

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 15, 2026
10:17 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
BETTY RAMBUR, PhD, RN, FAAN, Vice Chair
LYNN BARR, MPH
PAUL CASALE, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
THOMAS DILLER, MD, MMM
STACIE B. DUSETZINA, PhD
KENNY KAN, FSA, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
JOSHUA LIAO, MD, MSc
GOKHAN METAN, MSc, PhD, NACD.DC
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
WAYNE J. RILEY, MD, MPH, MBA
SCOTT SARRAN, MD, MBA
GINA UPCHURCH, RPh, MPH

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

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P R O C E E D I N G S

[10:17 a.m.]

1
2
3 DR. CHERNEW: Hello, everybody, and welcome to
4 our January MedPAC meeting. The January meeting is amongst
5 the most important meetings of the year, not that they're
6 all not important, but in January, we vote on our update
7 recommendations. And we're about to do that this morning.
8 So thank you very much for joining us. I think we've --
9 the staff has done a great job through a lot of material.

10 You may notice a new year, and I hope you all had
11 a good new year. We have a new look to GoToMeeting. So
12 thank you for working through our new GoToMeeting look.
13 Paul has a new beard. So we are ready to go with
14 everything new. It is actually Paul, not his evil twin and
15 --

16 MR. MASI: It could be both.

17 DR. CHERNEW: It could be both. And we're going
18 to go through. So we're going to start with our update for
19 physician and other health professionals fee schedule and
20 is -- who's starting? Geoff is starting. Geoff.

21 MR. GERHARDT: Okay, great. Good morning. Good
22 morning, everyone.

1 In this session, we'll present our assessment of
2 the adequacy of current payment rates for physicians and
3 other health professional services and present the draft
4 recommendation on how to update Medicare's payment rates
5 for clinicians in 2027.

6 The Commission discussed payment adequacy for
7 clinician services and considered the Chair's draft
8 recommendation at the December meeting. For those watching
9 online, a copy of these slides is available in the
10 materials section of the webinar's control panel on the top
11 right-hand side of the screen. The icon has a paperclip on
12 it.

13 Our presentation will begin with a quick overview
14 of use and spending under Medicare's physician fee
15 schedule. We'll then dive into our findings regarding
16 beneficiaries' access to care, the quality of care, and how
17 clinicians' revenues compare to their costs. We'll end
18 with the draft recommendation and your discussion and vote.

19 In 2024, 1.5 million clinicians billed Medicare's
20 physician fee schedule for 679 million encounters, with
21 27.8 million beneficiaries in fee-for-service Medicare.
22 The Medicare program and fee-for-service beneficiaries paid

1 a total of \$93.8 billion for fee-schedule services in 2024.

2 This slide shows the four domains the Commission
3 looks at when developing annual recommendations about how
4 to update payment rates for each Medicare fee-for-service
5 sector. In the case of clinicians, we'll explore
6 beneficiaries' access to care, quality of their care, and
7 growth in clinician revenue and costs. Unlike other
8 presentations you'll see, due to data limitations, we do
9 not assess clinicians' access to capital for fee schedule
10 services.

11 The first indicator we'll look at when assessing
12 adequacy of clinicians' payment rates concerns
13 beneficiaries' access to care. This year, we continue to
14 find that Medicare beneficiaries have relatively good
15 access to clinician care. Our 2025 survey found that
16 beneficiaries aged 65 and over reported access to care that
17 was generally better than that of privately insured people
18 aged 50 to 64. Similar shares of clinicians report
19 accepting new patients with Medicare and private insurance.

20 The total number of clinicians billing Medicare
21 is increasing, although the mix of clinicians is changing,
22 and the number of clinician encounters per fee-for-service

1 beneficiary increased by 4.5 percent in 2024.

2 The second category of indicators we look at
3 concerns the quality of clinician care. It's difficult to
4 assess the quality of clinician care due to issues with
5 MIPS. However, quality indicators we track remained
6 relatively stable in 2024.

7 Ambulatory care-sensitive hospital use remained
8 stable from 2023 to 2024 and below pre-pandemic levels.

9 We also find that patient experience scores are
10 relatively stable.

11 The final categories of indicators for clinicians
12 is their revenue and costs, which we find to be somewhat
13 positive. Unlike many other sectors, clinicians do not
14 submit cost reports. So we rely on other data sources to
15 assess revenue and costs.

16 Spending on fee-for-service -- sorry -- fee
17 schedule services per Medicare fee-for-service beneficiary
18 increased by 4.1 percent in 2024.

19 Clinicians' input costs, as measured by the
20 Medicare Economic Index, grew by 4.3 percent in 2022, but
21 are projected to moderate in the future, growing only by
22 2.1 percent in 2027.

1 Median all-payer compensation grew by 6 percent
2 for physicians and 2 percent for advanced practice
3 providers in 2024.

4 Private insurance payment rates increased faster
5 than Medicare's payment rates in 2024 and are now 147
6 percent of fee-for-service Medicare payment rates.

7 Overall, our assessment is that most of the
8 indicators across our three domains suggest payment rates
9 are adequate, but relatively high growth in clinicians'
10 input costs are a concern.

11 To provide context, this slide shows a long-term
12 view of how clinicians' input costs compare to fee schedule
13 updates and fee schedule spending per beneficiary. Over
14 more than two decades, MEI growth consistently exceeded fee
15 schedule updates. From 2000 to 2024, the cumulative
16 increase in fee-scheduled updates, the bottom line, totaled
17 14 percent, compared with MEI growth of 56 percent, the
18 middle line.

19 We also showed changes in fee schedule spending
20 per fee-for-service beneficiary, which includes the
21 combined effects of changes in updates, volume of care,
22 intensity of services, and changes in coding practices by

1 clinicians over time.

2 As you can see in the top line of the figure, fee
3 scheduled spending per fee-for-service beneficiary grew by
4 a total of 104 percent over the same period, far outpacing
5 MEI growth.

6 Given that our beneficiary access measures remain
7 similar to the commercially insured population, while fee-
8 scheduled payment rates have not kept up with MEI growth,
9 suggests that increasing fee schedule rates to closely
10 reflect inflation has not been necessary to ensure
11 beneficiary access to care.

12 I'll now turn things over to Rachel.

13 MS. BURTON: Since ensuring there is an adequate
14 supply of primary care providers is a key concern of the
15 Commission, here we recap some actions CMS has taken in
16 recent years that are expected to increase total payments
17 for primary care providers.

18 In 2021, CMS substantially increased payment
19 rates for many types of evaluation and management visits.

20 In 2024, it began paying for the G2211 visit
21 complexity add-on code.

22 Over the years, CMS has introduced and refined

1 various types of care coordination and management codes.
2 Starting in 2025, CMS began making monthly payments per
3 beneficiary for advanced primary care management services
4 as an alternative to using these codes.

5 In 2026, CMS increased payment rates for time-
6 based services, like E&M visits, and applied an efficiency
7 adjustment to the work portion of the values of non-time-
8 based services, such as procedures and imaging. Moving
9 forward, we will monitor the use of these codes and any
10 changes in the supply of different types of clinicians.

11 I'll now turn to the draft recommendation, which
12 reads: For calendar year 2027, the Congress should
13 increase payment rates for physician and other health
14 professional services by 0.5 percentage points more than
15 current law.

16 Current law updates under MACRA are scheduled to
17 be 0.75 percent for qualifying clinicians in advanced
18 alternative payment models, and 0.25 percent for all other
19 clinicians.

20 As a result, the effects of the draft
21 recommendation plus MACRA updates would be an update of
22 1.25 percent for A-APM clinicians and 0.75 percent for all

1 other clinicians in 2027.

2 In terms of implications, we currently estimate
3 that this draft recommendation would increase spending
4 relative to current law by roughly \$750 million to \$2
5 billion in one year, and by 1- to \$5 billion over five
6 years, since our recommended updates are permanent
7 increases that would be built into subsequent years'
8 payment rates.

9 The draft recommendation should maintain
10 clinicians' willingness to treat fee-for-service Medicare
11 beneficiaries and maintain beneficiaries' access to care.

12 With that, we look forward to your questions, and
13 I'll hand it back to Mike.

14 DR. CHERNEW: Great. Terrific job, and we have a
15 queue building.

16 Remember, we're only going to do one round. You
17 don't need to state your vote, because we're going to do a
18 roll call after the round. We're moving through a lot of
19 material. So please be cognizant of the time.

20 And I think, Brian, you're first.

21 DR. MILLER: Thank you for your hard work on this
22 chapter and making it more complete and detailed.

1 I want to be clear that this recommendation from
2 MedPAC is a net negative payment update for physicians,
3 nurse practitioners, and physician assistants who are Part
4 B providers. The divergence of OPPS and PFS rates over the
5 past 20 years has driven massive consolidation, and we are
6 not seeing the forest from the trees with this year's
7 update. Our measures do not measure what we think they do.
8 For example, salary is a measure of corporate cross-
9 subsidization for the over half of physicians who are
10 employed.

11 We are also recommending a net negative update
12 when last year we recommended MEI-1 after two years of
13 public work to get to consensus, which was a consequence of
14 six years of efforts by former Commissioner Larry Casalino
15 on this issue.

16 Our margin recommendation has changed by 4
17 absolute percentage points. despite no meaningful change in
18 our measures, and therefore, I do not support this
19 recommendation.

20 MS. KELLEY: All right. I have a comment from
21 Kenny next. He says that he recognizes the longstanding
22 tension between health plans and physicians. After two

1 years of work, the Commission got to consensus last year on
2 MEI-1 percent or a 1.3 percent update for 2026. This year,
3 with the same indicators and same signals, we are
4 recommending a net negative update of minus 2.2 percent.
5 This is inconsistent.

6 Plans and policymakers must recognize the
7 implications of negative payment updates and their long-
8 term impact towards consolidation.

