuring. I'm usually thinking about it from the someone is trying to pick a plan that works well and supports their care and access to care. So I think that is one reason that I think local market-level quality measures for thinking about at least the beneficiary experience in picking a plan I think are very valuable.

And I have no idea exactly how to get there, but I liked Kenny's suggestion about the geographic variation within a contract. And I had also been thinking along those same lines, and could you use something MCBS data and look at the same contract but geographic variability to see, you know, how often is it happening. Is the overall rating for Aetna, let's say, like is that telling you that it's pretty consistent across?

So I'll just say, you know, if I'm thinking about how I'd like it to be operational, it would be more at the beneficiary and local level, market level.

You know, I think the chapter does a really nice job in the presentation that the quality bonus program as it's set up and as it's flagging for quality doesn't seem to be working very well. So I think getting better

information about the quality of plans to beneficiaries when they're choosing would be good.

For the analysis on the ambulatory-sensitive conditions I think that it's an important analysis, but I will kind of continue to maintain that I think the things that I worry about for beneficiaries are specialty care access. And I think that when I was looking at the chapter, on page 11, you have this category of getting needed care as one option. And I think you could think about trying to answer that around network adequacy, and what's included in the network for specialty care, if we're trying to get at that conceptually for people when they're thinking about selecting a plan.

It's a little bit harder for me to think we'd see a lot of variation, even for the ambulatory-sensitive conditions, but I could imagine we'd see a little bit more of that happening with specialty care. So just putting in a plug for that in future workstreams.

And then I feel like this is one of those -- and I'm going to get the adage wrong, but it's something like when you're a hammer, everything you see is a nail. I'm going to say something about using Part D as one way of

thinking about making the risk adjustment more standardized across MA and fee-for-service. So if you start to go down that path, I realize there are selection issues there because you have to focus on the people who have Part D. But that information should be at least a little bit less prone to having differences between coding or the way that we get information between encounters and claims, because those drug claims are all coming the same way. In the field of pharmacoepidemiology there have examples of people that have had only access to drug data to do research, and they've made a pretty good run at it, so not using other clinical information.

In all I'm incredibly supportive of this work and think it's very important for Medicare beneficiaries to have better information on the quality of MA. Thank you.

MS. KELLEY: Lynn.

MS. BARR: Well, there's a lot to think about here, because I think we're comparing apples and oranges, and we're really trying to make them look the same, but they're not, and I don't think they're ever going to be the same.

So I think it's incredibly important for this

work, for patients, taxpayers, and CMS to understand the quality of care they're getting with the choices they're making. But I don't see a path forward in the current structure where we're actually going to get meaningful information, and I honestly think we should abandon this work. Because I don't think you're ever going to get to an answer that says this is fee-for-service versus MA, because they are so different.

And what I believe we need to do is to make the same system for all patients and all providers. So I really want to know the MA score for my doctor. I don't really care about the aggregate plan number. I want to know my doctor, my hospital, how does MA perform in my community with my doctor. And right now I know we all want to blow up MACRA, right -- everybody wants to blow up MACRA -- but we have an opportunity to blow up both of these systems at once and make one system for quality reporting that we can compare.

And then given that MA is half of Medicare now, every doctor should have an MA score and a fee-for-service score, because they're reporting this data anyway. And you could then analyze, oh wait, all these doctors have better

scores on MA than they do on fee-for-service -- again, getting rid of HRAs and things that are outside of that physician -- because then you'll normalize for coding. A doctor is not going to code differently for MA and fee-for-service within his practice. He's going to have how he practices.

So I recommend that we don't continue trying to make something work that can never work because it is so incredibly different, and that we instead start thinking about how we have one quality program for all Medicare beneficiaries, and then we can then start analyzing the differences. Thank you.

VICE CHAIR NAVATHE: Maybe I can just add one piece of context. So I appreciate your comment, Lynn, and Stacie, yours as well. So obviously it is complex space. There is a lot of asymmetry that you are pointing out.

I think just one very general point here is I don't think we've arrived at this work, or the motivation for this work is so much trying to figure out plan choice, per se, so much as trying to understand how we can go about measuring quality in MA at a high level, and that's why some of this is -- there is both the component of variation

between plans or between contracts in MA as well as lit review on the MA fee-for-service part of it.

So I just wanted to give that one piece of context. I don't think that necessarily changes the meaning of what you said, but I just wanted to point that out.

MS. KELLEY: Brian.

DR. MILLER: I have a couple of comments. This was a good start, more narrow and then go broader. One is I thought this was a fun paper. As an MA nerd I enjoyed reading this.

A few sort of technical comments. On page 7 you sort of denoted a cliff effect is bad. I'm not necessarily sure that's always the case. I know the difference between a 4.5 and a 4.6 star teriyaki restaurant, and I don't think that the beneficiary would value necessarily the difference between a 4.5 and 4.6 star plan. So cliff effects may be uncomfortable for us, but we have to draw a line somewhere that seems like a reasonable kind of a line drawn.

We talked about VIP measures on page 11, that the notion of VIP is, of course, fun to think about. But we probably should have more description in the chapter about

that because not everybody is going to have read the prior VIP chapter about the proposed quality rating system.

So two sort of more overarching comments, one of which is I agree with Lynn. I think it's a little bit of chasing our tail to say we're going to look at MA versus fee-for-service quality with two quality systems. And taking this to sort of think about how to rescue the work, I mean, it still may need to go back and meet its final demise, but to think about saving this work we have a quality rating system in fee-for-service -- providers, hospitals, home health, doctors, et cetera. It is not perfect and it has lots of problems. Probably that have some sort of great rating system in fee-for-service because we have a fee-for-service plan, and I think we can all agree it should probably grade people. Again, we can agree and disagree as to whether that grading is fair or good, or not. It probably needs to be improved.

MA plans should also have their own way of grading doctors. Different plans may have different ways of doing it, and that's actually probably a good thing because again, if there are 17 different opinions about how quality measurement should and could be done there are

probably 10 to 20 ways in which quality measurement could be done. So that variation is good, and technology could actually help decrease that administrative friction.

But then we have MA plan quality rating, which I think is also important, and I agree that the star rating system is not necessarily always the best. It should be fixed. And I actually think that if we have a star rating system why is there not a star rating for the fee-for-service plan. Because if I am a beneficiary shopping at the county level, I probably want to know whether fee-for-service is outperforming MA or not. Because if I can choose amongst 4-star MA plans, and fee-for-service is actually a 5-star plan and I don't know that, that beneficiary we put at a disadvantage. And in other counties where MA is a 5-star plan and fee-for-service is 3.5, the bene doesn't know that either.

So if we want to have a more equitable playing field and actually help benes make better decisions, and their families are legal proxies if they're incapacitated, we should have a quality rating system that grades the fee-for-service plan and also the MA plans. And it doesn't necessarily have to be budget neutral because if the fee-

for-service plan beats MA, it should get paid more, and then that money, through a variety of technical policy adjustments could flow through to the fee-for-service providers -- hospitals, doctors, home health, et cetera.

And so I think if we're going to continue this work, we need to think about a unified quality rating system, like Lynn said, although it needs to be across MA and fee-for-service so we're not just dumping a bunch of money into MA and then not putting money into fee-for-service, and then grading MA and not grading fee-for-service. We shouldn't have a Lake Wobegon effect where the average MA plan is 4.5 stars in many counties, and it's probably not titrated appropriately. So I think we should think about this work in the context of quality rating for all Medicare plans, MA or fee-for-service.

So that's big font number. Big font number two is about pages 31 to 33, where we are talking coding intensity and favorable selection. As I said, I believe that my analytical concerns, which I brought up at the September 2023 meeting, about coding intensity, the November favorable selection chapter, which we discussed in November of 2023, and also in January, my analytical

concerns about this related to measuring the different components of coding intensity, recognizing that two of them are definitely overpayments. Fraud is bad. DOJ picks you up to go to jail. Upcoding, I mean, I think that's bad and should be repaid.

That clinically appropriate coding intensity is not an overpayment, and that as a Commission we need to have a policy nuance differentiated between an overpayment versus a differential payment. We also have a bunch of other flaws that remain unaddressed, such as including EGWPs, which are not available to the general beneficiary. The average Medicare beneficiary cannot enroll in an EGWP, the Employer Group Waiver Plan. So we included that in our measurement, which is a violation of a policy arm across the entire Medicare program policy community.

So I think that until we fix that analysis and fix those analytical flaws, or account for them, that we should not be referencing our favorable selection and coding intensity across those three pages. Thank you.

MS. KELLEY: Greg.

MR. POULSEN: Thanks. This has been really interesting, and I'm vastly more confused than when we

started the discussion. Let me say that first.

I had the same sort of whoa tilt that Stacie just had, but it popped into my mind that as I talk to -- and I suspect you all have the same thing, where Medicare beneficiaries or potential beneficiaries come to me and ask for advice, and it's almost always which plan should I choose. They make the decision of MA versus fee-for-service based on a whole series of things that are not generally what we would put into these kind of quality metrics. They make them based on convenience. They make them based on coverage. They make them based on cost and a series of other things.

So I would plus-one on the ideal thing here is to make things that allow comparability between the plans that people actually are selecting between. They make their fee-for-service versus MA plan on some other characteristics than what we're talking about here, I think. That's certainly been my experience.

I would note that we really are talking in the quality area here and it's explicit in this document -- it was not in the 2020 document, when I looked it over -- was that we're really talking about two different area: the

quality metrics that are in this and looking at it in the correct geographic area that people are making their decisions regarding. I think those are worth considering separately, and I think that we might decide that one is more important than the other. I certainly think one is.

I think that as we look into these kind of metrics I believe that we do see enormous -- and again, I'm sort of going on anecdote, but enough anecdotes that it may become data -- that suggest that the same program is variable across geography, and it's based on the providers that they work with, the relationship they have with those providers, and in many cases the way they pay those providers can vary geographically.

So I very much like the idea of looking at the smaller geographic areas, because that's where people are making their decisions, by and large. They live in a place. They're getting care in that place. So how it works for them within that geography I think is incredibly relevant.

I know there are problems with doing that. You talked about them. And as always, Katelyn and Ledia, you guys do a great job of bringing these out, and you did a

nice job of talking about the challenges that would be associated with some of those smaller geographies. But the very fact that there are plans that serve only one of those geographies and are able to report suggested that there are ways around that, that we can get there from here.

So I think that we can and we should, and that that would give us real value at the decision-making that we really want to support. There's a lot of academic decisions that are interesting, but the ones that I think are most important are the simple decisions of which plan do I pick. And I think that we're headed down that path by looking at that smaller geography.

The other thing that I guess I believe when we get into the discussion about changing the metrics on which we judge quality, we run the risk of goring everybody's ox. Everybody has a dog in this fight. This is going to be incredibly politically challenging to make a wholesale change in the way that we measure quality. There have been huge investments made on the part of providers, plans, and others to do the current program. I don't think that means it should remain static, but I have a strong perspective that we would do better to change it over time by putting

additional metrics in, taking other metrics out, and moving, over a period of time, to a value-based system.

I respond the same way that Brian did. I don't worry about the cliff issue as much. In fact, I think it makes it better. I think it makes us not look at a 4.2 versus a 4.3, and is that something that makes a difference to me. I think binary is too much, good plan, bad plan. But something that falls into that, you know, half a stop, seems like a reasonable approach to me.

So my inclination would be, and my recommendation would be that we look at adding metrics that we think are valuable, taking away metrics that we think are not valuable, and focusing on geographic areas that are the actual points of decision-making for individual beneficiaries.

Thanks so much for the great work, guys.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. Very interesting and challenging work, and very interesting comments.

I am going to bring up something that I haven't heard said here, and you may not have to agree with me. Quality, in many ways, is such a blunt term, and it leads

to the more is better. And I'd like to think about outcomes, both short- and long-term outcomes both of treatment but also with watchful waiting.

And the table on page 11 reminded me about how concerned I am about measurement-driven overscreening, screening-driven overtreatment, and then the cascade of events that occur from that, which can also cause harm. People become patients when they really shouldn't be.

There's an article in January that I strongly agreed with that talked about the diminishing mortality benefits of cancer screening with improvements in treatment, and it's talking a lot about breast cancer screening. Part of the reason I feel the need to bring that up is as a woman, you know, I think I can say that. I mean, I'm very concerned about breast cancer overscreening and the number of people that become patients. And yet it's just accepted that this is a great metric. I'm very concerned about that.

Colonoscopy or a screening that isn't really looking at age I'm very concerned about. I'm very concerned about the harm that can happen to some elders because of the treatments, dehydration and everything.

So I think we really need to, if we're going to raise quality, what are the outcomes? What are the things that make a difference?

I hope that in everything we're thinking about we're really also including whether that's sensitive to measurement-driven behavior and measurement-driven harm.

I did like, I think Larry's talking about ambulatory care-sensitive ED visits. That seems less problematic to me.