9 He opposes the recommendation and supports a
10 viable path towards private practice and a competitive
11 marketplace.

12 And I have Paul next.

13 DR. CASALE: Great. Thank you and my thanks for
14 just a tremendous chapter.

15 Just a few comments, mainly around access data,
16 which, again, you do a great job, and I thought there was a
17 few things I wanted to point out within there as it relates
18 to access. And one is it relates to finding new PCP or new
19 specialists, and I know you compare the Medicare to private
20 insurance. But a few things stood out.

21 One was that although it seemed like a third or
22 so were able to get a PCP within two weeks, if you look at

1 the ability to get them -- whether it took six weeks or
2 more to get a new PCP was, again, a third. So on the other
3 side, there's still a struggle in terms of finding either
4 new PCP and for specialists, it was 37 percent for
5 Medicare.

6 So I appreciate the work to continue to keep an
7 eye on access. I think it continues to be a major
8 challenge.

9 And also in the report on the focus group
10 response, the beneficiaries said that at times to see a
11 specialist, it could take months to years, and that's not
12 unusual, at least in my experience, when I hear from
13 beneficiaries, particularly looking for specialists.

14 And then I wanted to underscore my appreciation
15 for including the MSSP ACO CAHPS data in terms of access to
16 specialists. Again, it's declining, which was pointed out,
17 82 percent to 76 percent, so appreciate you adding that
18 layer of data to the access.

19 And then just a couple of other points. One is
20 it's remarkable how you're able to bring in all of the
21 research, even very timely research. The Zhu paper around
22 concierge and direct primary care data, I mean, that's

1 really kudos to all of you for doing that. And in that,
2 they highlighted that, and I think we all know this, for
3 PCPs in particular, concierge practices continue to
4 increase dramatically for practices, 83 percent. And the
5 corporate-affiliated practices are skyrocketing in that
6 paper, 576 percent. So we see this tremendous growth
7 around concierge, and again, I hear it from beneficiaries
8 who are trying to find particularly primary care, this
9 tremendous movement towards concierge.

10 And then as you're looking at the data, you
11 highlight the incident-to issue. That really makes it hard
12 to understand access to care and the role of NPs and PAs
13 and other APPs, so important. So I appreciate that
14 comment.

15 And then finally, on the quality side, the
16 ambulatory care-sensitive hospitalizations, for the chronic
17 care conditions like hypertension, which were important, I
18 would suggest maybe in future to consider heart failure
19 because that one also has a lot of variability around it.
20 And it's something that might be helpful when we're looking
21 at quality of care.

22 So thank you.

1 MS. KELLEY: Greg.

2 MR. POULSEN: Thank you. I'll be really quick.

3 I am supportive of the recommendation, but with
4 the concern that was brought up by others in that I think
5 access is a good measure. But when access changes, I think
6 it's going to change very, very rapidly. We'll see lots
7 and lots of people move very, very quickly. We've seen
8 that in MA and a few markets right now where people have
9 just said, okay, I'm done, and everybody else looks around
10 and says me too. And I think that that's a concern. So we
11 need to keep our finger very much on that pulse.

12 So while I think that I'm supportive of the
13 recommendation with some hesitation, I do think we need to
14 be very, very cognizant of the fact that when things start
15 to get significantly different, they could get that way
16 really quickly.

17 MS. KELLEY: Scott.

18 DR. SARRAN: Superb chapter. Excellent work.

19 One thing I'd like to see incorporated into our
20 write-up is that given that, as you note, that as we parse
21 data on access and quality, particularly ambulatory care-
22 sensitive hospitalization and ED visits, by vulnerable

1 populations under age 65, persons of color, low income, et
2 cetera, we do note that there are significant pockets of
3 access and quality issues that have not improved or may be
4 worsening.

5 In the context of all the excellent work CMS has
6 done establishing new codes that incent comprehensive
7 coordinated care, not just for primary care docs, but for
8 specialists who deliver a lot of chronic disease care, we
9 want to make sure that we follow up to see if the use of
10 those codes, number one, is being directed proportionally
11 or even better than proportionally at the vulnerable
12 populations. And most critically, number two, is having
13 some positive impact, so just the importance of sort of
14 saying, hey, we've done some really good work in terms of
15 public policy around those new codes. Let's see if they're
16 having the desired effect, particularly with vulnerable
17 populations.

18 Thanks.

19 MS. KELLEY: Tamara.

20 DR. KONETZKA: Adding my thanks for a great
21 chapter.

22 Two very brief comments. One is my understanding

1 -- and I should let staff clarify this if needed, but my
2 understanding and the reason I was in favor of this
3 recommendation was that it actually does come out to pretty
4 close to MEI-1, based on all the discussions we've had in
5 the past, if you look at it compared to current law.

6 And so then for the same reasons, you know, I
7 think we're really balancing. Even if we have uncertainty
8 over these access measures, we're really balancing those
9 against, you know, the very real cost that would be imposed
10 on beneficiaries if we raised payment rates more. I think
11 it's always important to remember that part.

12 My only other brief comment was about the volume
13 and intensity. You know, thank you for being responsive
14 and filling out that paragraph a little bit more with some
15 more literature on, you know, whether there are possible
16 behavioral responses on the parts of physicians. I think
17 I'm still a little bit uncomfortable with the conclusion
18 that there's probably not behavioral responses in volume
19 and intensity. It's just something I'd like to keep track
20 of into the future. Like, can we somehow parse out how
21 much is coding, how much is sort of behavioral response on
22 the part of physicians, and how much is just due to

1 technology and changing demographics? Obviously not for
2 March, but into the future, it would be great to keep our
3 eye on that.

4 Thank you.

5 MS. KELLEY: Mike, that's all I have for
6 questions.

7 DR. CHERNEW: Perfect.

8 Thank you all for your comments. A few very
9 quick things, but we're about to go expeditiously to a
10 vote. The first one is, obviously -- and people will be
11 able to read the chapter when it comes out in March --
12 we're very concerned about issues of access in a whole
13 range of ways. That's why we have an above-current-law
14 update, which I thank you, Tamara, you're right. It
15 basically approximates MEI-1. And with some of the other
16 coding things going on, the total revenue and other things
17 going in is probably a little bit more than that one way or
18 another.

19 But just to keep people on the same page for our
20 last recommendation on MEI-1, the recommendation was not to
21 have an MEI-1 update. The recommendation was to have that
22 into the default baseline, and then every year, we would go

1 through the exercise we're going through now and make a
2 recommendation relative to that. So that's just sort of
3 where we were.

4 And a lot of these issues, to your point, Greg,
5 really do end up being workforce issues, and I think as a
6 broad point, there's a lot of stuff that goes on here. But
7 one way or another, a little bit on the update is probably
8 not the core workforce issues. I think we need a lot more
9 concerted effort to understand a whole bunch of workforce
10 training things going on, and I think that's the core thing
11 that will drive access.

12 But anyway, that's just my two cents as we try to
13 thread this needle, but for now, we're going to go through
14 the votes.

15 So, Dana, we're going to do this in the
16 particular roll call way. So, Dana, call the roll.

17 MS. KELLEY: All right.

18 Voting on the recommendation that reads: For
19 calendar year 2027, the Congress should increase payment
20 rates for physician and other health professional services
21 by 0.5 percentage points more than current law.

22 Yes or no?

1 Lynn?
2 MS. BARR: Yes.
3 MS. KELLEY: Paul?
4 DR. CASALE: Yes.
5 MS. KELLEY: Robert?
6 DR. CHERRY: Yes.
7 MS. KELLEY: Cheryl?
8 DR. DAMBERG: Yes.
9 MS. KELLEY: Tom?
10 DR. DILLER: Yes.
11 MS. KELLEY: Stacie?
12 DR. DUSETZINA: Yes.
13 MS. KELLEY: Kenny is a no.
14 Tamara?
15 DR. KONETZKA: Yes.
16 MS. KELLEY: Gokhan?
17 DR. METAN: Yes.
18 MS. KELLEY: Brian?
19 DR. MILLER: No.
20 MS. KELLEY: Greg?
21 MR. POULSEN: Yes.
22 MS. KELLEY: Wayne?

1 DR. RILEY: Yes.

2 MS. KELLEY: Scott?

3 DR. SARRAN: Yes.

4 MS. KELLEY: Gina?

5 MS. UPCHURCH: Yes.

6 MS. KELLEY: Betty?

7 DR. RAMBUR: Yes.

8 MS. KELLEY: Mike?

9 DR. CHERNEW: Yes.

10 MS. KELLEY: And Josh is not present.

11 DR. LIAO: I am, and I'm a yes.

12 MS. KELLEY: Oh, Josh is here. Thank you, Josh.

13 I'm sorry, can you say again?

14 DR. LIAO: Yes.

15 MS. KELLEY: Thank you.

16 That's it, Mike.

17 DR. CHERNEW: All right. So thank you all for

18 that.

19 We are now going to just take a quick breath.

20 We're going to change the folks that are presenting, and

21 we're going to come back in a minute or two, and we're

22 going to do hospital inpatient and outpatient services.

1 So, again, to the staff, I know you've been
2 thanked a lot, but I guess we can never thank you enough.
3 So thank you.

4 [Pause.]

5 DR. CHERNEW: All right. We're ready to go.
6 Alison, lead us off.

7 MS. BINKOWSKI: Thank you, Mike. Good morning
8 and welcome back to MedPAC's January 2026 public meeting.
9 The audience can download a PDF version of these slides in
10 the Materials section of the control panel on the top
11 right-hand side of the screen.

12 In today's update to the December presentation on
13 hospital payments I will provide a brief overview of
14 hospital use and spending under fee-for-service Medicare;
15 summarize our assessment of payment adequacy indicators for
16 fee-for-service Medicare payments to hospitals; and
17 conclude with the draft recommendation presented in
18 December. Your mailing materials include additional
19 information, including some updates in response to
20 Commissioner comments during the December meeting.