And I just have to say I agree with almost everything Lynn said, but I just have to say something about MACRA. I know there are a lot of problems with MIPS, but I have to be on record as saying one of the things that I very much like about the law is one way or another providers are taking on financial risk for costs of care, whether that's alternative payment models right away and then MIPS over time. So I know MIPS people have been unhappy with, but that is the golden nugget in there to me, moving to providers really taking on risk and accountability for care. Thanks.

MS. KELLEY: Kenny.

MR. KAN: Just two quick points in Round 2.

Number one, like Greg and Brian I believe we should look at separate quality measure for fee-for-service, because this will better allow MA benes to make better informed apples-to-apples comparisons when they pick between MA and fee-for-service.

And then number two, if we could take a look at the 36 studies and then compare the measures that they used and pick from that universe of stars measures, if we can pick maybe perhaps no more than 20 quality metrics that matter, what would they be, and how would we actually use that for MA and fee-for-service. That would be very helpful.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you on the really heavy lift in terms of putting this chapter together. Greg and I are probably not the only ones that are getting confused through this conversation.

You know, the way I kind of think about just quality in general is that it needs to map to some sort of strategic purpose or plan, and that's where I wrestle with. Because we go deep into the weeds, but I still don't understand what the plan is for MA. You know, when it was

first implemented, I think it was pretty clear. It was an alternative for fee-for-service, it was meant to reduce costs and provide good quality of care based on certain incentives being aligned. But it's evolved into something else.

So what the MA plans have figured out is that they can capture higher reimbursement through coding, you know, what's called coding intensity, and I think Brian and I are not big fans of coding intensity. But nevertheless, they figure out a way to gain better reimbursements, and then reinvest that into new benefits, like dental, vision, and hearing, which allows them to grow their membership and create scale, which creates value for the consumer. And then what we call selection bias is actually consumers making choices, that that's a lot better than fee-for-service, and they don't have the maximum out-of-pocket benefit.

So we sometimes get trapped in these terms, like coding intensity and selection bias as being negative, when, in fact, probably from an MA plan perspective some of those opportunities represent actually an evolving and perhaps improving MA system in certain circumstances.

The other thing, too, is that based on that we have to think about whether the spend on MA is appropriate or are we actually overpaying. You know, again we talked about overpayment a lot, but should we be thinking about whether the spend is appropriate and whether some of the budget variances that we're seeing is either favorable or unfavorable. You know, these are sort of better terms for me personally. Because if the plan is taking their margins and they're reinvesting in better benefits, as I mentioned before, including transportation services, because I'm elderly, I can't get around as much, and this MA plan is offering me transportation services to my office visits, well, that's a major plus that's providing value to the consumer.

Likewise, if they're taking that extra revenue and they're investing in case management resources, and they're using those case management resources to make sure that their hospitalization rates are low at their particular market level, that's great. If they're reducing ED visits because they are creating same-day appointments with their doctors, then that's great. If they're investing in medical homes with that additional revenue,

then that's great too because at the end of the day that helps out complex diabetic patients, congestive heart failure patients, if they are better managed at home instead of having to go to the ED or have an unplanned hospitalization. And likewise, if they're creating better access then it also addresses certain equity issues within their local market.

So I'm not sure that the coding intensity necessarily is a bad thing if it's being used to reinvest in the care of the patient with the additional revenues. We have to really separate out whether we are overpaying or whether the spend is appropriate.

That gets back to the objectives again. If the basic goal of the MA plan is to simply reduce costs, and that's fine because maybe we shouldn't be looking at the extra benefits or the additional resources initially spent in case management, but if we're okay with the additional spend then maybe it's okay to have better benefits as well as better case management. They're not necessarily mutually exclusive. But if we can clarify those things that makes it easier to actually align the quality goals, which I think for MA is looking more like a value-based

plan than, let's say, a quality plan per se, that's really consumer driven but also allows for a beneficiary to have a better quality of life.

So I think I would welcome a discussion, at some point, not necessarily today, on what we think is the goal of our MA plans, moving forward, because it would inform, I think, future discussions around MA plans in different chapters that we have.

Thank you. A great report.

MS. KELLEY: Scott.

DR. SARRAN: Yeah, really great work. Four quick comments. First, just reinforcing I think this is very important work, both in terms of how consumers make choices, and although I agree that right now I don't think a lot of choices would be made at a traditional Medicare versus MA level based on available information. We just don't have that available information, so I don't think we know how that will be used until we put that out there. But I think from a perspective of consumers making choice it's important. And I also think, Lynn, Robert, and others have reinforced on it's important to understand the value that MA is or isn't creating. So hugely important work,

again, for at least a couple of important reasons.

Second, on this issue of measuring and bonusing at the market or the contract level, I think we could debate whether you bonus it at the market or plan level. I think the take-home I have is let's measure at both levels for a while and then get our legs under us to make a decision. So I don't think we need to feel obligated to decide where it should be bonused today. Let's start measuring it, to the extent possible, at both levels.

Third, in terms of admissions, ED visits, et cetera, I really think we should be reporting on ambulatory care-sensitive admits, ambulatory care-sensitive ED visits, and overall admit rates. It's a three-dimensional kind of thing we're trying to get at, and the more angles we look at that object the better we will see it.

For one thing, there are a lot of things you can do as a plan, particularly if you have provider alignment, to change the boundary between admission and ED/observation stay. So looking at admits and ED together is helpful. And I've always looked at MA through the lens of saying, you know what, everything other than elective admission is preventable, if you sort of go up to a higher altitude and

look at what really optimal care looks like. So I think looking at overall admit rates is valuable.

And lastly, kind of a plus-one on Stacie's comments about the star -- actually, I have one more comment -- accessing specialty care. I think that is so crucial because when I think about overall what we're trying to do for the beneficiary in terms of the MA program there is value that might be perceived by a, call it, relatively health beneficiary, with risks that are 1 to 2, maybe. And that's a lot of good stuff, but it's not necessarily lifesaving of function-saving stuff. But then there's enabling the right care for the people whose lives or function truly depends on access to and coordination with superb specialists, and between those specialists and the primary. So I think kind of continuing to focus on that is just crucial.

And the last thing, the comment about stars, and do we try to migrate away from stars as we recommended? You know, I think it probably would be picking such a huge fight with some valid pushback around the disruption. I think mapping out a migration pattern from stars today to a stars of tomorrow as we talked about a value where we head

would be revenue neutral, we have a smaller number of true outcome measures, et cetera.

But I think articulating why it makes sense to migrate to something new and then addressing the industry and saying, hey, we're committed to make this a migration rather than a flip a switch overnight might give us a higher chance of realistic success.

That was 4 minutes and 3 seconds. Just saying.

VICE CHAIR NAVATHE: Scott is trying to propose a new best practice, I think.

MS. KELLEY: Brian, did you want to go ahead. I think you had a follow-up response to Robert.

DR. MILLER: Yeah. I agree with all of Robert's comments, and wanted just to say that I think that one of the things that we all tend to forget is that the biggest benefit of MA to the beneficiary that probably affects their spending and affects access is the inclusion of Medigap. That statutory out-of-pocket maximum makes a big difference, because otherwise you have to go by the out-of-market, and it's often individual risk rated and very expensive. Again, not that MA plans aren't perfect, but the inclusion of that and Part D, it's not that I don't

think that case management or shower grab bars or whatever don't matter. They do matter. But the inclusion of those two basic components of a health benefits package drive a lot of access and quality opportunity.

I think in addition to responding to Scott's comment, an on-point response to that is I agree that we need to go from stars of today to stars of tomorrow. It's making me think about the expanse on the Syfy channel when you said that. I would say that the key component is that stars should not just apply to MA. It also needs to apply to fee-for-service. Otherwise will be unfairly benefitting MA over the fee-for-service marketplace.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. I've been trying to think more during the discussion about other quality measures, as you guys requested. Just as a general point, I think that measures that try to capture all aspects of quality, like potentially preventable admissions or ED visits, are valuable. I think individual measures like colonoscopy rates, although colonoscopy rates are important, I think much less valuable. And there is big literature on this now. They're so gainable. There's teaching to the test,

putting the effort into some things when other things are more valuable.

I mean, thinking about those kind of individual measures, if this is the quality of what clinicians provide, this is what gets measured, and probably this is what potentially could get measured. Still way smaller than the big circle. So I do think we should look more, as you guys have been doing, for more global measures of quality.

And one other one, potentially could be patient experience. There is a whole literature on this too. There are probably people here who are a lot more familiar with it than I am. But at least at a highly abstract, conceptual level, patient experience could be a useful measure. And I realize it can be expensive to collect sufficient numbers of responses, especially at a local level, for example, but, you know, we spend, what, is it half a trillion dollars a year on Medicare Advantage and a large amount on fee-for-service Medicare as well. And programs that we spend that much money on, I think it's just worth spend like 0.0000001 percent more of the budget on trying to collect sufficient numbers of patient

experience measures.

So going forward, some more thought might be given to whether there would be value in doing that, at what level to do it, and making the budget argument as well, something along the lines of what I just made.

Once again, I think I was shorter than Scott.

MS. KELLEY: Cheryl, did you want to go ahead?

DR. DAMBERG: Yeah. I just want to plus-one what Larry just said about capturing more information on patient experience, and given what we spend relative to what it costs to field these surveys, I mean, that sort of seems a lot but it's not. It's a drop in the bucket.

MR. POULSEN: Could I jump on that one too and just say my organization, at least, and I suspect others, we survey 10 times as many commercial beneficiaries as we do Medicare beneficiaries, and there is no reason why we shouldn't do that. If it makes sense financially for people who are actually having to pay their own bills, it probably makes sense for Medicare.

VICE CHAIR NAVATHE: Gina? We're into mythical Round 3 now.

MS. UPCHURCH: Yeah, sorry. Yeah, this is just

to build on what Greg just said. I think a lot of times if you ask people their experience, whether they're in a Medicare Advantage plan or fee-for-service, a lot of times their complaints will be like, you know, it didn't cover something that wasn't considered -- my annual physical, they wouldn't give me a physical. So there would have to be some sort of judgment of it, or some filter to judge it by, because some of those things just aren't covered by Medicare. I mean, sometimes they may be covered by a Medicare Advantage plan, but there needs to be some filter on that. Like was it something that was supposed to be covered, or not supposed to be covered, and we need to know that. The people think I need an annual physical, and that's what they really want.

VICE CHAIR NAVATHE: Great. Ledia and Katelyn, thanks for a great session.

So just a couple of wrap-up points, and some of the things I'll reflect back to you. You know, I think in some sense I would say that our intent here of this session was really to think about if we are indeed paying more for MA, what are we getting from that from a quality perspective to understand the value, and then what does

that variation look like within MA.

The intent up front was not so much about plan choice and selection, but I think we hear the feedback loud and clear, that in some sense those are kind of intertwined concepts. So trying to separate them might not be that tenable, based on the feedback that you all have given. So I think that's a helpful point.

I think another point that was loud and clear was just the system asymmetry between MA and fee-for-service, and the desire to think about, down the road, as we consider work around MA quality and just MA in general and MA and fee-for-service, how that system asymmetry might be less and/or eliminated, and what that would mean, what that would entail. That's obviously a whole swath of things, so we'll have to think about how to fit that in. But I think that was another kind of big theme that we heard from all of you.

We heard some conversation about the coding and selection pieces. I would say the point here was not really to revisit that per se but to just point that out in the context of the literature as we try to interpret what the literature is telling us. So what the magnitudes are

and all those things are less important. It's more just that it's hard to interpret the literature in that context.

And I think the analytic suggestions are really well taken. So I think we'll take all this back, all the feedback that you've given and then synthesize that and chart out what the path forward looks like. And I think there are a lot of different moving parts here, so I just wanted to acknowledge that we heard that from you all.

The other part that I'd like to just restate again is this is preliminary work. So I think part of the idea here was to share stuff with you, get your high-level reactions before we invest a lot of time going down any particular path. So I would say from that perspective you all have done a fantastic job of giving very thoughtful comments that will help us to kind of try to get our ducks in a row in terms of what next looks like, and I think there are a number of different considerations that we have, including improving some analytic work along the way.

So with that I think we will tie up the session and tie up today's meeting. For those listening at home we want to hear from you as well. Please submit your comments at meetingcomments@medpac.gov or through the website,

medpac.gov/meeting. And we will reconvene tomorrow morning at 9 a.m. Thank you.

[Whereupon, the meeting was recessed, to reconvene at 9:00 a.m. on Friday, March 8, 2024.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 8, 2024
9:00 a.m.

COMMISSIONERS PRESENT:

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

AGENDA PAGE

P R O C E E D I N G S

[9:00 a.m.]

VICE CHAIR NAVATHE: Welcome back, everyone, to the second day of our March meeting. It is once again a sunny day in Washington, D.C., so I hope it is where you are, as well.

Just a quick reminder that Chair Mike Chernew is presently out for this session, but he will be back in April. Well, he is on, but he will be back in this chair, in April. He will be back well before then, I'm sure, in action, as Mike is a very high-energy person, as you all know.

Today we'll be going through two topics, Medicare's Acute Hospital Care at Home program, and then further work on inpatient psychiatric facilities. And with that let me turn it over to Evan and Jeff,

MR. CHRISTMAN: Thank you. Greetings. This morning we will discuss Medicare Acute Care Hospital at Home program. This presentation is available in the control panel on the right-hand side of your screen.

Today's presentation provides an overview of the program that we plan to include in the June 2024 report,

and I would like to recognize Pamina Mejia for her support in this project.

The presentation will have three parts. We will review the development and features of the Hospital at Home model of care. Next, we will examine the experience of the fee-for-service Hospital at Home program established during the public health emergency. Finally, we will turn our attention to considerations for the future of the ACHaH program.

First, the program I will be discussing is fee-for-service's version of a model of care referred to as Hospital at Home, which provides inpatient acute care at a beneficiary's home in place of a stay at a regular hospital.

Hospital at Home programs have been operating in health systems abroad for many decades, and experimentation with them began in the U.S. in the 1990s.

Adoption of Hospital at Home has been relatively modest in the United States, but during the pandemic interest in the model increased due to concerns about hospital capacity. These concerns led fee-for-service to establish a Hospital at Home program called the Acute

Hospital Care at Home program, or ACHaH for short.

Under ACHaH, hospitals apply for a waiver to provide the services for a standard inpatient stay in a patient's home.

Payment under ACHaH is the standard amount under the inpatient prospective payment system. No additional payment is made if a patient has to be escalated from the home to the facility-based care.

Under ACHaH, patients must be evaluated at a hospital. After accepting ACHaH services, their care take one of two paths. Beneficiaries in the early-supported discharge will have a shortened overnight stay at the hospital and leave early to receive the rest of their acute care at home. Beneficiaries in the admission avoidance model will be sent home immediately with in-home acute services for all of their stay.

Though CMS's authority for the program expired at the conclusion of the public health emergency, Congress extended the program through 2024.

As you may recall, we last discussed the program at the September 2023 meeting. Since that meeting, we have completed a number of interviews and a site visit with

several hospitals that operate programs ACHaH programs. These efforts were important because this is a new model of care, and their first-hand reflections helped to fill the information gaps in the literature and Medicare administrative data. We sought their views specifically on their implementation efforts and policy challenges they confronted.

Though I will include findings from these interviews throughout the presentation, I want to note a few key themes. First, the specific clinical and service components of each program varied, and reflected decisions hospitals made about their needs and their capabilities. The goals and market context of a hospital influenced the decision to participate in ACHaH.

ACHaH volume had increased at these during the program, though as we will note later it still accounts for an extremely small share overall of inpatient services.

Finally, clinical staff had very positive views of the care model for patient experience and quality, but we did not review any formal data on these issues with them.

Before we turn to outcomes of ACHaH, I want to

detail some of the nuts-and-bolts program elements hospitals need to address, and these fall into the four broad categories you see on this slide.

Starting on the first of the slide, first, a hospital operating this model will establish clinical criteria and other requirements that define the conditions, services and other requirements that define the conditions, services, and other factors that indicate a patient may be served safely at home. In general, the programs seek to identify patients that are sick enough to need an inpatient hospital level of care, but are medically stable enough to be served through intensive clinical services in the home. Patients meeting these criteria, generally after being evaluated at the hospital, will be sent home to receive their acute services.

Moving to the second column, under Medicare hospitals are required to provide two in-person clinician visits, and one daily consultation with a doctor.

In addition, as you can see in the third column, hospitals provide the full range of services a beneficiary needs in the home. The services available can vary based on patient need and hospital capability, but generally

include pharmacy, diagnostic services such as labs and radiology, food, and in some cases personal care services.

Finally, ACHaH programs often establish a geographic area for their operations, and one goal of this is to ensure that beneficiaries are near the hospital in the event of a medical emergency. In general, for the programs we spoke to the service area was often a certain radius from the hospital.

Across each of these four areas hospitals have broad discretion to determine the inclusion and exclusion criteria for patients, clinical services offered, and geographic area covered. In our conversations with hospitals, the decisions about these things reflected their local context and capabilities. So for example, some hospitals indicated that ACHaH was a way to address overstressed inpatient bed capacity, or a tool to address back-ups in the emergency department. Many hospitals had established Hospital at Home programs before the pandemic because of the interest of a private payor and expanded during the emergency.

The scope of the program would also reflect the amount of staff and infrastructure a hospital was willing

to commit to the program. Some staff noted that ACHaH had to compete with other new investments that were often more familiar to hospital leadership.

Staff also noted that programs generally start small and limited in scope and grow with time. Hospitals may expand the scope of services and patients they serve as they gain experience with the care model.

One of the key question is how outcomes under ACHaH compare to usual care. Since ACHaH is a new program, it is still being studied. However, outside of Medicare fee-for-service a number of randomized trials have been conducted of Hospital at Home prior to the pandemic.

We discussed this at our September meeting, and I have summarized information from two systematic reviews and a trial conducted at Brigham and Women's Hospital. All of the trials in the systematic review and the Brigham trial were randomized.

Overall, the trials suggested that relative to usual care Hospital at Home patients had similar rates of mortality, mixed results for length of stay, and generally no difference in patient function. There was also some evidence that Hospital at Home might have lower rates of

readmissions.

For cost, the evidence was inconclusive, with the Brigham study finding lower costs, but the systematic reviews noted a lack of evidence.

The patient experience for Hospital at Home patients was equal or better than usual care across these two studies. We collected qualitative views on outcomes from the hospitals we interviewed. Generally, they believed the model resulted in equal or better health care outcomes, though it was not always clear Hospital at Home was less costly. They also noted that patient satisfaction for Hospital at Home was generally very high.

Though the health services literature and the input shared from hospitals gives us an important window into the outcomes for Acute Care Hospital at Home, it is important to note the limitations of this literature and the limitations inherent in the design of the ACHaH program for measuring outcomes.

First, most of the trials in the systematic reviews I mentioned were conducted in other countries. Consequently, the results reported may reflect how these countries use inpatient and outpatient care, and may not be

applicable in the U.S. health care system.

I would also note that the Brigham study reflects the experience of one health system with a small study population. Overall, while these studies suggest some possible positive outcomes from ACHaH, they have important limitations, and I would note were less conclusive for some outcomes such as cost.

Studying ACHaH using Medicare data will be challenging. First is that ACHaH is only offered to beneficiaries that meet a facility's criteria, and beneficiaries can decline the service. Reasons for declining cited by beneficiaries include a lack of familiarity with the model and that some patients may have a strong preference for usual care.

This has implications for evaluation because Medicare administrative data will not capture the hospital's clinical inclusion and exclusion criteria, or the reasons that a beneficiary accepted or declined the program. As a result, constructing comparison groups for ACHaH and usual care be challenging.

In addition, the hospitals participating in ACHaH are also a small, self-selected sample of IPPS hospitals.

It is not clear that the experience of these hospitals would necessarily generalize to other providers.

This chart gives you an appreciation for some of these points. In 2022, there were about 6200 discharges under ACHaH. The 26 largest programs account for 71 percent of the volume.

Though it is not shown on this chart, on a monthly basis volume was increasing during 2022, so the low volume may reflect that many programs have been in a start-up phase, but overall these numbers indicate that volume remains low, and in 2022, only 37 percent of approved hospitals with waivers to participate in ACHaH had at least one discharge under the program.

We compared the attributes of hospitals active in ACHaH to other hospitals, and found that they tended to be higher volume, non-profit teaching hospitals with higher occupancy.

Though we have not interviewed hospitals that did not implement a program, our conversations with participating hospitals noted several concerns that may explain why some hospitals have not yet implemented a program. They noted that the program required upfront

investments in staff and infrastructure. Hospitals facing resource constraints or a tight labor market may wish to focus on existing challenges before creating a new service.

ACHaH programs have to meet state and local regulations, and the care model cay raise regulatory concerns that have to be addressed before proceeding.

Finally, ACHaH also have to gain support from physicians for referring to a program that will be new to them. Addressing their patient safety and clinical care concerns requires sustained effort.

Understanding the cost of ACHaH relative to usual care is an issue that hospitals and policymakers must also consider. The data from all of our sources suggests that ACHaH patients get fewer of some services, such as labs and physician consults.

But the cost per unit of care could also be higher because it is being provided in the home and not a facility, for example due to the travel time staff incur to provide in-home care. In our conversations with hospitals and our review of the literature, it is not clear that the savings from fewer services offset the higher per-unit costs of in-home care.

Lower readmissions might be another source of savings, but the current evidence for this is mixed, and the evaluation challenges I mentioned will make it difficult to measure in ACHaH.

The current regulations defining the model were developed during the pandemic, and there are several aspects that could be reviewed to understand their impact for beneficiaries and the program. Assessing hospital practices in these areas would be helpful in determining future directions for policy. Examples of areas CMS could examine include the frequency and intensity of remote patient monitoring and the use of virtual physician visits. In our conversations with ACHaH hospitals it appeared that these patients generally do not get in-person physician services at home.

CMS may also want to examine the timeliness of hospital response to urgent patient inquiries, and it also may want to measure the impact of ACHaH on informal caregivers. Depending on how it is implemented, it could increase or decrease their burden, and understanding this impact would be important.

Pulling back from the implementation of the

program, I will briefly walk through two key considerations that Medicare will face in thinking about the future of ACHaH. These are broader questions that may be difficult to resolve before the program's expiration date.

First is that measuring outcomes for ACHaH will be challenging because of the issues I mentioned previously, such as beneficiaries will have unobserved differences in severity, variation in program criteria and services across hospitals, and that participating hospitals are a small, self-selected group of providers.

As an example, I would note that a CMS-funded pilot of a Hospital at Home program in 2014 ran into these problems. They conducted a Hospital at Home pilot in New York city, but CMS's evaluators were unable to conduct a quantitative analysis of outcomes because administrative data lacked important information for measuring patient severity.

Another issue is ensuring appropriate use of ACHaH. Though the program requires that patients meet Medicare's criteria for inpatient admissions, some studies suggest that physicians vary in their clinical judgment and application of these guidelines, so it is not clear how

effective they may be for delineating between ACHaH and other alternatives.

As a result, ACHaH may overlap with other home-based services, such as home health or hospice. Ensuring that beneficiaries are not diverted to ACHaH from other appropriate low-cost sites of care will be important. However, this risk likely varies across the different models for delivery Hospital at Home. The early supported discharge model, because it includes an overnight stay at the hospital, likely has the lowest risk. The admission avoidance model, where a beneficiary is evaluated at the hospital but goes home for care, is probably a slightly greater risk. Finally, admitting patients to ACHaH from a community health care setting without first visiting the hospital may present the great risk among these models.

We plan to present this information in a chapter in our June 2024 Report to Congress, and welcome any comments or questions you have. In your discussions, you may want to consider some of the issues we have identified to date, such as the potential impacts for a broader range of hospitals implementing ACHaH programs, whether there are specific areas CMS should examine to consider future

refinements to the program's requirements. There are a few listed on this slide and more in your paper. And whether the current program safeguards need to be refined or improved.

This completes my presentation, and I look forward to your questions.

VICE CHAIR NAVATHE: Thank you, Evan. Just very quickly, this is work that the intention is really to provide information to Congress. You know, they have to make the decision by the end of the year. We are not making a recommendation here, however, so we want to try to provide as much information, and as Evan said, this will be a chapter in the June report.

So with that let me turn it over to Dana for the queue.

MS. KELLEY: Okay. I have Stacie first.

DR. DUSETZINA: I'm taking myself out, Dana. Thanks.

MS. KELLEY: All right. Then I think I have Brian next.

DR. MILLER: Thank you. This is one of the nerdiest chapters, almost as nerdy as the one with the

systematic review yesterday, which I appreciate, and I appreciate the Commission's work for transparency to find a way to post that online in a timely fashion.

A couple of clarification questions. Did I hear correctly that the systematic reviews had studies that were primarily in other countries?

MR. CHRISTMAN: Yes, and I think that reflected the evidence base that was available at the time. The reviews were completed in the latter half of the last decade.

DR. MILLER: Which countries were those, if you don't mind me asking?

MR. CHRISTMAN: I'm going to get in trouble here, and I'm going to say I can't exactly enumerate them, and I'm going to say they're generally, you know, your European OECD, Spain, Germany. But the exact countries I'm not going to be able to recover. One of the biggest ones outside of the U.S. is Australia.