21 As a reminder from December, to pay general acute
22 care hospitals for the facility share of providing

1 inpatient and outpatient services, fee-for-service Medicare
2 generally sets prospective payment rates under the
3 inpatient and outpatient prospective payment systems.

4 In 2024, over 3,000 hospitals were paid under
5 these systems, and collectively payments under these
6 systems, including those for uncompensated care and
7 separately payable drugs, totaled nearly \$185 billion.

8 More details on our payment adequacy framework
9 and our assessment of the adequacy of fee-for-service
10 Medicare payments to hospitals were presented in December
11 and are in your mailing materials, so today I will briefly
12 summarize the results from each of the four categories of
13 indicators.

14 Our first category of payment adequacy indicators
15 relate to beneficiaries' access to hospital care. We found
16 these indicators were positive in fiscal year 2024.
17 Specifically, hospitals continued to have available
18 capacity in aggregate, including an aggregate occupancy
19 rate of 71 percent, though some exceeded capacity at times.
20 The supply of hospitals was relatively steady at about
21 4,500, and the volume of fee-for-service hospital services
22 per capita increased: inpatient stays per beneficiary

1 increased 1.5 percent and outpatient encounters per
2 beneficiary increased 4 percent.

3 Our second category of payment adequacy
4 indicators relate to the quality of hospital care. We
5 found these indicators were mixed in fiscal year 2024.
6 Specifically,
7 fee-for-service Medicare beneficiaries' risk-adjusted
8 mortality rate improved slightly, while the readmission
9 rate worsened slightly, and most patient experience
10 measures remained stable from last year, though many
11 remained low.

12 Our third category of payment adequacy indicators
13 relate to hospitals' access to capital. We found these
14 indicators improved. Specifically, in 2024, hospitals'
15 all-payer operating margin increased to 6.5 percent;
16 financial statements from eight large hospital systems
17 suggest that hospitals' all-payer operating margin
18 continued to increase in 2025; and the measures of
19 hospitals' access to capital improved in both fiscal year
20 2024 and 2025.

21 Our fourth and final category of payment adequacy
22 indicators relate to the comparison of fee-for-service

1 Medicare payments and hospitals' costs. We found that
2 hospitals' fee-for-service Medicare margin remained low but
3 increased in fiscal year 2024, and we project a continued
4 increase in 2026. Specifically, in 2024, hospitals' fee-
5 for-service Medicare margin remained low but increased
6 slightly to -12.1 percent. Furthermore, among the 13
7 percent of hospitals that we identified as relatively
8 efficient based on their historic performance, the median
9 fee-for-service Medicare margin was slightly negative, at -
10 1 percent; and looking forward to 2026, we project
11 hospitals' fee-for-service Medicare margin to increase
12 about 2 percentage points, to negative 10 percent in
13 aggregate and positive 1 percent for the median relatively
14 efficient hospital.

15 As a reminder, since 2023, the Commission has
16 recommended implementing the Medicare Safety-Net Index. As
17 described in more detail in our March 2023 report, our
18 recommended MSNI better targets hospitals that serve large
19 shares of low-income Medicare patients, better targets
20 hospitals with lower all-payer margins than the current
21 disproportionate-share hospital metric, and has other
22 advantages, such as direct payments to hospitals for both

1 their fee-for-service and Medicare Advantage patients.

2 Other safety-net programs, such as the 340B drug
3 program, could continue to use other metrics.

4 As shown in the figure on the right, we found
5 that in fiscal year 2024 the MSNI continued to better
6 target Medicare resources to hospitals with low all-payer
7 margins.

8 In considering how to update fee-for-service
9 Medicare payments to hospitals, the draft recommendation
10 aims to balance several objectives. These include
11 maintaining payments high enough to ensure beneficiaries'
12 access to care; maintaining payments close to hospitals'
13 cost of providing high-quality care efficiently to ensure
14 value for taxpayers and beneficiaries; maintaining fiscal
15 pressure on hospitals to constrain costs; and limiting the
16 need for large, across-the-board payment rate increases by
17 better targeting Medicare payments to Medicare safety-net
18 hospitals serving large shares of vulnerable Medicare
19 patients

20 I now turn to the draft recommendation. The
21 draft recommendation reads:

22 The Congress should, for 2027, update the 2026

1 Medicare base payment rates for general acute care
2 hospitals by the amount specified in current law, and
3 implement the Medicare Safety-Net Index described in our
4 March 2023 report with an additional \$1 billion added to
5 the Medicare Safety-Net Index pool.

6 In terms of implications, the draft
7 recommendation is estimated to increase spending relative
8 to current law by \$750 million to \$2 billion in 1 year and
9 \$5 billion to \$10 billion over 5 years. We estimate this
10 increased spending would increase hospitals' fee-for-
11 service Medicare margin by less than 1 percentage point
12 above current law in aggregate, and by 3 percentage points
13 for hospitals in the highest MSNI quartile. We also expect
14 this recommendation will help maintain hospitals'
15 willingness to treat fee-for-service Medicare beneficiaries
16 and maintain beneficiaries' access to care by improving the
17 financial stability of hospitals serving large shares of
18 low-income Medicare beneficiaries.

19 I now turn it back to Mike.

20 DR. CHERNEW: Great. This is such important
21 work, and thank you very much. So we are going to then go
22 through the queue, and Brian, I think you have a comment.

1 DR. MILLER: I do. Thank you for this work.
2 Hospital CEOs tell me that the OPPS hand-washes the IPPS
3 hand, and in fact, a hospital CEO I know called me over the
4 holidays when I was on vacation to remind me of this fact,
5 which was one of which I am well aware of. Which makes me
6 worry that perhaps we are not updating IPPS high enough and
7 that the OPPS update is too high and should be lower. I do
8 think that these updates should probably be separate.

9 I appreciate the staff adding in estimates for
10 site neutral expansion to accepted off-campus locations and
11 on-campus locations. In particular, I noted that
12 implementing, per the staff's calculations, off-campus
13 accepted locations would result in an increase in all OPPS
14 payments to other facilities due to budget neutrality,
15 which was an excellent catch by the staff, and would
16 increase payments to rural hospitals. And noting that
17 we're all concerned about rural hospitals and access and
18 them continuing as a going concern, I thought that was a
19 very interesting finding, and think that we should also
20 look at this question for on-campus HOPDs. Great work.

21 MS. KELLEY: I have Lynn next.

22 MS. BARR: Thank you very much. I always enjoy

1 your work so much. Five years of just great information.

2 Thank you so much.

3 I just want to say that the Medicare Safety-Net
4 Index recommendation we made in 2023 is critically
5 important to shore up the safety net, and particularly
6 rural hospitals. We all know that rural hospitals are
7 going to be disproportionately affected by what's coming,
8 and the safety net is going to be disproportionately
9 affected by the Medicaid cuts. This is a small amount of
10 additional money but it's mostly redistribution.

11 The DSH formula was invented when Medicare wasn't
12 as prevalent as it is today. So now everyone's DSH, and
13 therefore nobody's DSH. So what we need to do is go back
14 to the thoughts behind DSH and make sure that we are
15 targeting the safety net hospitals and preserving them and
16 preserving access, because we can see in all of our
17 indicators that the safety net is suffering this
18 proportionally and will continue to do so. So I really
19 urge Congress to adopt our recommendations about the
20 Safety-Net Index. We're just really recalculating the DSH
21 formula. We're not getting rid of 340B. There is no
22 reason to oppose this, and it is really what DSH was

1 intended for.

2 So thank you for this great work.

3 MS. KELLEY: Gina.

4 MS. UPCHURCH: Yes. Let me pile on. Thank you
5 for this tremendous amount of work and taking our feedback
6 from the last meeting.

7 We know with decreased subsidies to the
8 Affordable Care Act plans, as Lynn mentioned the Medicaid
9 cuts coming down the pile potentially, we're going to have
10 more uninsured people. We are reminded, through EMTALA,
11 that hospitals need to stabilize folks. I know our job is
12 not to look at all payers, but the reality is that that's
13 in place.

14 The other thing related to Medicare is when they
15 hit Medicare age, they're going to be sicker. So it makes
16 sense to me to support this recommendation, and I'm really
17 thankful for the Medicare Safety-Net Index additional
18 support.

19 And just another reminder that the squeeze from
20 340B pricing on hospitals is another thing they're having
21 to keep their eyes on. And we know, just even locally,
22 that charity care policies are already changing, and

1 they're getting tighter because hospitals can't take it all
2 on. So we need to keep an eye on the charity care and
3 hardship policies of these hospitals, because they're
4 already starting to get tighter.

5 But thank you for this great work, and I support
6 the recommendation.

7 MS. KELLEY: All right. I have a comment from
8 Kenny. He appreciates the additional commentary on site
9 neutral and its implications. That said, given CMS
10 direction and MedPAC's earlier diligent advocacy on
11 fostering site neutrality, he believes that we need to have
12 two separate updates to better inform the issue and
13 interface with the physician fee schedule update. As such,
14 he struggles with the chair's recommendation as he is
15 unable to fully assess its accuracy, and he will abstain
16 from voting.

17 I have Paul next.

18 DR. CASALE: I'm adding my thanks for a
19 tremendous chapter. Just a very brief comment, which is
20 looking at the hospital patient experience data. You know,
21 the share of patients who get discharge information is
22 around 86 percent, but understanding their care is like 52

1 percent. So it speaks to that fragmentation of care that
2 really, I think, is one of the many drivers of increasing
3 costs, unnecessary care. I appreciate that you've included
4 in that, but I just want to continue to highlight the
5 opportunity for hospitals to help to reduce that
6 fragmentation through better coordination of care. Thank
7 you.