DR. MILLER: And that's okay that you don't remember that enumerated list of countries, but we should probably enumerate that in this study so that readers understand that it's not a systematic review of Hospital at

Home in the U.S., that it's a systematic review of Hospital at Home in other countries, and we should enumerate those countries so that they can better understand and interpret that evidence. Because some of those countries probably have similar delivery systems to the U.S., and some of them probably have very different ones. Australia is probably more similar. You can imagine a country like Russia would have a very different delivery system.

MR. CHRISTMAN: I agree with you, Brian, and we'll put that in. And I just want to add in fairness to the literature I can't recall. There were a few U.S. ones too. I think you're following my point exactly. We'll clarify this. Thank you.

DR. MILLER: Yeah. I'm not knocking this as MAC reviews at all. I was just surprised when I heard that because those systematic reviews have fed to me as evidence of domestic efficacy, and if it's domestic and international we should parse that.

The other thing I was wondering about, well, two other things. One is Table 1 on page 13. The MGH study didn't have any p values, so I was wondering, were there any differences, and were they statistically significant?

And I'm asking because it is a small n.

MR. CHRISTMAN: You know, I'm not going to be able to recover that. I can check. I believe the readmissions rates were so different that, you know, they might be significant. But you're right. Overall the sample size is small.

DR. MILLER: So we should add that, and the reason I say is the mean length of stay didn't have statistical testing for significance of difference, two-sided T test or whatever would be appropriate, but it did have a significantly overlapping confident interval.

And then my other question was looking at the length of stay mentioned on page 10, it said that the length of stay ranged from an 8-day reduction to a 15-day extension. That's pretty wide, which suggests we lack precision and accuracy. And then my question, if we have such a range in the systematic reviews, which I recognize are imperfect, is there a reason why we're then highlighting a study of 91 individuals at a single academic medical center in New England?

MR. CHRISTMAN: The short answer is that's the best study that's been completed and published in the

United States.

DR. MILLER: Okay. That makes sense then. We should probably add then that there is limited evidence and that as a consequence of limited evidence then the systematic review is including a lot of studies from other countries that were then highlighting this MGH study, because then the chapter will read differently. I still think there's something very interesting and good here, but this will help people make better decisions. Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you, Evan, for this information. A couple of questions for you. So if somebody, are they still eligible for short-term rehab in a skilled nursing facility after Hospital at Home if they have to end up going? Do they get that?

MR. CHRISTMAN: The short answer is yes. From an administrative and eligibility standpoint, a Hospital at Home stay is a regular stay, and everything else that would attach, would attach to a Hospital at Home stay.

MS. UPCHURCH: Okay. Thank you. I've come to know a little bit about home infusion, and it's interesting. Home infusion -- and I think you all know

this, but if the drug is a Part B drug, as in Boy, immunotherapy and some other things, immunoglobulin therapy, then the per diem is covered. But it's an antibiotic, which is a lot of what is infused in the home, there is actually a per diem that's not covered by Medicare.

So if the individual that's getting antibiotic in the home, it may cost them more to be in the home to get the antibiotic. So they could save money, potentially, by going back into the hospital proper. So I'm wondering, with this, with Hospital at Home you can get a D drug without a per diem. Would that be correct?

MR. CHRISTMAN: Yes. I mean, this is right because it's inside the IPPS bundle, so the cost sharing would be whatever attaches for the normal IPPS.

MS. UPCHURCH: So that's one of the big problems just with home infusion, antibiotics. Individuals themselves have a per diem that are not covered. Some Medicare Advantage plans cover it but traditional Medicare does not cover it.

Do we believe that Medicare Advantage plans, do we have any sense if they're interested in this Hospital at

Home model more so than traditional Medicare?

MR. CHRISTMAN: I can yes to the first, and the second, meaning the interest of Medicare Advantage plans relative to fee-for-service, I can't tell you. But they're definitely active in this space. They do have some programs.

MS. UPCHURCH: And commercial products, so that's sort of tells you something. And lastly -- and I brought this up when we talked about this the first time -- you talk about these outside vendors that get involved, whether it's bringing food, or the paramedic that starts coming into the home. There are some of these things that could potentially continue on after the Hospital at Home hospitalization. Do we know that, because that would have continuity of care and some other things that would be really positive for the individual, over time. Do we know if that continues for many of these services?

MR. CHRISTMAN: Well, from the Medicare fee-for-service program perspective there is nothing there other than the normal pre-pandemic services. I think the Mount Sinai program, they thought of it as a 3-plus-30, a 3-day Hospital at Home stay and then 30 days of follow-on

services. So I would say some folks are probably working on the edges of that, but it would be more in the pilot phase, or for an MA plan you're probably moving somebody over to whatever your sort of disease management care. But from the Medicare fee-for-service perspective, Hospital at Home ends at the discharge.

MS. UPCHURCH: Okay. I had the good fortune of riding with the community paramedics in Durham around some, and a lot of the people that they see regularly -- this is not Hospital at Home, though, this is community paramedics -- are older adults that were frequently going to the hospital and they're trying to keep them from doing that. I can see a warm handoff, especially if they met them at Hospital at Home, that is just incredible at keeping people in the home post-discharge.

So thank you. I'll have a Round 2 comment. Thank you.

MS. KELLEY: Lynn.

MS. BARR: I just have a quick question. What was the motivation in other countries to do this? It seems pretty clear from the U.S. side; I've got capacity issues. I can make more money on an orthopedic surgery than I could

on this chronic patient. You know, I mean, there's a business case here that I can see in the data that makes sense.

So I'm just curious as to what was the motivation for other countries to be in this program, with a different system?

MR. CHRISTMAN: I am going to practice to the top of my license in thinking about the motivations of foreign countries.

[Laughter.]

MS. BARR: Welcome to MedPAC, Evan.

MR. CHRISTMAN: Yeah. Honestly, I would say that their issues are generally kind of the same. They're looking to deal with an inpatient capacity problem, also a belief that in-home care has certain advantages that they want to avail themselves of. And now you can see me barely struggling for air, but my understanding in some cases, and even in very remote areas where building a large hospital would be impractical, so it's easier to distribute and figure out how to distribute people and do it remotely.

But broadly speaking, capacity and belief in the model of care and its benefits are I think are the Hospital

at Home's main calling cards. As you point out -- forgive me, it's kind of cryptic -- but as they say, market characteristics and strategic considerations always weigh in this, but those two things, I think, generally motivate people to try this model.

MS. BARR: Awesome. Thank you. And then a follow-up question. Is an in-person physician visit typical in other countries? I mean to me the idea of not actually having a physician laying hands on the patient -- I'll let the doctors speak in the room -- is a little terrifying. So is that common in other countries?

MR. CHRISTMAN: I can't answer that. The practitioner and how frequently they go, obviously it varies a lot, what a nurse does, what a doctor does. And now I'm sinking under the water, so I'm going to stop now.

MS. BARR: Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: Okay. A couple of quick clarifying questions. First, let me continue your torment. I'm going to ask you one more thing about the international space. I think this is about the international space. I was also struck by what Brian mentioned about the review

coming up with effects on length of stay of -8 to +15 days, which seems huge, a huge effect on length of stay, and then the Brigham study coming up with a 0.7-day difference in length of stay. I mean, are these just completely different systems, where the average length of stay is different, or was the implementation of these programs so different? I just have a hard time reconciling those two.

MR. CHRISTMAN: I guess when I read the literature and tried to think about this, I think definitely there are probably some differences in implementation across these sites -- populations, services, goals, where they want the outpatient care system to take over. And without sort of really stepping and asking people pretty granular questions -- because I think the questions you're raising are correct ones. How much are people going in person? How much are they using remote management? How sick are these patients? In their country do they just hold people longer for a given discharge than we do here?

So the reason we cite those studies is I think whenever this model comes up, I think the first concern people always have is patient safety. Can you send people

home safely? And this is the reaction I'm looking for from you folks, I guess, but my takeaway has been I get that there are all these other differences, but in general, the patient safety box is pretty full. It's not demonstrating a lot of danger. There are a lot of other questions about how the implementation varies and the effect, but I guess part of the reason I included that was I know that people have this profound concern about sending acute patients home or just trying to show that it's been done safely.

MS. BARR: Okay, thank you. That's helpful. And just to be clear, that review was very helpful, so I'm glad it's in there. I was just trying to reconcile those very different results.

So my other clarifying question is, in terms of other services people might be getting, I want to make sure I understand what happens. So let's say somebody in the middle of a home health stay in their home, whether that's a community-initiated one or a post-acute one, and then has some adverse event and needs a hospitalization, then home health then, for example, if they're getting visits by therapist and an RN, in the home health do those services just stop, or would they overlap?

MR. CHRISTMAN: They should stop, and anything the patient needs should be provided by the hospital.

MS. BARR: Okay. And anything else, even sort of like drug delivery kinds of things, other things that the patient is getting, I mean the hospital stay would still have to supply the drugs, just like the person would be in the hospital, right?

MR. CHRISTMAN: Exactly.

MS. BARR: Regardless of what else they have at home.

MR. CHRISTMAN: Exactly. You know, another way to think of this program is that when CMS explains the requirements, they basically say it's a hospital stay, and they literally have two lines saying we've waived these two requirements for a hospital stay, and it's things like you have to be in a building with modern sprinklers. So you can be at home. But everything else in the hospital, consolidated billing and administrative requirements, attaches.

VICE CHAIR NAVATHE: If I could just jump in real quick. Evan is doing an outstanding job of swimming, as always. I just wanted to add that I think we hear that

there are a lot of challenges with evaluations, and that's something we've tried to bring to the chapter, but we'll definitely work to clarify that.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I'll save my enthusiasm for this work for Round 2. But briefly, to comment on Tamara's comment, the skill set between the home health team and the acute hospital home team would be a very different skill set, so I think that's another piece.

I just have a question about Slide 8. One of the most interesting things to me is the potential differences in hospital-acquired conditions, because there are certain kinds of conditions you wouldn't have at home, because you're not exposed to as many individuals. But there are so many interactions, for example, with infections because now you're in the home. So I'm curious if anything has been done around hospital-acquired conditions in this space, and then related to that -- that's my second question, so that first.

MR. CHRISTMAN: The short answer to your question is that, you know, the most studied outcomes for Hospital at Home are mortality and readmissions, and the more

granular things you're talking about, patient safety indicators, I haven't seen work on that.

DR. RAMBUR: Yeah, it would be really interesting to think about how you'd operationally define hospital-acquired conditions in the home.

And then the related question I have on that is -- and perhaps I'm wrong -- but I assume that hospital value-based purchasing, also the data from Hospital at Home goes into that, because that's a Medicare requirement.

MR. CHRISTMAN: Right.

DR. RAMBUR: And how does all that work when you have a lot of factors like noise and things that aren't relevant, or not parallel?

MR. CHRISTMAN: My understanding is that these should be included as like a regular discharge and any of the rest of CMS's requirements. So if they were in the DRG subject to that program, their outcomes would be picked up.

DR. RAMBUR: That's very interesting. Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Thanks, Evan. You've taken a topic that most of us, I think, know very little about, and framed it very nicely, provided a lot of detail, as well.

I think it will help Congress and congressional staff, for sure. And I enjoyed reading it.

Just one clarifying point, maybe to think about when you're polishing off the report. And I may be wrong about this, but it seemed to me -- and this is a common problem -- it seemed to me as I read through the document that the word "cost" was used in two ways. And this is always tricky, and people always have to confront this, I think. But it seems particularly acute in this setting.

Cost can be, well, what does it cost the hospital to do this and to organize these various services and to get food to the patient, as they are allowed to eat, and so on. And then there's the way that cost is often used loosely in the research literature, which is Medicare spending or allowed amounts, or what Medicare and the beneficiary spend.

So I'm not sure I'm right about this, but you might want to just look through it and see if it is, indeed, that word used in both ways, and if so, what you can do to clarify.

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

VICE CHAIR NAVATHE: Great. Before we move to Round 2 just a heads up that we have just a little over 30 minutes and a nice list of Commissioners. So just please keep your comments as brief as possible. Thanks.

MS. KELLEY: Lynn.

MS. BARR: Thank you, and thank you for this work. You know, I just find it hard, as a Commissioner, to understand like we've got so many payment models. Do we really need another payment model, is kind of the first thing that comes to mind, how this just increases the complexity for patients and for policymakers. You know, you have all of these unintended consequences, but sort of limited kind of evidence. I'm not sure that this is something that I would support going forward, honestly. It seems very inefficient, and I understand that there could be some benefits, but it doesn't seem like a fairly promising models, based on what I've seen so far. Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: I have a much more optimistic view than that. But my comments here really fall under the idea of possible extensions and future work.

So it occurs to me that what's been done so far, you know, all of these fairly small studies, you know, it was kind of like a Phase 1 drug trial. Can we do this safely, and maybe a preliminary examination of some of the costs. And to me, when I think about people who need to avoid hospital admission, I would be interested in sort of extending this model to people who are now excluded, right. I was interested to read in the chapter that like people with cognitive impairment are excluded.