8 MS. KELLEY: Greg.

9 MR. POULSEN: Thanks. I just want to make note
10 that hospitals are paid through a hodgepodge of different
11 sources today, and some of them we've talked about very
12 explicitly, MSNI, 340B. I mean, there's a bunch. And at
13 least in my view they individually, none of them make a ton
14 of sense, but collectively they provide support for
15 organizations.

16 And then Brian mentioned something that I think
17 would help us to move in that direction over time. I'm
18 certainly not suggesting that for this round, but I do
19 think that creating the IPPS and OPSS as different
20 characteristics going forward, so that we can look at them
21 individually, look at their validity and their value
22 individually, going forward, would be a beneficial effect,

1 not to mention that each of them individually are bigger
2 numbers than most of the other things we're going to vote
3 on in the next few minutes. So I think that probably makes
4 sense.

5 But I'm supportive of the recommendation,
6 grateful for the good work, and that would just be
7 something we might consider going forward.

8 MS. KELLEY: Cheryl.

9 DR. DAMBERG: Again, thank you so much for this
10 work. So the recommendation has two components, and I
11 really want to focus on the Medicare Safety-Net Index. I
12 strongly support that aspect of the recommendation. That's
13 a really important feature of the recommended update. It
14 better targets resources to those most in need, and it will
15 serve to strengthen the margins for those facilities that
16 serve those with the greatest needs. So I also strongly
17 support the recommendation that Congress should work to
18 include that.

19 MS. KELLEY: I think that's the end of the
20 comments, unless someone wants to jump in. Mike?

21 DR. CHERNEW: Okay. So in a second, we'll go to
22 a vote. I just want to say, for those at home that haven't

1 yet seen them, we did take seriously this issue of IPPS
2 versus OPPS margin. We did do some analysis on that. And
3 we found, at least in the work that was done, that the
4 margins seemed similar between IPPS and OPPS, anecdotes
5 aside. The challenge, of course, is the issues of OPPS
6 dovetail with ASCs, for example, that we'll talk about
7 later, dovetail with physician office, dovetail with site
8 neutral stuff. I actually think many of you are strongly
9 supportive of sort of a more holistic view, and should the
10 next chair -- that's going to be the first time I've said
11 that in public -- should the next chair want to do that, I
12 think that's worthy of some broader thinking and fits with
13 the general sense of trying to continue to target things
14 better to the extent we can. But we always do, as we do
15 with the safety net work, have a separate workstream for
16 that, as we do with site neutral, and then bring that
17 thinking into what we're doing.

18 So that's just sort of the plan. But where we
19 are now with the update is trying to get a general sense
20 where we can apply all of our criteria, like access to
21 capital and things which are hard to separate out between
22 IPPS and OPPS, and a whole bunch of other things.

1 So there's a lot there. I do think the delivery
2 system is changing dramatically, and keeping a pulse on
3 those changes is important. But this is where we are in
4 our update recommendation.

5 So now we are going to move through the votes.
6 Dana, do you want to do the roll call?

7 MS. KELLEY: All right. Voting on the
8 recommendation, which reads, the Congress should, for 2027,
9 update the 2026 Medicare base payment rates for general
10 acute care hospitals by the amount specified in current law
11 and implement the Medicare Safety-Net Index, described in
12 our March 2023 report, with \$1 billion added to the MSNI
13 poll.

14 Voting yes or no, Lynn?

15 MS. BARR: Yes.

16 MS. KELLEY: Paul?

17 DR. CASALE: Yes.

18 MS. KELLEY: Robert?

19 DR. CHERRY: Yes.

20 MS. KELLEY: Cheryl?

21 DR. DAMBERG: Yes.

22 MS. KELLEY: Tom?

1 DR. DILLER: Yes.
2 MS. KELLEY: Stacie?
3 DR. DUSETZINA: Yes.
4 MS. KELLEY: Kenny?
5 MR. KAN: Abstain.
6 MS. KELLEY: Tamara?
7 DR. KONETZKA: Yes.
8 MS. KELLEY: Gokhan?
9 DR. METAN: Yes.
10 MS. KELLEY: Josh?
11 DR. LIAO: Yes.
12 MS. KELLEY: Brian?
13 DR. MILLER: Abstain.
14 MS. KELLEY: Greg?
15 MR. POULSEN: Yes.
16 MS. KELLEY: Wayne?
17 DR. RILEY: Yes.
18 MS. KELLEY: Scott?
19 DR. SARRAN: Yes.
20 MS. KELLEY: Gina?
21 MS. UPCHURCH: Yes.
22 MS. KELLEY: Betty?

1 DR. RAMBUR: Yes.

2 MS. KELLEY: Mike?

3 DR. CHERNEW: Yes.

4 MS. KELLEY: Okay.

5 DR. CHERNEW: Thank you all, and again to the
6 staff, thank you for all of the work and all the extra
7 stuff you did, when there's a lot going on, so I really do
8 appreciate it. So again, thank you.

9 DR. CHERNEW: We're now going to have our next
10 transition to what's going to be an even more rapid
11 lightning round of how we're going to go through this. But
12 we're going to move to assessing the payment adequacy of
13 SNFs, home health agencies, rehab facilities, outpatient
14 dialysis, and hospice. And Dana, if I have this right,
15 we're going to have a brief presentation on each. We'll
16 then go to a vote, and then the next presentation and the
17 next vote. So we're all on the same page. So okay, let's
18 switch over. Thank you.

19 [Pause.]

20 DR. CHERNEW: Okay, everybody. Gina, Paul,
21 Cheryl. All right.

22 MR. MASI: We're live.

1 DR. CHERNEW: I know we're live. People at home
2 get to see the sausage making.

3 All right. We are now going to go through all of
4 the post-acute sectors and dialysis. They're all
5 important. We've had a lot of discussion on these, and so
6 we're going to have a brief presentation on each and then a
7 vote. I think, Brian, you're going to start with SNF. Is
8 that right?

9 MR. KLEIN-QIU: That's right. I will start again.
10 Good morning. We present our work assessing payment
11 adequacy for skilled nursing facility services. The
12 audience can download a PDF version of these slides in the
13 Materials section of the control panel on the top right-
14 hand side of the screen.

15 We will review the indicators for SNF using the
16 same framework you saw in the other sectors. This
17 presentation summarizes information that was presented in
18 more detail at our December meeting, and there is more
19 information presented in your mailing materials. Those
20 materials were updated to reflect Commissioners' discussion
21 and questions at the December meeting.

22 This slide provides an overview of the SNF sector

1 in 2024. That year there were about 14,400 SNFs, most of
2 which also provide long-term care that makes up the bulk of
3 services this sector provides. The median fee-for-Service
4 Medicare share of total facility days was 8 percent.

5 In 2024, there were 1.5 million fee-for-service
6 Medicare-covered SNF stays. The program and its
7 beneficiaries paid \$34 billion for care in SNFs and SNF
8 care provided in swing beds.

9 As discussed in the December 2025 meeting, the
10 four categories of payment adequacy indicators were
11 generally positive. Our access indicators show that supply
12 of facilities and volume declined slightly, but neither
13 reflects adequacy of fee-for-service rates. Occupancy
14 rates increased to about their pre-pandemic levels.

15 Measures of quality show little or no change.

16 SNFs have adequate access to capital and the
17 sector remains attractive to investors. The total margin
18 improved compared to 2023.

19 In continuation of a now decades-long trend, the
20 average Medicare margin in 2024 was high. Factoring in
21 expected changes to payments and costs, the projected
22 margin for 2026 is even higher at 25 percent.

1 The draft recommendation reads:

2 For fiscal year 2027, the Congress should reduce
3 the 2026 Medicare base payment rates for skilled nursing
4 facilities by 4 percent.

5 In terms of implications, on spending, relative
6 to current law, spending would decrease by between \$2
7 billion to \$5 billion in 1 year and by between \$10 billion
8 to \$25 billion over 5 years. We do not expect adverse
9 effects on access to care due to continued provider
10 willingness and ability to treat fee-for-service
11 beneficiaries.

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

13 DR. CHERNEW: Great. So I think -- I'm just
14 working through Dana -- do we have anyone in the queue? My
15 computer is a little frozen.

16 MS. KELLEY: I don't have anyone in the queue.
17 Oh, I'm sorry, Brian.

18 DR. CHERNEW: Oh, Brian and Tamara, then. I'm
19 having a little tech issue.

20 MS. KELLEY: Brian, you go ahead.

21 DR. MILLER: Tamara was first.

22 MS. KELLEY: Oh, I'm sorry. Tamara.

1 DR. KONETZKA: Yes. Thank you so much, Brian,
2 and Carol, if you're listening. I always appreciate your
3 work on this. Two brief comments. One, really appreciated
4 the simulations of the nursing home care compare star
5 ratings at the end. I would really love to see one that
6 has more of a percentile. I know it was probably not
7 possible for March, but I just think that's the only thing
8 that probably would eventually be implemented. So it would
9 be great to see that at some point.

10 But about the draft recommendations here, I think
11 given the constraints of this exercise, where we don't
12 really consider the effects of other payers, except in a
13 sort of viability and access to capital sense, given the
14 constraints of this exercise and given Commission
15 principles, the recommendation makes sense. I think
16 margins are really high, and they're high kind of across
17 the board. So even sort of the lowest group of margins are
18 still attracting some pretty high margins.

19 I say that within our constraints this makes
20 sense, but I just want to sort of voice that it's
21 increasingly sort of unsatisfying to have these
22 constraints. I think in the nursing home sector there are

1 a lot of sources of uncertainty right now. There is
2 workforce. There is the Medicaid cuts. There are
3 pressures from MA. And so I really think it's important,
4 as we move forward, to sort of move beyond the constraints
5 of this particular exercise and look at the sort of overall
6 viability of SNF payment and the welfare of the
7 beneficiaries who are in there, looking at models like I-
8 SNPs that can sort of break down some of those barriers
9 across payers.