And I think it's exactly people who are really frail or have dementia, for whom that stress of that hospital admission, the actual physically going to the hospital, is so bad for them. They're much more likely to get delirium or a decline in cognitive function after that hospitalization. Just that stress of transfer is really high. And I think maybe they were excluded so far because, you know, you don't want to take the riskiest patients and try this new model on them. But the people who are in these now are basically the healthier patients, right, for whom it maybe doesn't make that much different to them to be home or not.

So what I would love to see in sort of future

trials of this model is can we take those patients for whom hospitalizations are really risk and see if we can serve them at home, and see what their outcomes are. Can we avoid some of that delirium or cognitive decline or just all kinds of stress? And I think if the model can evolve in that direction -- and that will require sort of thinking about what the real benefits to patients and beneficiaries rather than sort of a capacity benefits to the hospital. I mean, that might happen too, but this would be a sort of different perspective on it.

And I think if the model can evolve in that direction, we also have to think about evolving the measures to evaluate it. And since these are still kind of small trials, you know, even if things take more data collection, I think we could sort of require certain data to be collected, or maybe that's not such a big lift.

And in particular, I think we want to look at those outcomes, sort of how do patients actually benefit health-wise, not just in terms of readmissions but also in some of these things like delirium. How do patients benefit, so we want to start collecting data on that or finding a way to measure that.

And then really importantly, we need to start measuring for this, and I would say for all models of care that are provided in the home we really need to start measuring the caregiver outcomes. And it's mentioned in the chapter a little bit, but it seems like most of these programs so far really haven't captured that data, and to me that's such a critical piece of it. Are caregivers better off? Would they rather just have the person in the hospital? How do they cope with this? Is it better for them or not? Or what do they need to make this model successful?

And then sort of along those same lines there were a couple of suggestions or a couple of pieces of suggested evidence that maybe duals were actually doing better under these models. And it occurs to me the caregiver and family support in the home environment is so important to the success of a model like this, that perhaps duals who are getting home and community-based services through Medicaid are at somewhat of an advantage.

Because I think unlike the Medicare services in home health that would stop, people can continue getting Medicaid home and community-based services while they would

have this hospitalization. At least that's my assumption. And I think that could be one way in which there are these sort of positive synergies between the two programs, because perhaps having those supports in the home would make a Hospital at Home more feasible.

So those are my thoughts about how I'd really like to see this program evolve, and with it sort of the measures, especially that caregiver piece.

MS. KELLEY: Brian.

DR. MILLER: Thank you for this, and I also wanted to thank you for your extra zippy response time on naming countries. I appreciate that. I remain confused why it took me seven weeks to get a response on a question about Medicare Advantage that I was promised at a public meeting, so I appreciate the speedy response here.

A few thoughts, and I'm going to integrate some thoughts from the last discussion we had about Hospital at Home. One is the emergency response time of 30 minutes. As a practicing hospitalist I can tell you that if I take 30 minutes to respond to a decompensating patient, they are probably in the intensive care unit or they're dead. So that's not an adequate response time, and it's actually

faster to call 911 if we truly are looking at a 30-minute emergency response time.

What that does confirm, because the very limited evidence we have suggests that safety is not necessarily an issue, which suggests that we actually are doing what I thought we were doing in this program, from looking at Table 4 on page 21, which is that we are cherry-picking patients who might not necessarily meet criteria for hospitalization. I believe my colleague, Scott Sarran, has mentioned the challenges of Milliman and InterQual criteria and how they can be subjective in their application by physicians.

I also noticed that we were unlikely to select sort of immobile patients, based upon this, which means we're not selecting patients who are frail, as my other colleague mentioned, or patients with dementia. So what this suggests is that this program is taking people who may or may not necessarily meet hospital criteria who might be healthier but still sick.

And so my question, I guess, is it doesn't really make sense to pay hospital-level rates for that population, but clearly there is something there, right, because some

of these patients are not cutting with primary care access or urgent care access. And I think we all have anecdotal stories in addition to data-driven surveys that access to outpatient care for Medicare beneficiaries is a lot worse than we think it is. It's not easy to get a quick appointment if you need it. Like if you need to see the doctor today, the answer usually is go to the emergency room.

So I think that there is something in this model for observation care, perhaps, at home. I'm not sure that it merits hospital-level payment.

There were a couple of other things. One is I think we should note that the program transfers manual labor of care from the hospital to the beneficiary and their family or support network, because when you're in the hospital you have a nurse or a patient care tech, I mean, rarely, but sometimes the doctor helping turn you, get you to the bathroom, and eating. If you're at Hospital at Home you don't have that level of support. And so in some ways, actually, the Hospital at Home program discriminates against the poor who might not have a great support network. That's a big concern to me from an equity and

consumer protection angle.

And then the comment on page 26 about limited data, it's just confusing to me. This program has been around, in varying forms, for years, and then we have the public health emergency version for several years. And we have one study with 91 patients. And looking at the data, 285 hospitals participated, 105 hospitals were actually active, and 51 of those hospitals had fewer than 25 discharges.

So it's unclear to me why we would push policymakers to expand a program which doesn't even have what I would call Phase 1 evidence, has preclinical evidence. And so I think we should go back to the drawing board and see if there is something else here. And I do think that there is something here that would be beneficial to beneficiaries and be cost effective, but I don't think this current formulation is it. Thank you.

MS. KELLEY: Jonathan.

DR. JAFFERY: Thank you, and Evan, thanks. This is a great chapter, great presentation. I would maybe suggest that going forward you refer to it as ACA. You might save like 20 minutes.

MR. CHRISTMAN: I'll take it. Not be confused with the A-C-A, ACA.

DR. JAFFERY: Oh yeah. So a couple of things, and I'm going to sort of respectfully disagree with some of my fellow Commissioners, particularly Lynn.

So one of the last things I did in my last gig was to get this going, and first off, Evan, you referenced the fact that basically there are two things you have to say that would make it different. It's a very extensive process of interviewing with CMS staff. People are dedicated to making sure that this is meeting the same criteria. And a lot of the models, you can have some telehealth visits after some initial visits. And thinking about what other countries have done in the past, obviously the use of tele-visits has changed dramatically in the last couple of years, so that's a big evolution.

But I'm not sure why we would -- well, first off, I don't think that the chapter's point -- and I didn't read this as a pushing expansion per se. I mean, as Paul pointed out, we're providing analysis to the Congress of the current state, as they ponder whether or not to extend the program as it currently exists, to being with, extend

it in time. I think that we spend a lot of time talking about innovation, and I think that's what this is, so I don't really see it as another payment model.

And I think we could say the same thing about why do we even have ACOs to begin with, or bundled payments? They have complicated things, certainly, but we did them for a good reason, because we've got inefficiencies and we've got capacity issues and things like that. And actually extending things, just putting things into op stays or post-acute care won't solve the problem for many of them. We see that the data shows, the table shows that the places that have used it most are places with higher capacity, you know, higher bed usage, lower capacity, I guess, in that regard.

And we all know, we've talked about it many times, the difficulty for many places, especially in these larger urban settings, of getting people to post-acute care. It's just not there.

You know, in terms of the payment models -- well actually, even before that, in terms of the uptake, the fact that there hasn't been many, so it is difficult to stand up. So it's like anything else that's new. It takes

some time. And we're seeing some increased uses of it, but it's going to take some time.

And one of the challenges to standing something up like that, as we all know, is the uncertainty about whether it's going to be around. So if you don't know if it's going to last beyond December you're not about to try and invest in a service line to do this. You've got different priorities. So that kind of certainty, I think, is really important for operators of health systems as they're trying to make these decisions.

And that sort of gets to, is the per unit cost more expensive? Perhaps. It's new. You're going to have low volume. Once you have some certainty that it's working and you get some buy-in and you're able to use it more readily then you're going to have those costs go down.

Brian's comment about why are we paying the same amount, I think a lot of people believe that in the long run that may not be the case. We'll see. We think that about a lot of things and often it doesn't pan out.

But again, it's like many things. We're supporting the innovation. We're supporting the implementation. And we'll see if it's helpful and possible

to lower the costs later on, if those costs of input in fact are lower.

I think this notion of, you know, are there differences in severity of the people, it's absolutely true but it's sort of a feature, I think, not a bug, though. You don't want the really, really sick, unstable people to be taken care of at home, but you do want people who can't quite avoid the hospitalization but can be at home.

And this notion of we may see more volume if we see more direct admissions to -- I mean, I think that's exactly the point. People start this up often with that early discharge model, like you mentioned in the chapter, because it's easier to get started. But then they move towards that other model, and I think we can think of many examples, all the clinicians here. If anybody here showed up at their doctor's office with a really bad cellulitis -- otherwise healthy, really bad cellulitis -- and would need to be in a hospital for five days, or could be at home for five days getting the same care, I think we all know what we would choose.

And actually there are other models where people are doing things with this in terms of things that we would

consider extremely complicated, like bone marrow transplant, and that's to Betty's point about hospital-acquired infections. You know, if I don't have any neutrophils, the last place I want to be is in a hospital setting.

So I think there are a lot of important opportunities, and I don't think the tenor of our discussion should be to stifle innovation. I think we should be thoughtful and cautious about all the issues that you put forward about outcomes, about safety, about quality. It's very difficult to get a randomized trial here. We've got one. It's not big, but it is real. And so I think we should also consider data from other countries. There's no reason that we should be completely exclusive of it, not that anybody has said that we should. But I think there is some data out there, and as we continue to explore that.

The only other thing I wanted to comment on was the very last paragraph of the chapter talks about targeting, chronic conditions, exacerbations, and other things could be avoided if we managed chronic conditions in the community. The whole paragraph seemed a little bit out

of place for me. Maybe there's something else that can be said to frame it. I just wasn't sure where you were going with that, and then the chapter just ended.

Other than that, though, I thought the chapter was excellent, and I think that it's really important that we provide CMS and Congress with this information on an ongoing basis so they can continue to evaluate the program. Thanks.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. This is a great chapter. I think it's also a fascinating chapter too because it's almost like the poster child of how difficult it is to do disruptive care models right at the bedside or even in an office practice. So it generates a lot of interesting conversation.

You know, this is still very much a new program. It only started in November of 2020. And so I do think it shows promise, but I agree with Jonathan. It's experimental and we have to treat it as an experimental program that may show promise or it may show something else.

I don't know whether the current model will be

what we end up with at the end of the day. Right now it's trying to replicate a hospital type of environment in the home. I know a couple of institutions that have tried and have gotten out of it because the logistics are extraordinarily difficult to do.

And sometimes people are talking about, well, maybe it's not necessarily a Hospital at Home that we need. Maybe it's care at home. In other words, there are patients that we hold onto for an extra day or two because we're not quite comfortable that an earlier discharge is necessarily safe. But if they had a different level of intensity in the home environment it could be safe for certain patients. So maybe it will evolve into something like that. It's really hard to know.

There was a suggestion I made the last time this came up about the need to study this further, about could this be a CMS demonstration project. I think several Commissioners thought maybe, but is it the right place for it. But I think there was some general agreement that studying this is probably warranted. But if there was a way of kind of nudging a different arm of government around some sort of Federal grant for a multisite prospective

study, I think that would be helpful.

The other thing that I was kind of thinking about, since the last time we talked about this, is that the logistics are really challenging for hospitals to really do. So whether you're talking about staffing, equipment, diagnostics, pharmaceuticals, and the coordination between different types of clinicians, not to mention the measurement piece -- you know, are we doing it right, are we doing it safely -- and the whole idea of adoption where clinicians and institutions and patients and families feel that they're comfortable with this particular model, it requires a heavy lift. I'm not even sure, in many circumstances, hospitals is the right group to actually lead an effort like this. I wonder if this is best for even startup companies in health care that may be interested in doing this type of work, that can create the economies of scale that is actually necessary to make it function.

You know, similar to how hospitals contract with inpatient hospice providers or inpatient dialysis providers or home health on the outpatient arena, this may be more amenable to a private company that could kind of pull this

together in a way that kind of makes sense and is cost efficient, as well.

But we will see. I think this is a multiyear innovation, and where it lands is where it lands. But I think we need to give it a little bit of time.

But great chapter, and I enjoyed reading it. Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks. I'll try to be brief because many Commissioners have already touched on some of the comments I was going to make.

You know, I agree. I think we should continue. This is still very experimental, as Robert just said. I feel like we're in the alpha stage of testing. And generally I would say I'm very supportive of innovation. Again, I don't think we're where we're ultimately going to land, but I think it's still beneficial to continue to let hospitals experiment with this, see what they learn.

And to Jonathan's point, I think we definitely need some clarity for hospitals about sort of how long CMS is going to allow them to be in this game, so that they can make the kinds of investments. Because it's clear from the

excellent description in the chapter about some of these sort of barriers to getting these things jump-started, with all the regulatory requirements that they have to meet.