10 So I just wanted to voice that it is the right
11 decision within these constraints, but I hope we can move
12 beyond the constraints. Thanks.

13 MS. KELLEY: Brian.

14 DR. MILLER: Thank for this work from the three
15 of you. I appreciate Scott and Tamara pushing I-SNPs and
16 thinking about the long-term care population within the SNP
17 population. I really liked the work that you all did on
18 the proposed rebalancing of star ratings away from
19 inspections and towards staffing. That's a way of getting
20 at staffing that is a dynamic way rather than a specific,
21 rigid requirement of a business model. And I'm very
22 supportive of the recommendation for reducing costs.

1 I guess my question is are there other tools,
2 because we have the Comptroller General who came and talked
3 with us about payment rules, the guidance, program
4 competition, fraud, waste, and abuse. We have a range of
5 tools, and I'm wondering if there's a way that we can
6 reduce payment but also improve the marketplace. I think
7 of the post-acute care, and particularly the skilled
8 nursing facility marketplace is suffering from a two fruit
9 cup problem, as they call it, where the focus is on
10 compliance instead of performance, because you want to meet
11 the requirements of participation, which are lengthy,
12 detailed, micromanage-y, and then there is, I believe it's
13 an 843-page guidance document that follows that at the
14 federal level.

15 So can we look at pushing some of the compliance
16 regulations to the state and local level, which are
17 duplicating, frankly, the federal compliance, and then move
18 the regulatory regimen from skilled nursing facilities more
19 towards performance-based regulation and push the
20 facilities to perform rather than collapsing the ceiling
21 and floor. And then we could use that to better parse
22 payment and performance in this space.

1 MS. KELLEY: Scott.

2 DR. SARRAN: Yep. Very briefly, first to Brian's
3 comment, yeah, I think the ratio of regulations to useful
4 outcome from the regulations is pretty poor in this
5 setting.

6 I very much appreciate the work that we've done
7 to push on changing the formula for measuring quality,
8 accentuating the staffing component. I think that's
9 excellent.

10 And to Tamara's point, what I think is within our
11 swim lane, reasonably, over a short period of time, is to
12 understand the impact of MA payments on SNF, because we're
13 increasingly looking at a smaller and smaller piece of the
14 nursing facility pie. A piece of that pie is outside our
15 swim lane, of course because it's Medicaid. But in
16 totality, understanding how MA impacts the overall margins
17 of nursing facilities is very important.

18 MS. KELLEY: Mike, that is all I have in the
19 queue.

20 DR. CHERNEW: Great. Again, thank you, Brian,
21 for the presentation. Dana, I think we should move right
22 through to the vote, and then maybe as we're doing that, we

1 could start the transition to home health. Evan, you're
2 going to be doing home health? So we're going to do the
3 vote, and then we're going to go to Evan.

4 MS. KELLEY: Voting on the recommendation which
5 reads: For fiscal year 2027, the Congress should reduce the
6 2026 Medicare base payment rates for skilled nursing
7 facilities by 4 percent.

8 Voting yes or no, Lynn?

9 MS. BARR: Yes.

10 MS. KELLEY: Paul?

11 DR. CASALE: Yes.

12 MS. KELLEY: Robert?

13 DR. CHERRY: Yes.

14 MS. KELLEY: Cheryl?

15 DR. DAMBERG: Yes.

16 MS. KELLEY: Tom?

17 DR. DILLER: Yes.

18 MS. KELLEY: Stacie?

19 DR. DUSETZINA: Yes.

20 MS. KELLEY: Kenny?

21 MR. KAN: Yes.

22 MS. KELLEY: Tamara?

1 DR. KONETZKA: Yes.

2 MS. KELLEY: Gokhan?

3 DR. METAN: Yes.

4 MS. KELLEY: Josh? I think Josh is having
5 trouble with his microphone. Brian?

6 DR. MILLER: Yes.

7 MS. KELLEY: Greg?

8 MR. POULSEN: Yes.

9 MS. KELLEY: Wayne?

10 DR. RILEY: Yes.

11 MS. KELLEY: Scott?

12 DR. SARRAN: Yes.

13 MS. KELLEY: Gina?

14 MS. UPCHURCH: Yes.

15 MS. KELLEY: Betty?

16 DR. RAMBUR: Yes.

17 MS. KELLEY: Mike?

18 DR. CHERNEW: Yes. Okay. Josh is having problems
19 with his microphone. Do you want to read in his vote?

20 MS. KELLEY: Josh has sent a message saying that
21 he is having mic problems but his vote is a yes.

22 DR. CHERNEW: Great. Thank you, Josh. And now

1 we're going to jump onto Evan talking about home health.

2 MR. CHRISTMAN: Thanks, Mike. Next, I will recap
3 the payment adequacy indicators for home health and then I
4 will present the draft recommendation. More detailed
5 information on our indicators is in the paper you received,
6 which has been updated to reflect your comments from the
7 December meeting.

8 Before turning to our indicators, here is a brief
9 overview of home health care in Medicare fee-for-service.
10 In 2024, there were about 12,000 agencies participating in
11 the fee-for-service program. Those agencies served 2.7
12 million fee-for-service beneficiaries, and delivered 8.3
13 million 30-day periods of home health care. Total fee-for-
14 service payments in 2024 equaled \$16.0 billion.

15 This brings us to a summary of our indicators,
16 which are generally positive. The supply of home health
17 agencies declined by 1 percent in 2024. I would note that
18 this is excluding California, particularly Los Angeles
19 County, but we would note that if we did include it that
20 the supply would've increased. We note that in L.A. there
21 has been high growth in spending and the supply of home
22 health, in an area that has experienced significant program

1 integrity concerns, and we talk a little bit about that in
2 the chapter.

3 Ninety-seven percent of beneficiaries live in a
4 ZIP code with two or more home health agencies, and the
5 fee-for-service Medicare per capital volume increased.

6 For quality of care, the fee-for-service Medicare
7 beneficiaries risk-adjusted discharge to community rate was
8 stable, and the patient experience measures also were high
9 and were stable.

10 For access to capital, the all-payer margin was 5
11 percent in 2024, and we note that while acquisition of home
12 health agencies has slowed in recent years, some firms
13 still continue to acquire HHAs and expand.

14 For payments and costs, we noted that the fee-
15 for-service Medicare margin in 2024 was 21.2 percent, and
16 the projected fee-for-service Medicare margin for 2026 was
17 19 percent.

18 This brings me to the draft recommendation. It
19 reads, For calendar year 2027, the Congress should reduce
20 the 2026 Medicare base payment rate for home health
21 agencies by 7 percent.

22 Relative to current law, spending would decrease

1 by between \$750 million to \$2 billion in 1 year and by
2 between \$10 billion to \$25 billion over 5 years. We do not
3 expect this recommendation to have an adverse impact on
4 access to care, and we expect continued provider
5 willingness and ability to treat fee-for-service
6 beneficiaries.

7 This completes my presentation and I turn it back
8 to you, Mike.

9 DR. CHERNEW: Thank you. My computer is
10 periodically freezing, so I'm going to have to ask Dana if
11 you have anyone in the queue.

12 MS. KELLEY: I don't have anyone in the queue,
13 but I'll pause for a minute to just make sure. Okay.

14 DR. CHERNEW: Okay. Then we will go to our roll
15 call vote. And I realize as we -- oh, okay, Gina is trying
16 to get in.

17 MS. KELLEY: I'm sorry. Go ahead, Gina.

18 MS. UPCHURCH: Sorry. I sent it to the wrong
19 thing.

20 First of all, thank you for the great work. Just
21 quickly, I just want to show appreciation for agreeing to
22 look forward in future work at the delays in home health

1 getting initiated. I just think that's a problem, and I'm
2 glad we're moving that direction.

3 And then a second consideration is how fee-for-
4 service Medicare and Medicare Advantage make it more or
5 less difficult to get potential DME in the home. For
6 example, grab bars, a chair in the shower, just seeing how
7 those compare related to DME access.

8 So thank you for the work, and I certainly
9 support the recommendation.

10 MS. KELLEY: Tom.

11 DR. DILLER: I'm new to this process and just
12 kind of raising an issue. I recognize that we are only
13 considering fee-for-service Medicare and its effects on
14 this. But we just voted for SNF reduction of 4 percent
15 with margins at 25 percent, and these margins are 21
16 percent and we're voting for a 7 percent reduction. So I
17 guess I'm not sure I follow the logic of how we came up
18 with those.

19 But in general I am supportive of the
20 recommendation. I do think that reductions in spending
21 need to occur.

22 MS. KELLEY: Greg.

1 MR. POULSEN: Just a real quick comment. I just
2 wanted to make sure that we -- it's in the chapter and we
3 discussed it last time, but I just wanted to put in the
4 record for info for everybody who is listening that the big
5 differences in home health and hospice, which we'll talk
6 about, between the performance and the cost perspectives of
7 for-profit and not-for-profit agencies. And I just wanted
8 to mention that in passing.

9 MS. KELLEY: Okay. I think that's all we have in
10 the queue.

11 DR. CHERNEW: Great. And so first we're going to
12 take a vote in a second, and then I think we're going to
13 move on to IRFs, and I think that's Laurie. But first let
14 me do the vote. I want to say one thing for Tom's comment.

15 These are always challenging in these situations,
16 particularly when the margins are very high and we're
17 trying to largely just signal the direction. I think the
18 issue between, say, home health and SNF had to do with sort
19 of other challenges in the sector and how we thought that
20 would be the case. I think my general view is that despite
21 margins that are very high, we have to be cautious when we
22 make changes. And so we make recommendations that are

1 signaling a direction, but we certainly don't go all the
2 way as we could go. And then it's just a judgment call
3 between all the other things that are going on in these
4 sectors, that it's very complicated.

5 But, you know, hopefully the bigger message is
6 the direction than the specific number. Anyway, okay.
7 Let's do the vote, Dana.

8 MS. KELLEY: All right. Voting on the
9 recommendation, which reads, For calendar year 2027, the
10 Congress should reduce the 2026 Medicare base payment rates
11 for home health care services by 7 percent.

12 Voting yes or no, Lynn?

13 MS. BARR: Yes.

14 MS. KELLEY: Paul?

15 DR. CASALE: Yes.

16 MS. KELLEY: Robert?

17 DR. CHERRY: Yes.

18 MS. KELLEY: Cheryl?

19 DR. DAMBERG: Yes.

20 MS. KELLEY: Tom?

21 DR. DILLER: Yes.

22 MS. KELLEY: Stacie?

1 DR. DUSETZINA: Yes.

2 MS. KELLEY: Kenny?

3 MR. KAN: Yes.

4 MS. KELLEY: Tamara?

5 DR. KONETZKA: Yes.

6 MS. KELLEY: Gokhan?

7 DR. METAN: Yes.

8 MS. KELLEY: Josh? Still having trouble with his
9 microphone, I think. Brian?

10 DR. MILLER: Yes.

11 MS. KELLEY: Greg?

12 MR. POULSEN: Yes.

13 MS. KELLEY: Wayne?

14 DR. RILEY: Yes.

15 MS. KELLEY: Scott?

16 DR. SARRAN: Yes.

17 MS. KELLEY: Gina?

18 MS. UPCHURCH: Yes.

19 MS. KELLEY: Betty?

20 DR. RAMBUR: Yes.

21 MS. KELLEY: Mike?

22 DR. CHERNEW: Yes. And Josh was able to send a

1 message that his mic is still not working.

2 MS. KELLEY: All right. Thank you. And his vote
3 is yes. Thank you. All right then.

4 DR. CHERNEW: All right. So now we're going to
5 go to Laurie on IRFs. Am I right?

6 MR. MASI: Yes.

7 DR. FEINBERG: Next, we continue with the update
8 to Medicare's payments to Inpatient Rehabilitation
9 Facilities, which I will refer to as IRFs. This
10 presentation summarizes information that was presented in
11 more detail at our December meeting, and there is more
12 information presented in your mailing materials. Those
13 materials were updated to reflect Commissioners' discussion
14 and questions at the December meeting.

15 This slide provides an overview of the IRF sector
16 in 2024. There were about 1,170 IRFs and about 435,000
17 stays. Medicare spent about \$11.0 billion paid by Medicare
18 and its beneficiaries on IRF care provided to fee-for-
19 service beneficiaries. Fee-for-service Medicare accounted
20 for about 51 percent of IRFs' discharges.

21 As we discussed in the December 2025 meeting, in
22 summary, our four categories of payment adequacy indicators

1 for IRFs were generally positive. First, in terms of fee-
2 for-service Medicare beneficiaries' access to care, IRFs
3 continue to have capacity that appears to be adequate to
4 meet demand.

5 Second, in 2024, we are now reporting claims-
6 based quality measures developed by CMS. We looked at the
7 rate of successful discharge to the community and the rate
8 of potentially preventable readmissions. The median
9 facility risk-adjusted rate of successful discharge to the
10 community remained stable at 67.5 percent during the fiscal
11 year 2023 and fiscal year 2024 period. The median risk-
12 adjusted facility rate of potentially preventable
13 readmissions was 9.2 percent, also stable.

14 Third, as I noted in your paper, two-thirds of
15 IRFs are hospital-based. These IRFs access capital through
16 their parent institutions. The all-payer margin for
17 freestanding IRFs was 12 percent in 2024. Freestanding
18 IRFs maintain good access to capital markets.

19 Fourth, Medicare payments and IRFs costs
20 indicators were positive. In 2024, the aggregate Medicare
21 margin was 17.1 percent. We project a margin of 18 percent
22 in 2026.

1 And so that brings us to the draft
2 recommendation. The draft recommendation reads, For fiscal
3 year 2027, the Congress should reduce the 2026 Medicare
4 base payment rate for inpatient rehabilitation facilities
5 by 7 percent.

6 To review the implications of this
7 recommendation, on spending, relative to current law,
8 spending would decrease by between \$2 billion to \$5 billion
9 in 1 year and by between \$10 billion to \$25 billion over 5
10 years. On beneficiaries and providers, we don't expect
11 adverse impacts on access to care, and we expect continued
12 provider willingness and ability to treat fee-for-service
13 beneficiaries

14 I now turn it back to Mike.

15 DR. CHERNEW: Laurie, thank you. I think we have
16 Brian in the queue.

17 MS. KELLEY: Yep. Go ahead, Brian.

18 DR. MILLER: Thanks. I really appreciate the
19 staff effort to flesh out this chapter. It's gotten much
20 more meaty without getting really long, and I know that's
21 hard, so thank you.

22 I noted that the indirect allocation of overhead

1 may account for differences in some of the costs between
2 freestanding and hospital-based IRFs, and it's nice to see
3 that that has been emphasized.

4 One thing that I also wanted to call out from
5 this chapter is I noted that there are increasing margins
6 with size, which again, you know, obviously we're thinking
7 about appropriate payment level, but at the broader level
8 suggests economies of scale and systematized operations.
9 And that's something I think that we should look at in the
10 IRF industry and see do the other parts of the hospital
11 industry actually have that, and if not, what is the
12 difference? Because that's something that we want to see.

13 I also know that many of my fellow Commissioners
14 have concerns about access to post-acute care in MA and
15 would note that there's no network adequacy requirement for
16 IRFs for MA, and that's probably something we should
17 consider commenting on, maybe not in this particular
18 context, but in another context.

19 And similar to my comment on SNFs, I support the
20 payment recommendation, but wonder if there are other tools
21 that we can use to get to that same spot rather than just a
22 payment cut. I'm obviously supportive of the payment cut.

1 The qualifying condition list is 20 years old. It can
2 vote, serve in the military, and in some states, buy
3 alcohol. Perhaps there is a broader list of beneficiaries
4 who would benefit in terms of conditions from intensive
5 therapy that IRFs offer, which would also then modulate
6 profitability of the industry and improve functional
7 status.

8 So I think, do you want to make Hyundais or do
9 you want to make Rolls-Royce? Hyundais have fewer profits,
10 but there are more of them. Rolls-Royce is more profit per
11 vehicle but fewer vehicles. Is there a way to modulate the
12 profitability of the industry and get the profit margin
13 more to where we think the payment level is appropriate by
14 looking at regulatory tools that would change the
15 populations treated?

16 MS. KELLEY: That's all I have in the queue,
17 Mike.

18 DR. CHERNEW: Okay.

19 Laurie, thank you.

20 I think we're now going to take the vote, but
21 then maybe we only have a few chairs up there, so I think
22 we might want to switch over to the dialysis and hospice

1 teams. But let's go through the vote.

2 MS. KELLEY: All right. Voting on the
3 recommendation, which reads: For fiscal year 2027, the
4 Congress should reduce the 2026 Medicare-based payment rate
5 for inpatient rehabilitation facilities by 7 percent.

6 Voting yes or no.

7 Lynn?

8 MS. BARR: Yes.

9 MS. KELLEY: Paul?

10 DR. CASALE: Yes.

11 MS. KELLEY: Robert?

12 DR. CHERRY: Yes.

13 MS. KELLEY: Cheryl?

14 DR. DAMBERG: Yes.

15 MS. KELLEY: Tom?

16 DR. DILLER: Yes.

17 MS. KELLEY: Stacie?

18 DR. DUSETZINA: Yes.

19 MS. KELLEY: Kenny?

20 MR. KAN: Yes.

21 MS. KELLEY: Tamara?

22 DR. KONETZKA: Yes.

1 MS. KELLEY: Gokhan?
2 DR. METAN: Yes.
3 MS. KELLEY: Josh?
4 [No response.]
5 MS. KELLEY: I think still having trouble with
6 his mic.
7 Brian?
8 DR. MILLER: Yes.
9 MS. KELLEY: Greg?
10 MR. POULSEN: Yes.
11 MS. KELLEY: Wayne?
12 DR. RILEY: Yes.
13 MS. KELLEY: Scott?
14 DR. SARRAN: Yes.
15 MS. KELLEY: Gina?
16 MS. UPCHURCH: Yes.
17 MS. KELLEY: Betty?
18 DR. RAMBUR: Yes.
19 MS. KELLEY: Mike?
20 DR. CHERNEW: Yes.
21 MS. KELLEY: And we've received a message from
22 Josh that his vote is yes.

1 DR. CHERNEW: Wonderful.

2 And so now we're going to do dialysis, and is
3 that going to be -- is Grace doing dialysis? Yeah. Grace,
4 you're up for dialysis.

5 DR. OH: Next, we will turn to outpatient
6 dialysis facilities. More detailed information on
7 indicators is in your mailing materials.

8 Since the December meeting, we have made minor
9 editorial changes to reflect Commissioner feedback and
10 added text to clarify certain items as indicated in the
11 memo we sent you.

12 In 2024, there were roughly 240,500 fee-for-
13 service beneficiaries on dialysis, receiving on average 2.8
14 dialysis treatments per week at around 7,600 facilities.
15 Total fee-for-service spending for dialysis services was
16 about \$7.6 billion.

17 The indicators assessing payment adequacy are
18 generally positive. To recap what you have seen in
19 December, between 2023 and 2024, capacity as measured by
20 in-center stations declined by 1 percent but appears
21 aligned with demand, given that the number of all Medicare
22 beneficiaries on dialysis and both fee-for-service and MA

1 also declined by 1 percent during this time. Access
2 appears to be stable.

3 As for quality in 2024, all measures remain
4 steady or improved, with the exception of ED visits, which
5 increased, and mortality, which was stable but still
6 elevated relative to before the COVID-19 pandemic.