I do think one thing that could be helpful, and I think you touched on many of these things throughout the chapter, is if CMS is going to continue to invest in this, if there was some way, we could have a table in the chapter that summarized the key areas that we think are critical for evaluation. It's almost like the evaluation plan in bullet points for CMS and hospitals who are going to invest in this.

I mean, clearly, given that this is in the alpha stage, there is a lot to be learned through qualitative work, whether that's conversations with caregivers to understand their experience, better understanding of some of the contextual factors that are in play across these many varied implementations of this model. Thank you.

MS. KELLEY: Betty.

DR. RAMBUR: Well, I'm probably a little bit more in Jonathan's camp on this. I am very enthusiastic about this model and where it will evolve. AI remote monitoring is only going to get better and better. So I think that at

our peril we ignore this.

The current system is totally built around providers' needs, providers' convenience, and this is actually a family-based model in which they are embedded in the community where they live, in their real lives.

So I'm supportive, in part, because hospitalization can really totally destabilize some people, and the example that Jonathan gave of a person who is immunosuppressed in some way, I don't want to be in the hospital when I'm that person. So I think this is an opportunity and we have work to do.

Jonathan point out that it's new and it takes time, and I just wanted to underscore the team-ness that's important in this. We are talking here about the physician getting ready. It's really the whole team.

And I'm a little less concerned than Lynn about not having the doctor right there, because the availability of physicians in a hospital -- sometimes you're able. Let me put it that way, and one constant is the nursing care. So I think this actually has a lot of potential and it needs some work.

Operational definitions of key terms that really

have nuances in the home I think is important, and I can't even begin to think about how that would be taken on. But also underscoring the importance of what Tamara said about the family experience. I think that's really important.

So I think it's really important work to keep an eye on because it'll be here one way or another, I believe. Thanks.

MS. KELLEY: Gina.

MS. UPCHURCH: Plus-one Betty's comments there.

I'm a member of the American Geriatric Society, and they have something called special interest groups. So I just went to a meeting of Hospital at Home, maybe 2 years ago, maybe it was. The enthusiasm for the clinicians in the room -- physicians, nurses -- over this model and how it treat people, being person-centered and family-centered. Now I know there is going to be disparity of who can have health in the home, but Tamara's comments about people that may have community-based services that support them in the home, this being layered on top of that.

I understand Jonathan's comment for right now you do want to target people that don't need all that help in the home, but if we could layer this, or CMS could help

layer this on people who have that help and support in the home, but it's more person-centered and family-centered versus provider- and hospital-centered, I just think it's a great potential.

And the people, again, that were doing the work, that were in the people's homes, clinicians, were just very enthusiastic about how well they thought this model would work.

MS. KELLEY: Scott.

DR. SARRAN: So two brief comments. First, understanding Lynn and others' concerns about the administrative burden of new payment models, I do think it's ideal to have this available to beneficiaries as a clinical model -- that's how I look at it. It's a clinical model, not a payment model -- for the reasons, and I think they're really strong, as Tamara points out, for elderly and the risks of hospitalization. Betty, Gina, as you point out in a truly patient-centered world we want to have as many options as possible for where and how care is delivered, and we want to make the decision, or we want to enable that decision about which option is chosen to be made by the care team in concert with the patient and the

direct caregiver, which is usually, of course, as we know, family.

So I strongly agree we should want to see this continue, and to others' points, for more than another year, because a year at a time does not give providers who need to do the significant infrastructure work that Jonathan and others raised, sufficient certainty to make the investments in it. So I do think we do want to continue it.

Also, quickly, a side point about MA. Since most MA plans reimburse hospitals using the Medicare fee-for-service payment structure -- the rate may vary up or down a percent or two, but it's typically based on the Medicare construct of payment -- continuing this in Medicare fee-for-service will most easily enable it be used in MA. Discontinuing it in fee-for-service may be a real headwind for it growing in MA.

The second point is just briefly to reinforce that even though I don't think this will expand too quickly and create a lot of danger and risk, I think there are natural headwinds around the infrastructure needs as well as the risk management concerns, I still we have to

acknowledge we've not ruled out there being a significant safety signal that may not come to light until it's expanded quite a bit and we have a lot more numbers.

So I think monitoring for safety signal, as well as maybe less critical, but importantly, monitoring, as Brian points out, for potential for overuse and the sort of soft admit kind of thing -- it's an old term -- as well as risks that potential beneficiaries and caregivers are coerced into a model that isn't really the best thing or consistent with their wishes and their capabilities. So I think monitoring for those signals is critical.

Two minutes, 34 seconds. Just saying.

[Laughter.]

DR. SARRAN: Just trying to set a bar here.

MS. KELLEY: Jaewon.

DR. RYU: Yeah, I'm also a big fan, very supportive. I couldn't have said it better myself, Betty, Gina, Tamara, Jonathan, Scott. I just completely agree with those comments. I think it's an important chapter because it's an important model.

I also love how Scott said he'd use this as a clinical model, not really a payment model. I think that's

exactly right. There's an awful lot of care that needs to be in the hospital. There's an awful lot of care that doesn't need to be, and should be at home. And there's even more that lands in the in-between. And I think this model really accommodates that.

It also allows us to migrate the system away from a facility-centric model, which is what we have today. And I think those kinds of things we should continue to support as a Commission.

In many ways I feel like this is similar to some of the discussions we've had around telemedicine. You know, there are concerns around safety or abuse or potential for abuse, but there is also a lot of overwhelming good that can come out of the model, and I think this is exactly one of those aspects.

It is still early. I think there still is quite a bit of fine tuning and learning to do. But I think the status update provides the right kind of information that can inform that migration over time.

I think even though it is a clinical model we do have to think about payment, and I think that Scott is exactly right. I think it's got to be enabled in a fee-

for-service environment, because I think that's how you get uptake in the MA space. But I think the cleanest environment where a model like this flourishes, and maybe where we don't need to be as concerned about all those other considerations, is in the space of prepayment, population-based payment, whether it's an up-and-down APM model or payer-provider partnerships, integration, or fully integrated system. I think there they clearly have an incentive to only pursue models that get to the right value outcomes. And I think they need the flexibility, and I think those environments are the places where you could trust that flexibility, and we should continue to try to encourage.

I think that's about it. Thank you.

MS. KELLEY: Greg.

MR. POULSEN: Thanks. Jaewon just said everything that I was going to say, and said it better. And I would just reinforce the point that he made at the end, which was to Scott's point. Even in MA today the majority of hospitals are still being paid fee-for-service, and so they're following the fee-for-service model. In the integrated systems that aren't in that, I think there is

huge interest in this right now, and I think that within the next 18 months we'll have some additional datapoints to look at from the integrated models that have been implementing this over the last few years and don't have the same concerns about having the rug pulled out from under them later on. So I think there are models that we'll be able to examine.

I'm also very, very enthusiastic about this. My biggest concern are the boundary definitions of, you know, what is inpatient-inpatient, what is hospital-hospital, what is Hospital at Home, what is home health. And all of those things, and every one of those has a boundary layer that becomes very difficult to define. Those all go away in a prepaid world, and therefore it becomes vastly easier.

So I think that, again, I think from a clinical perspective this is incredibly beneficial, and I just want to add on to the thanks for a great chapter. I think this is going to be really useful for everybody to learn from.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. I came into this discussion with quite an open mind, and the more charitable Commissioners might say, well, of course, you always do,

but others may disagree. I think a number of Commissioners now have made the compelling case that this deserves more time and a better look.

Robert's comments really struck me, and Jonathan's. The economies of scale on this are huge. The logistics are getting food, diagnostics. Robert gave a partial list, and there are more. It would be nice if you were doing this for more than eight patients, right. So you really need some scale to make this work, and I can get the scale in the short amount of time, and you'll never get it if you think the program is going to end in a year or two. This is really something that no hospitals is going to do, is going to invest much in, unless they really know there's some time.

And the model is never going to be inexpensive enough if there aren't these economies of scale. And again, the model is only authorized for another year. The private vendor idea is interesting, but they're not going to get into something if there's no more certainty than that, that it's going to be around more than 12 months.

So there might be more discussion in the chapter, I think, of this problem, that it does seem to me that

given what it would take for a hospital to make this work, or for private vendors to work with the hospital to make this work, it needs years. And if it doesn't get that it's never really going to get beyond the scale that we see it at now, which is pretty small.

I think there is enough evidence. I mean, we can disagree about this, but it seems to me that there's enough evidence that isn't not super dangerous, that at least so far there hasn't been a great deal of overuse. I think there's enough evidence to warrant a longer trial, at least three, four, even five years. It could be stopped if there's danger signs that it really is dangerous, but there needs to be some certainty for people who are going to get involved in this that this is going to be around for a while so they can build up some scale. Otherwise we'll be having the same discussion three, five years from now that we've just had, and we'll get nowhere.

So I would like to see some allusion to that and some consideration in the chapter. So I think it's a critical issue.

MS. KELLEY: I think that's the end of the Round 2 queue.

VICE CHAIR NAVATHE: Great. Thanks, Dana.

So a very brief recap and then we're actually going to go right into the next session, just from a time management perspective. You know, obviously an interesting topic that's part of this broader trend in health care of care in the home, and interesting to think through how it fits in. There is obviously sort of a mixed set of opinions, to some extent, some enthusiasm, some who have more concerns or are less enthusiastic. I think we hear loud and clear the feedback that it's very difficult, obviously, to evaluate. There are a lot of evaluation challenges, and I think we can bring some of that forward.

Nonetheless, we are not making a recommendation here, so I think the discussion that was had here is really helpful, because I think it allows us to bring forward some of the consideration, especially from those of you who have expertise across many different domains and sectors.

So thank you for a very thoughtful discussion, and we will close here and move to the next topic about inpatient psychiatric facilities.

[Pause.]

VICE CHAIR NAVATHE: We will go ahead and proceed

with our presentation here on trends in the inpatient psychiatric facilities. So Betty, I will turn it over to you.

DR. FOUT: Thank you. Good morning. In this session, I will provide an update on trends and issues in Medicare inpatient psychiatric services. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

Before I start, I would like to thank my co-authors, Alison Binkowski, Pamina Mejia, and Jamila Torain.

This presentation is organized as follows: some background; an update on Medicare's lifetime coverage limit on stays in freestanding inpatient psychiatric facilities, or IPFs; an examination of psychiatric stays in general acute care hospitals, also called scatter bed stays; and a summary and our discussion.

Last year, in response to a congressional request, the Commission published a chapter in the June 2023 Report to the Congress on utilization, payments, trends, and issues related to behavioral health services and the Medicare program. We had presented these findings

over three sessions and incorporated Commissioner feedback. We explored both outpatient and ambulatory behavioral health care and inpatient psychiatric care.

Through that work, we identified a few areas for follow-up pertaining to inpatient psychiatric services. The first is continued monitoring of the beneficiaries who reach the 190-day limit on Medicare inpatient psychiatric coverage in freestanding IPFs and whether their use of inpatient psychiatric services may have changed in response to the limit.

The second is exploration of inpatient psychiatric hospitalizations that occur in general acute care hospitals, referred to as "scatter bed stays." The June 2023 chapter focused only on inpatient psychiatric services taking place in IPFs, but noted that a substantive share of beneficiaries using inpatient psychiatric services received them in general acute care hospitals.

Under Medicare, coverage of treatment in freestanding psychiatric hospitals is subject to a lifetime limit of 190 days. This provision was established in 1965, with the implementation of Medicare, when most inpatient psychiatric care was provided by state-run freestanding

facilities.

The 190-day limit does not apply to hospital-based units, which compose about 60 percent of IPF stays. It also does not apply to psychiatric care in general acute care hospitals, which we will discuss more later in this presentation.

As shown on the table to the right, as of the end of 2022, nearly 50,000 beneficiaries, fee-for-service and Medicare Advantage, had reached the 190-day limit or were within 15 days of reaching the limit. This group represented 6 percent of beneficiaries who had any stays in a freestanding IPF and about 0.1 percent of all Medicare beneficiaries.

About 1,100 beneficiaries, who were alive through the end of 2022, exhausted the 190-day limit between 2022 and 2023.

Medicare beneficiaries exhausting their Medicare coverage of stays in freestanding IPFs may have some additional coverage though Medicare Advantage or Medicaid. In 2022, over 400 MA plans, or 9 percent of all plans, offered additional IPF coverage as a supplemental benefit in the form of additional IPF days or coverage of non-

Medicare-covered stays. However, only 3.6 percent of MA enrollees who had reached the limit or were within 15 days of reaching the limit were enrolled in one of these plans.

Many Medicare beneficiaries who use IPFs are dually eligible for Medicaid coverage, which would supplement their Medicare coverage. However, under the Institution for Mental Diseases, or IMD, exclusion there is no federal matching of Medicaid payment for inpatient treatment of individuals aged 21 to 64 in an IMD. IMDs are defined as institutions with more than 16 beds that primarily treat individuals with mental illness, and would thus apply to most freestanding IPFs.