7 Indicators of access to capital are positive.
8 The two large dialysis organizations have reported positive
9 financial performance related to their dialysis business
10 for 2024, including improvements in productivity. In
11 addition, both large dialysis organizations are also
12 vertically integrated, suggesting good access to capital.
13 The 2024 all-payer margin was 16 percent.

14 Finally, the aggregate Medicare margin was 4.5
15 percent in 2024. The projected aggregate Medicare margin
16 in 2026 is 4 percent.

17 The 2026 projection does not include the TDAPA
18 for certain ESRD drugs, which in the past has improved
19 Medicare margins.

20 Historically, the fee-for-service Medicare margin
21 has varied over time, including some periods in which it
22 was negative or near zero and other periods when it was

1 substantially positive, but beneficiaries' access to care
2 has remained positive over time.

3 Based on our findings that suggest that
4 outpatient dialysis payments are adequate, the draft
5 recommendation reads: For calendar year 2027, the Congress
6 should eliminate the update to the 2026 Medicare base
7 payment rate for outpatient dialysis services.

8 This recommendation would decrease spending
9 relative to current law by 50- to \$250 million in one year
10 and \$1 billion to \$5 billion over five years.

11 We do not expect adverse impacts on access to
12 outpatient dialysis care. We expect continued provider
13 willingness and ability to treat fee-for-service
14 beneficiaries.

15 That concludes the presentation, and I will now
16 turn it back to Mike.

17 DR. CHERNEW: Thank you. And now I'm back, and I
18 think, Scott, you are the first in the queue.

19 DR. SARRAN: Yeah, very brief comment.

20 Given that the ED visits are up over time and
21 hospitalizations are high, even though they're at a steady
22 level, and seeing how a large chunk -- I think now it's

1 more than half of the population -- has transitioned to
2 become MA or get their care through MA rather than fee-for-
3 service, we want to highlight, I think, how important it
4 will be to look over time at whether MA is able to
5 outperform the fee-for-service sector on those measures.

6 If so, that will be important learnings that we
7 will want to see translated into the fee-for-service system
8 in one way, shape, or form.

9 MS. KELLEY: Brian?

10 DR. MILLER: Thank you for this work.

11 Across the academic research policy and political
12 spectrums, there's broad concern about the duopoly market
13 in the dialysis space, and many of the other Commissioners
14 have commented on this in past years.

15 We know that consolidation results in higher
16 costs, decreased quality, and there's even some evidence
17 that it results in decrements in the patient experience.
18 And so the patients are trapped in an in-center duopoly
19 marketplace.

20 Again, thinking about just as for other
21 marketplaces, along the lines of other comments I've made,
22 I think that we should be thinking about regulatory and

1 other tools to change the competition dynamics in this
2 marketplace. It's not easy. I think doing some work to
3 explore how we improve access to and support for peritoneal
4 dialysis and home hemodialysis could increase competition
5 in this marketplace, meaningfully improve medical care for
6 beneficiaries, expand access to dialysis for beneficiaries
7 who can't get to in-center dialysis, and of course, lower
8 costs for the Medicare program.

9 I'm very supportive of the recommendation.

10 MS. KELLEY: That's all I have in the queue,
11 unless I've missed anyone?

12 DR. CHERNEW: Going once, going twice.

13 Okay. We are going to go through the roll call.
14 Dana.

15 MS. KELLEY: Okay. Voting on the recommendation
16 which reads: For calendar year 2027, the Congress should
17 eliminate the update to the 2026 Medicare base payment rate
18 for outpatient dialysis services.

19 Voting yes or no.

20 Lynn.

21 MS. BARR: Yes.

22 MS. KELLEY: Paul?

1 DR. CASALE: Yes.
2 MS. KELLEY: Robert?
3 DR. CHERRY: Yes.
4 MS. KELLEY: Cheryl?
5 DR. DAMBERG: Yes.
6 MS. KELLEY: Tom?
7 DR. DILLER: Yes.
8 MS. KELLEY: Stacie?
9 DR. DUSETZINA: Yes.
10 MS. KELLEY: Kenny?
11 [No response.]
12 MS. KELLEY: Tamara?
13 DR. KONETZKA: Yes.
14 MS. KELLEY: Gokhan?
15 DR. METAN: Yes.
16 MS. KELLEY: Josh?
17 DR. LIAO: Yes.
18 MS. KELLEY: Brian?
19 DR. MILLER: Yes.
20 MS. KELLEY: Greg?
21 MR. POULSEN: Yes.
22 MS. KELLEY: Wayne?

1 DR. RILEY: Yes.

2 MS. KELLEY: Scott?

3 DR. SARRAN: Yes.

4 MS. KELLEY: Gina?

5 MS. UPCHURCH: Yes.

6 MS. KELLEY: Betty?

7 DR. RAMBUR: Yes.

8 MS. KELLEY: And Mike?

9 DR. CHERNEW: Yes.

10 MS. KELLEY: All right. And I believe that --

11 DR. CHERNEW: [Speaking off microphone.]

12 MS. KELLEY: We did, but I don't believe we heard

13 Kenny. I'm not sure Kenny is still present. Did he send a

14 message?

15 MR. KAN: Yes, yes, yes.

16 MS. KELLEY: Oh, thank you. Thank you, Kenny.

17 Yes. Thank you.

18 DR. CHERNEW: And I think, Kim, you were going to

19 lead off on hospice, so, Kim.

20 MS. NEUMAN: Next, we'll review the indicators of

21 payment adequacy for hospice that we discussed at the

22 December meeting. There's more detail in your papers, and

1 the paper's been updated to reflect Commissioners'
2 discussion and questions from December.

3 So here's a snapshot of hospice in 2024. There
4 were over 6,700 hospice providers. These providers
5 furnished care to over 1.8 million Medicare beneficiaries,
6 including more than half of decedents. This involved 148
7 million days of hospice care, and beneficiaries on average
8 received 3.9 visits per week from hospice staff. Total
9 Medicare payments in 2024 were just over \$28 billion.

10 So next, we have a summary of payment adequacy
11 indicators, which are generally positive. First, in terms
12 of access to care, the supply of providers continues to
13 grow. The share of decedents using hospice, the number of
14 hospice users, and total days of hospice care increased.
15 Average and median length of stay increased. In-person
16 visits per week was stable.

17 As for quality, the most recent patient
18 experience measures from CAHPS were stable, and a measure
19 of visits at the end of life increased.

20 Access to capital appears positive.

21 Finally, we have margins. Note, different from
22 other sectors, we estimate historical margins for 2023,

1 because of the standard data lag, needed to calculate
2 hospice aggregate cap overpayments.

3 The 2023 aggregate Medicare margin was 8 percent,
4 and the 2026 projected Medicare margin is 9 percent.

5 So this brings us to the draft recommendation.
6 It reads: For fiscal year 2027, the Congress should
7 eliminate the update to the 2026 Medicare base payment
8 rates for hospice.

9 In terms of implications, the recommendation
10 would decrease spending relative to current law by between
11 \$250 million and \$750 million over one year, and between \$1
12 billion and \$5 billion over five years.

13 In terms of beneficiaries and providers, we do
14 not expect adverse impacts on access to care, and we expect
15 continued willingness and ability of providers to provide
16 care to Medicare beneficiaries.

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

19 DR. CHERNEW: Thank you.

20 I think, Brian, you're in the queue.

21 DR. MILLER: Very supportive of this
22 recommendation, really like this line of work.

1 I would say I have some concerns about this
2 marketplace and that hospice involves clinical tradeoffs,
3 and I'm concerned that the industry is seeking to change
4 the goals of hospice care in the Medicare program to expand
5 therapy and payment, rather than recognizing and balancing
6 those inherent tradeoffs.

7 I also wanted to highlight an unexplored area of
8 fraud, waste, and abuse, wherein hospice programs are
9 harvesting patients who are almost deceased from hospitals
10 by administratively discharging dying patients from the
11 hospitals, maintaining them in the hospital bed, and then
12 administratively admitting them to hospice while keeping
13 them physically in the hospital bed and using this to
14 reduce hospice length of stay and comply with length of
15 stay regulations.

16 I think the CMS Center for Program Integrity
17 needs to examine these practices. I think that we should
18 try and parse this data, if available, because it suggests
19 that hospices are manipulating length of stay in order to
20 allow for longer-stay patients who may be more profitable
21 for hospices.

22 Regardless of the legality or regulatory

1 appropriateness of this sort of action, it is, at the very
2 least, highly unethical, and I find that concerning.

3 I think also that there's more work for us to do
4 as a Commission on hospice and Medicare Advantage. I know
5 that we have lots of concerns about end-of-life selection
6 in Medicare Advantage that many other Commissioners have
7 voiced, and I also share those concerns. I think that we
8 need to do some work to think about how we can integrate
9 Medicare Advantage into the hospice benefit -- I'm sorry --
10 hospice into the Medicare Advantage benefit, and what are
11 the protections that we need for beneficiaries and hospice
12 providers? It might be around consumer education. It
13 might be around network adequacy and having extremely
14 rigorous, if not downright aggressive, network adequacy
15 regulation, because I think the answer from MA plans where
16 they say I don't want to deal with hospice and the answer
17 from hospice providers where they say I don't want to deal
18 with MA, I think that that is completely unrealistic, and
19 that we need to find a middle ground to make this work,
20 because if you're a Medicare beneficiary, you shouldn't be
21 switching benefit packages when you're at the end of life.
22 That's just an unfair burden to ask folks.

1 MS. KELLEY: Scott?

2 DR. SARRAN: Yes, very quick reinforcements of
3 Brian's points.

4 I'm very deeply troubled by the behavior that I'm
5 aware does occur, at least in pockets, around the
6 manipulation of a transition from an inpatient stay to a
7 hospice stay, not in the best interest -- done not in the
8 best interest of beneficiary choice or outcomes, and I also
9 want to make sure we keep on the table how we might
10 advocate for integration of hospice into the MA benefit
11 across the board, not via demonstration, in order -- done
12 with the appropriate protections that I know everyone's
13 concerned about.