Over half of Medicare beneficiaries using IPFs are dually eligible and younger than 65 and may thus have limited Medicaid coverage of IPFs. However, some states have made use of exceptions to provide additional coverage. For example, 12 states have Section 1115 demonstration waivers that allow states to receive federal Medicaid matching subject to meeting certain requirements and milestones.

Medicare beneficiaries who reached or were near the 190-day limit may be shifting the setting in which they

receive inpatient psychiatric services. We examined where fee-for-service beneficiaries obtained inpatient psychiatric care if they had between 0 and 15 lifetime psychiatric days remaining versus 16 to 90 days remaining using 2022 claims data. We limited the study population to those who had at least one stay in a freestanding IPF in the prior five years.

As shown in the first row of this table, in our analytic sample, there were about 17,000 beneficiaries with 15 or fewer psychiatric days remaining and 21,000 beneficiaries with between 16 to 90 days remaining.

Beneficiaries at or nearing the limit were less likely to have inpatient psychiatric stays at freestanding IPFs than beneficiaries further from the limit, or 7.8 percent vs. 19.9 percent. They were more likely to have stays at hospital-based IPFs, and more likely to have psychiatric stays at a general acute care hospitals compared with those further away from the limit.

Overall, beneficiaries at or near the limit were slightly less likely to have any inpatient psychiatric stay, 35 percent, compared to those further away from the limit, 38.4 percent.

Based on these differences, which were statistically significant at the 1 percent level, it is possible that some beneficiaries at or nearing the limit may have shifted their inpatient psychiatric care to hospital-based IPFs and general acute care hospitals, or stopped receiving any inpatient psychiatric services, in response to Medicare's limitation on coverage at freestanding IPFs.

We now pivot to discussing inpatient psychiatric stays with general acute care hospitals, or "scatter bed" stays.

Medicare pays freestanding and hospital-based IPFs for care provided to fee-for-service beneficiaries using the IPF prospective payment system. To be paid by Medicare, IPFs must meet certain criteria related to staffing and provision of psychiatric services, among other requirements. Payment is made per diem, based on the patient's diagnosis related group, or DRG, presence of comorbidities, total length of stay, and various other adjustments depending on the IPF teaching status and location.

In contrast, scatter bed stays have a psychiatric

principal diagnosis but take place in general acute care hospitals. For fee-for-service beneficiaries, Medicare pays acute care hospitals a per-stay payment under the inpatient PPS, or on a cost-basis for critical access hospitals, that depends on the stay's DRG, among other adjustments.

Prior research on scatter bed stays has suggested that they play a role in supplementing IPF beds, though other researchers found the evidence to be mixed and varied by state. There is also limited research on quality of care. An older study on scatter beds concluded that quality may be lower compared to IPFs in terms of fewer psychiatric visits, more ancillary services, and shorter lengths of stay.

Scatter bed stays are a large share of inpatient psychiatric stays. The left side of this figure shows that inpatient psychiatric stays per 1,000 fee-for-service beneficiaries have decreased over time, but the share of scatter bed stays, shown in orange, has increased relative to IPF stays, shown in blue. In 2022, scatter bed stays composed 30 percent of all inpatient psychiatric stays.

We observed a similar pattern among Medicare

Advantage enrollees, as shown on the right side of the figure. Among both fee-for-service and Medicare Advantage beneficiaries, the overall volume of inpatient psychiatric stays has decreased, though the decline in volume is not as pronounced among MA enrollees.

The characteristics of fee-for-service Medicare beneficiaries who had scatter bed stays in 2022 differed from those who had IPF stays. As shown in this table, scatter bed patients were older. The average age for beneficiaries using scatter bed stays was 63, versus 58 for those using IPFs. Scatter-bed patients also tended to have more moderate or severe comorbidities, and had shorter lengths of stay.

In contrast, fee-for-service Medicare IPF patients were more likely to be disabled, low-income, and have greater Part D spending on psychotropic drugs, if they were covered by Part D. Rural location was similar among beneficiaries using scatter bed stays or IPF stays.

The patterns were similar when comparing MA enrollees using scatter bed stays versus IPF stays in 2021, which is the most recent MA encounter data available. They were also generally the same when we compared beneficiaries

using scatter bed stays to those using hospital-based IPFs.

We found differences in the raw rates of follow-up services in the 30 days following discharge for Medicare fee-for-service beneficiaries using scatter beds versus IPFs. The blue bars in this chart represent follow-up care received after IPF stays and the orange bars present follow-up care received after a scatter bed stay using data from 2018.

As shown in the left blue bars, 19 percent of the time, beneficiaries discharged from IPFs were readmitted within 30 days but they were less likely to be admitted to a general ACH after the IPF stay. They were admitted 10 percent of the time.

The opposite was true for beneficiaries discharged from scatter bed stays. As shown in the left orange bars, beneficiaries discharged from scatter bed stays had lower rates of IPF admissions, 13 percent, but higher rates of readmission to a general acute care hospitals, or 19 percent. Note that the readmission to the general acute care hospitals would include both scatter bed and other types of stays.

Patients using scatter bed stays were more likely

to be admitted to post-acute care than those using IPF stays, less likely to receive outpatient partial hospitalization services, and less likely to have a visit with a behavioral health practitioner in the 30 days after discharge.

These figures do not adjust for differences in the characteristics of patients who used scatter bed versus IPF stays and the findings are consistent with patients using scatter bed stays tending to be older with more comorbidities, as was shown on the last slide. However, we did find similar patterns when adjusting for differences in risk scores and age between the two groups.

Most hospitals had some, but not many, scatter bed stays. In 2022, among IPPS hospitals with at least 500 fee-for-service stays, which are over 70 percent of hospitals, 94 percent had some scatter bed stays. The median number of such stays was 12, which represented a very small share of all fee-for-service stays, about 1 percent, on average.

However, a few IPPS hospitals had very high shares of scatter bed stays. In 2022, 32 percent of IPPS hospitals with at least 500 fee-for-service stays had a

hospital-based IPF unit, down from 36 percent in 2017. That is, scatter bed stays occurred in general acute hospitals both with and without separate IPF distinct part units.

We interviewed a small number of hospitals that had over 200 scatter bed stays in 2022. They emphasized that hospital admission occurs only when the patient has medical conditions that need to be treated, but they were less clear on how the principal diagnosis, psychiatric versus another condition, would be determined. Some hospitals have psychiatric units, or wings, that are not designated as IPFs, meaning the stays in this wing would appear to be scatter bed stays in our definition. We also learned that some hospitals without psychiatric units may not have psychiatric clinicians available.

The Medicare fee-for-service payment system for IPF stays differs from the payment system for stays in general acute care hospitals. IPF stays are paid using the IPF PPS, which pays per diem, whereas most scatter bed stays are paid under the IPPS, which pays per stay. The two payment systems also have differences in the types and levels of other adjustments made to determine the final

payment.

The table on the left compares lengths of stay and payments for psychiatric stays with a DRG of psychosis. Psychosis is the most common type of psychiatric stay, accounting for about 85 percent of IPF stays and 60 percent of scatter bed stays.

Among psychosis stays, IPF stays tend to be longer, 16 days, on average, compared with IPPS stays, which were 10 days, on average.

Payment per stay was higher under the IPF PPS, about $13,000 compared to less than $10,000 for scatter bed stays under the IPPS. But payment per day was higher for IPPS scatter bed stays, over $1,000 compared to $880 for IPF stays. That is, for the psychosis DRG, scatter bed stays tend to be shorter and have a higher payment per day compared to IPF stays.

To summarize, for Medicare's 190-day limit on stays in freestanding IPFs, about 50,000 beneficiaries were affected in 2022. We found some evidence of shifts in setting of care for inpatient psychiatric services, and generally less inpatient psychiatric services used among beneficiaries nearing the limit.

For scatter bed stays in general acute-care hospitals, we found that a substantial share, about 30 percent in 2022, of inpatient psychiatric care took place in scatter beds. Patients using scatter beds versus IPFs differed. Scatter-bed patients tended to be older with more comorbidities and shorter lengths of stay. And Medicare fee-for-service payments for IPF stays differed from scatter bed stays paid under the IPPS.

Next, we'll answer your questions and would like to hear your ideas for future work.

Thank you very much, and I now turn it back to Amol.

VICE CHAIR NAVATHE: Great. Thanks, Betty, for a very clear presentation.

So just as a reminder to Commissioners, this is work that started with a congressional request, and this is follow-up work that was really pursued due to Commissioner interest. This work itself is informational. There is no plan right now for it to be a chapter in the June report.

So with that I will turn it over to Dana to run the queues.

MS. KELLEY: I have Cheryl with a Round 1

question.

DR. DAMBERG: Thanks. This is great work, and I appreciate your summary.

I have two questions. One, the slide where it shows these type of stays are declining over time, do we know what's driving that? Are these patients being better managed in the outpatient setting, better pharmaceutical management?

DR. FOUT: I think it could be all those reasons. We also have pondered why the volume has declined so drastically over time. I don't think we have a good response as to the reasons, and if you have ideas for us to look into, we certainly can.

In our chapter last year we did look at ambulatory care. We didn't see a lot of patterns where those were going up. That doesn't mean that's not the reason or more Part D drugs another reason either. But we don't have a great explanation for that, and we would like to know more.

DR. DAMBERG: Yeah. I don't know this patient population at all, but I'm just kind of curious, sort of longitudinally, if you tracked people over time, are they

likely to have multiple stays over multiple years. And so you could look to see are they transitioning to other settings for ongoing care, might be a possibility.

My second question is in terms of the IPFs versus the general acute care hospitals, I know you talked about differences in comorbidities, but are the diagnoses related to psychiatric care different for people who end in IPF versus the general acute care hospitals?

DR. FOUT: We limited our study to the same DRG, so they would be in the same MDC, which is a group of DRGs, so psychiatric DRGs. So we sort of tried to control for making sure they were under the same umbrella of diagnoses. There are different distributions, but the diagnoses between scatter bed stays and IPFs were much more psychoses, like schizophrenia, and scatter bed stays were more like dementia, related to organic disturbances. So there were some differences within, but we did limit it to the same set of psychiatric MDCs.

DR. DAMBERG: Yeah, that's helpful information, and I think detailing that a little bit more in the chapter could shed some light.

MS. KELLEY: Gina, did you have a question?

MS. UPCHURCH: Thank you, Betty, for this. Just to follow up on the question that Cheryl just asked, I know in North Carolina inpatient standalone or independent inpatient psychiatric hospitals have closed. So if it's not there you can't use it. So I'm wondering if closures is a reason that contributes to that.

So if I understand, there are four places. There's freestanding inpatient psychiatric units, hospital-based psychiatric facilities, and they're the ones that have the 190-day limit, both the hospital-based and the independent, or just the independent?

DR. FOUT: Just the independent.

MS. UPCHURCH: Just the independent. Okay. And then you have hospital with psychiatric units that have not gone through the whatever, accreditation, to be a facility. And then you have scattered beds. That's what's in a general hospital. That is four ways that people can get sort of inpatient care. Okay.

Is there any --

VICE CHAIR NAVATHE: Dana, did you want to clarify?

MS. KELLEY: From our perspective, in terms of

the work that we've done here, we have classified any discharge from a hospital that's been paid under the IPPS is a scatter bed, even if the hospital is operating one of those kind of units, semi kind of units.

MS. UPCHURCH: Okay.

DR. FOUT: Those are considered scatter beds for our work here.

MS. UPCHURCH: Okay. All right. So I guess my question would be, with all of that do we know anything about the quality of the care that people are getting to their psychiatric needs in these different facilities?

DR. FOUT: Quality is hard to measure. There is, for IPF, a quality reporting program. It's mostly reporting right now. But I think CMS is doing work on the quality reporting program, and different metrics and surveys to measure. I think it's harder to get at the scatter bed stays because it might be in a psychiatric wing, and as Dana said we can't identify or distinguish whether it was in a psychiatric unit that was not an IPF or it was just a general acute care hospital, and those are not part of the IPF quality reporting program.

MS. UPCHURCH: And is it the hospital's decision

to -- you know, we had Evan trying to be the mind of a hospital or Medicare Advantage plan or a whole country, so I'm going to ask you if there is any sense if you're owning a hospital, is there a disadvantage to having psychiatric inpatient beds, financially? Is there something driving that potentially?

DR. FOUT: Do you mean an IPF or just --

MS. UPCHURCH: Yes, IPF versus just having scatter beds, deciding as a hospital which way you're going to go.

DR. FOUT: Yeah. That's a good question, and I think that's why we presented some information on the payment.

MS. UPCHURCH: Right.

DR. FOUT: We interviewed care managers at hospitals to discuss the decision-making for a scatter bed stay versus admitting into an IPF, but we have not been able to get to like the financial crew that might be able to better tell us what the decision-making process is there.

MS. UPCHURCH: I think that would be interesting for us to know. And my last question is just 190 days.

You know, why is that?

DR. FOUT: Well, it came with Medicare in 1965, and at that time the care was in freestanding facilities run by the state and already paid for by the state. And that was a provision to sort of maintain that.

MS. UPCHURCH: Limit their exposure somehow.

DR. FOUT: Yeah.

MS. UPCHURCH: Okay. thank you, Betty.

MS. KELLEY: I think that's all I have for Round 1, so we'll move to Round 2?

VICE CHAIR NAVATHE: Yes.

MS. KELLEY: Okay. And I have Stacie first.

DR. DUSETZINA: Great. Thanks so much for this work, Betty, and the follow-on analyses from the prior discussions here.

I think that the lifetime limits seem so archaic to me that we would still have this in place for our beneficiaries. And I think it was really helpful how in the analysis you highlight that a large percentage of those people who are near or hitting those limits are under 65 when they qualified for Medicare, which makes sense, conceptually. They have more time to accrue days to hit

that limit. But I think it also highlights just how this is a very medically complex group, and people who need care for probably most of their life, you know, and the fact that we have a limit here is really an embarrassment. I think we need it to be addressed.

I think it would help a lot to maybe, in the chapter, have a little bit more detail about the patients that are served by the program, just kind of helping the average reader catch up with how severely ill people are when they're using these services, especially now that the availability to access to psychiatric care is fairly limited kind of overall, and for these most severe service needs. So having a little bit more context, I think, about the clinical conditions, that would be really useful.

As far as future analysis, I have worked a little bit in this space many years ago, so I know just enough to be dangerous now because things have evolved a lot. But I think that what I've heard previously is that they are just incredibly long wait times to get into a bed, to get care, in general. So I think any information that we have on that.

Potentially talking with patients and their

families about access to care, especially when we think about having certain types of care limited. I think talking with mental health experts, like psychiatrists working in this space. I really worry a lot about the general acute care swing bed that doesn't have a psychiatrist available for people. That seems really not a great place for people to be.

And then I think that it would be really instructive, and maybe something we could do with the data as it is, of if you hit the limit theoretically, not for the people who do, but if you did, how much farther would you have to go to get to one of the psychiatric facilities that Medicare would pay for relative to the freestanding facility, and again, not just conditioning on people who are at the limit but thinking about in general. Like if you ended up on this circumstance, are we talking about a major difference in access to services for you. Because I think that's really important for kind of demonstrating that this is probably not a good policy to hold onto because everything else around the policy has changed over time, and it's probably worth refreshing it.

But thank you very much. This is excellent work.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. I was very happy to see this actually come back. There was a lot of discussion about the 190-day limit, in particular. It did feel very sort of archaic. It was developed in 1965. The rationale wasn't clear, and I'm not quite sure it's appropriate or relevant in 2024. So it's good to get some additional information around this.

I think at some point we'll likely pivot towards making some recommendations. I think probably some additional data could be helpful. You had mentioned between 2022 and 2023 that there were 1,100 individuals who basically were turned out because they had reached that 190-day limit. I wonder what the increment cost would be if we removed the cap in its entirety. Maybe that's something we could look at, because if we were to propose anything in the future it would be good to know what the costs are associated with that.

And another option, too, is, well, what if we increase the 190-day limit by 50 percent. That would be 275 days. How much would that reduce the 1,100? Would it reduce it from 1,100 to zero or to 25, or only in half for

example. It's nice to know if we can get at that data, to have a couple of options to look at, depending on what the costs are.

And then regarding scatter bed days, I'm glad that several case managers were interviewed around this topic, as well, because I do agree there is a proportion of psychiatric patients who have a dual diagnosis, where they have a medical condition that needs to be treated, and therefore they're not appropriate for a psychiatric facility. The issue is how to get at that data. I'm not quite sure how without some sort of medical record review.

But if there's something in the claims data that could kind of separate that out, that would provide some additional clarity in terms of why some of those patients, anyway, are being admitted to an acute care hospital setting.

Otherwise, except for those two requests, a really great report, and I am looking forward to further discussion on this.

VICE CHAIR NAVATHE: Just to jump in for one quick moment, I want to say thank you, Robert, for that conversation. That's very helpful, in particular thinking

about different types of policy options. I just wanted, actually patients around the cost analysis that we could do. So we can present different kinds of claims around the data. A key piece of this, from a federal standpoint, will be how patients shift across different sites of care and then across coverage under Medicaid versus Medicare. And we can do our best to think through that. But I wanted to surface that that's something that tends to reside on the CBO side of the street, so we'll be a little cautious when we have that discussion, but happy to provide information.

MS. KELLEY: Brian.

DR. MILLER: I am reminded of why insurance design needs to be updated. I think that this is the 1965 Lincoln Continental with drum brakes, not even disc brakes, let alone antilock brakes or airbags or rollover bars, or anything. I agree with everyone -- is there still a good policy rationale for a 190-day IPF freestanding limit. It seems like the answer is resoundingly no. Because depriving elderly beneficiaries with mental illness inpatient care due to an arbitrary limit that is 59 years old, seems imprudent if not stupid.

A few thoughts. On Slide 12 we noted the longer

IPF stay. I did want to denote that at least for psychiatric care that longer length of stay is not necessarily bad. Longer length of stay may actually be clinically appropriate, or in some circumstances, depending upon the patient and their diagnosis and what the psychiatrist is thinking, may actually be higher quality. So length of stay for psychiatric care, obviously from a patient perspective you want it to be shorter. But sometimes shorter is better. Sometimes shorter is not.

There was a question earlier about the migration to IPFs. Most of the hospital leaders that I know have shrunk or closed psychiatric beds not because they don't want to provide those services but because they are frequently not remunerative to the point where they provide a neutral margin, a positive margin. The joke of no margin, no mission is very true.

So as a consequence we've seen appropriate specialization where facilities have focused only on psychiatric care, hence why IPF care in the freestanding market has increased extensively. And that's not necessarily a bad thing because if you have a small IPF that's based at the hospital and it's struggling, versus a

larger IPF that's a sustainable facility tied to outpatient care or partial hospitalization care, that specialization may actually be beneficial for the elderly Medicare beneficiary who has psychiatric illness and needs ongoing care across the spectrum, not just inpatient but sometimes partial hospitalization or even outpatient or telehealth.

So I think that obviously we should think about whether that 190-day limit makes sense, and I'd say probably not, and it sounds like others think. We should also be cognizant of the fact that a freestanding IPF in this case might be a good thing because it allows for clustered specialized care for a beneficiary. And whether we like it or not, there's still a lot of stigma associated with mental illness, and so beneficiaries might not always feel comfortable going into a regular large hospital and then walking over to a different department.

So I think that having this specialization is a good thing. It potentially could increase quality, increase access, and allow care across the continuum. So we should be supportive.

MS. KELLEY: Scott.

DR. SARRAN: Betty, could you flip to Slide 10

for a moment, the one that showed the care people got in the 30 days post hospital. If I saw it right, it shows -- and it's 2018 data that still only 25 or 32 percent of beneficiaries received a follow-up visit with a behavioral health specialist in the 30 days post hospitalization. I think it's just worth highlighting that. I think that's old data, and I think things have gotten better. But that's abominable. I mean, it's just abominable. I mean, these people are sick enough to be requiring an inpatient level of psychiatric care, and they don't get a follow-up visit with a behavioral health practitioner in 30 days, 75 percent or 68 percent don't get a visit. That's just worth calling out as a gross failure of care delivery. So that's one comment.

The second is Brian and others' comments about what I would call the archaic and rigid nature of the benefit plan for IPF inpatient days, "archaic" and "rigid" are terms that I think characterize the broader lack of holistic, integrated, continuous, proactive, patient-centered care for many people living with serious mental illnesses, especially psychotic disorders, longstanding bipolar disease, et cetera, many of whom, as we know, are

dual eligible.

And I'd like us to see some comment in it about just, you know, we still have this huge unmet need in this country about, again, lack of the right kind of integrated care for those very frail, very at-risk, very disadvantaged people.

And, you know, as I think about it, it actually cries out for a different payment model. I mean, I'd love to see a FIDA I-SNP for people with psychotic disorders, you know, fully integrated because you have to integrate Medicare and Medicaid for this population. Otherwise you're going to fail to provide excellent clinical care, and you're going to fail to address housing and social determinants, et cetera, et cetera.

But it's very specialized. MA plans aren't going to do it, ACOs aren't going to do it, and no one else is doing it now. So if somehow we can call out saying, hey, let's think about how do we promote true innovation in this space, that would be great.

I rambled, but still came in at 2:51. Just saying.

MS. KELLEY: Cheryl.

DR. DAMBERG: I'm in the camp that believes this benefit is completely outdated, archaic, rigid. I think all those words appropriately describe this, and clearly it needs revisiting. And I liked Robert's idea, and Scott's idea that he just floated, about thinking about different designs for how to provide this care as well as the cost implications of making these kinds of changes, recognizing the limitations that Paul outlined.

And I also want to plus-one on the analyses that Stacie suggested and potentially offer up one more, which is I was struck by the statistic about while there are quite a few plans, MA plans, that offer supplemental IPF benefits, there seems to be very low uptake. And I was trying to understand whether there is an issue with the benefit or is it just a lack of awareness among Medicare beneficiaries that that's actually available to them.

And so as you think about future work that you do and maybe talking to beneficiaries, maybe that's an area you could explore.

MS. KELLEY: Larry.

DR. CASALINO: I mean, first of all, these people are really sick. I mean 190 days is like ten 19-day mental

hospital, psychiatric hospitalizations. Nineteen days these days is a pretty long psychiatric hospitalization. So these people are sick. And for those of us who live in cities and walk past them every day on the street, every time you do, you're diminished a little bit. That's the way I feel, at least I'm diminished a little bit. It's a bad thing. It's a disgrace how our country treats these people.

And what goes on in the psychiatric facility, it's important but it's the least of it. It's what happens after that. And, of course, as Scott knows, it goes way beyond whether you get a visit with a mental health provider or not.

So I just had to get that off my chest.

I think the 190-day limit, you know, I agree it's archaic, and we can call it all kinds of names, but I think we can maybe do better in what we publish, which is to try to focus expressly on what was the original reason for the 190-day limit, and are there any reasons now? And if there are reasons, could those reasons be dealt with in some better way -- I think we all think they could -- than 190 days. So if there are concerns about overuse, I guess,

that led to this 190-day limit law, can those concerns maybe be met in some other way? I think that could be an interesting discussion to have, actually. But it may not be that useful with Congress just to say something is really old and therefore it doesn't make sense anymore.

MS. KELLEY: That's all I have for Round 2, unless I'm missing someone. Gina, did you want to get in here?

MS. UPCHURCH: Yeah, sorry. Just to follow up on Cheryl's comment. So as one does, I was reading some summary of benefits for Medicare Advantage plans last night, and I was just looking at the pricing for if you go in the hospital for mental health issues. And it's very similar to just going in the hospital for something else. So again, this out-of-pocket exposure with Medicare Advantage plans, around $300 a day, something like that, for the first like eight days or something. Then you don't pay anything after that.

So getting at Cheryl's comment, do people know about the 190 days, and some plans may offer more than 190 days. So the few that I looked at, the summary of benefits, only one of them mentioned 190 days even being

available to people. It was more you were just thinking of hospital, 190 day, okay. Only one said you have 190-day inpatient, even mentioned it.

So you would have to do a very, very deep dive and call the insurance company to learn really. They are not advertising, that I could see, please come here because we will give you more than 190 day inpatient psychiatric. I don't think it's something they would choose. You'd have to go really deep dive to figure that out. Thanks.

VICE CHAIR NAVATHE: Go ahead, Betty.

DR. RAMBUR: Very quickly, if I may. I just wanted to underscore how important I think this work is, and I agree with all the comments. I just wanted to mention that I know that you know I worry about overuse a lot, and I heard your comments. This is a population I do not worry about overuse in, and whereas so much really work we need to do to create a really ethical and moral delivery system or support system.

I wanted to also comment on Brian's comment about remuneration. The places that have closed, in my experience, it's been that as well as the workforce crisis. There simply are not the people who are connected. So the

workforce challenges due tie in with this whole broader issue, as well.

But thank you for this important and actually very sobering work.

VICE CHAIR NAVATHE: All right. So without any further comments, thank you, Betty, so much for this work. Obviously a very important and population that we care a lot about that faces a lot of challenges. So thank you, Commissioners, for your thoughtful comments as well.

So that brings our March meeting to a conclusion. For those of you who are listening online we'd love to hear from you as well. Please submit comments at meetingcomments@medpac.gov or through our website, medpac.gov/meeting. And we will reconvene for our April meeting with Mike back at the helm. Thank you.

[Whereupon, at 10:58 a.m., the meeting was adjourned.]