14 And I will continue to highlight what you noted
15 in the report, which is that I think the numbers were 10
16 percent of decedent families gave a bottom rating, the
17 lowest rating to pain and suffering -- and symptom relief
18 rather, 9 percent gave the lowest rating to getting timely
19 help, continue to reinforce. Those should be considered
20 never events in hospice. Those are exactly what the
21 hospice benefit is designed to prevent. And the fact that
22 in roughly 10 percent of circumstances, we're failing to do

1 that, I think is extremely troubling.

2 Thanks.

3 MS. KELLEY: Mike, that is the end of the queue.

4 DR. CHERNEW: Wonderful. And thank you for your
5 comments.

6 A few generic reactions before we go to the vote.
7 It's been pointed out there's a lot of things to do in all
8 of these sectors beyond payment updates, and so I
9 appreciate that, and of course, we will do a lot of things
10 in these sectors beyond payment updates. So I appreciate
11 all of that, and I think another theme of all of this has
12 been -- and I think it's certainly true in the hospice case
13 -- there's a lot of heterogeneity, and we struggle with
14 heterogeneity just in general and how to deal with it.
15 It's particularly hard to deal within the update work, but
16 I think as a general point, it's hard to deal with that
17 heterogeneity and how to deal with the balance of figuring
18 out what you can manage and what you just can't
19 practically.

20 But in any case, we are not going to dwell on
21 that now. Instead, we are going to vote. So, Dana, can
22 you do the roll call?

1 MS. KELLEY: Okay. Voting on the recommendation
2 which reads: For fiscal year 2027, the Congress should
3 eliminate the update to the 2026 Medicare base payment
4 rates for hospice.

5 Voting yes or no.

6 Lynn?

7 MS. BARR: Yes.

8 MS. KELLEY: Paul?

9 DR. CASALE: Yes.

10 MS. KELLEY: Robert?

11 DR. CHERRY: Yes.

12 MS. KELLEY: Cheryl?

13 DR. DAMBERG: Yes.

14 MS. KELLEY: Tom?

15 DR. DILLER: Yes.

16 MS. KELLEY: Stacie?

17 DR. DUSETZINA: Yes.

18 MS. KELLEY: Kenny?

19 MR. KAN: Yes.

20 MS. KELLEY: Tamara?

21 DR. KONETZKA: Yes.

22 MS. KELLEY: Gokhan?

1 DR. METAN: Yes.

2 MS. KELLEY: Josh?

3 [No response.]

4 MS. KELLEY: Brian?

5 DR. MILLER: Yes.

6 MS. KELLEY: Greg?

7 MR. POULSEN: Yes.

8 MS. KELLEY: Wayne?

9 DR. RILEY: Yes.

10 MS. KELLEY: Scott?

11 DR. SARRAN: Yes.

12 MS. KELLEY: Gina?

13 MS. UPCHURCH: Yes.

14 MS. KELLEY: Betty?

15 DR. RAMBUR: Yes.

16 MS. KELLEY: Mike?

17 DR. CHERNEW: Yes.

18 MS. KELLEY: And Josh has sent a note saying

19 difficulties with his mic, and his vote is yes.

20 Okay. Thank you.

21 DR. CHERNEW: All right. So we're about to take

22 a break. I will say for those folks at home, this was a

1 pretty expedited discussion and set of presentations, but
2 understand that we have spent a lot of time and had a lot.
3 We talked in December about it. There's a lot of analysis
4 that has gone into all of this. So the expedited nature of
5 the voting doesn't reflect a sense that this is
6 unimportant. In fact, to the contrary, we think this is
7 amongst the most important things that we do, and I
8 appreciate all the staff time and all the Commissioner time
9 in the attention that you paid to all of these chapters.
10 So, again, thank you.

11 I'll say this again later, but I might as well
12 say it now. If you're at home and you want to reach out to
13 us, please reach us at meetingcomments@medpac.gov, or
14 otherwise, reach out to us. There's many ways to reach us,
15 and some of you will see the comment letters. And we have
16 read and discussed the comment letters, and we do
17 appreciate those that came in. So, for those listening,
18 thank you very much for the comments that you have sent us,
19 and please feel free to send more. In any case, thank you.

20 We're now going to take about a 10-minute break,
21 and we're going to come back at about five till noon, and
22 we will start our discussion of the mandated home health

1 chapter.

2 MS. KELLEY: Commissioners, please don't log off.

3 [Recess.]

4 DR. CHERNEW: Okay everybody. Welcome back. We
5 are now going to move to a more traditional session format.
6 We had two, three, mandated reports this cycle, yeah, three
7 mandated reports this cycle. This is one on home health.
8 Evan is going to kick us off and take us through the
9 material. Evan.

10 MR. CHRISTMAN: Thank you, Mike. Good afternoon.
11 We will look at the analysis for a mandated report about
12 the home health payment system that is due in March 2026.
13 This analysis reviews data presented last month but
14 includes new information I will highlight as we go along.
15 The audience can download a PDF version of these slides in
16 the Handout section of the control panel on the right-hand
17 side of the screen, with the paper clip icon. And I would
18 like to take a moment to thank some staff at Acumen who
19 have been invaluable in preparing this report: Hussain
20 Bakshi, Cheng Lin, Nolan Anderson, and Swad Komanduri.

21 Before I begin today's presentation, I want to
22 review the work we have done on this report as it will be

1 our last session before it is released.

2 In February 2018, Congress passed the Bipartisan
3 Budget Act of 2018. It has two changes that I will discuss
4 in a minute, but in brief, the law shortened the unit of
5 payment and eliminated therapy visits from the case mix.

6 The BBA required the Commission to present an
7 interim report on the impact of these changes in 2022, and
8 in that report, we found that the benefit appeared to be
9 stable after the implementation of the changes, though we
10 noted some limitations such as having only one year of
11 post-implementation data and the challenges of the
12 pandemic.

13 In October 2024, you reviewed a workplan for the
14 final mandated analysis required by the BBA. And in last
15 month's meeting we reviewed the results for some measures
16 of home health utilization and quality.

17 Today we will review the results from last month,
18 as well as an additional quality measure and new results
19 for financial performance and selected clinical groups.
20 All of this information will be included in our final
21 report in the 2026 March Report to Congress.

22 Today's presentation is similar to what we

1 reviewed in December. It again will have five parts.
2 First, I will provide a brief overview of home health.
3 Second, I will explain the policy changes the BBA of 2018
4 requires us to study. Then I will review how we conducted
5 the analysis and the results we discussed last month with
6 the additional measure. Next, I will present some new
7 results for the clinical groups and financial performance.
8 And then I will turn it over to the Commissioners for
9 discussion.

10 As reminder, here is an overview of the home
11 health benefit. Medicare covers care in the home for
12 beneficiaries that are homebound and require skilled care.
13 The covered services include nursing, physical,
14 occupational and speech therapy, medical social work, and
15 home health aide services. The bulk of services are
16 nursing and therapy.

17 A prior hospitalization is not required to
18 receive home health, and there is no limit to the duration
19 of care as long as a beneficiary meets coverage criteria.

20 Finally, there is no cost-sharing for home health
21 services in fee-for-service Medicare.

22 Here is a reminder of the BBA changes that I

1 reviewed with you last month. As you can see here, prior
2 to 2020, Medicare paid for home health care in 60-day
3 episodes. The BBA required that Medicare switch to the
4 shorter 30-day period. Also, the BBA required that the
5 home health PPS no longer use the number of therapy visits
6 provided during home health care as a payment factor. And
7 again, as we noted last month, the changes in BBA of 2018
8 reflected policy concerns raised by the Commission and
9 others in prior years.

10 One major issue was the use of therapy visits
11 provided during a 60-day episode as a payment factor.
12 Prior to 2020, the home health PPS had payment adjusters
13 that increased payments when additional therapy visits were
14 provided.

15 In our March 2011 Report to Congress, we found
16 that home health agencies adjusted the number of therapy
17 visits they provided to increase their payments and
18 financial performance. This led the Commission to
19 recommend the elimination of therapy from the home health
20 case mix in 2011.

21 Separately, the Senate Finance Committee
22 investigated therapy trends in home health, and concluded

1 that the inclusion of therapy was influencing how home
2 health agencies were providing these services, and they too
3 concluded that Medicare should move away from using therapy
4 as a payment factor in the system.

5 In 2017, CMS proposed, but did not finalize, a
6 new case mix system that had the two policies later
7 mandated by the BBA.

8 In 2020, CMS implemented the BBA-required changes
9 through a new system referred to as the Patient-Driven
10 Groupings Model, or PDGM. In PDGM, beneficiaries are
11 assigned to a payment group based on five dimensions of
12 severity. These include the timing of the current 30-day
13 period relative to prior home health services, the source
14 of the referral to home health care, 12 clinical groups
15 based on primary diagnosis, functional impairment, and the
16 amount and type of clinical comorbidities. You can see the
17 unique categories in each of the five dimensions on this
18 slide, and there is more detail on them in your paper.

19 The final mandated report due in 2026 is an
20 opportunity to assess PDGM with more years of post-
21 implementation data than we did in our interim report, and
22 to also use methods that account for pre-PDGM trends, and

1 we also used this as an opportunity to examine a broader
2 set of analytic measures.

3 The analysis I present today will use an
4 interrupted times series. In this method we use pre-PDGM
5 data from 2016 to 2019 to estimate a counterfactual of what
6 would have occurred in 2020 to 2023 in the absence of PDGM.
7 This approach is useful because it allows us to account for
8 pre-2020 trends that may have affected outcomes in the PDGM
9 era.

10 As noted in your paper, we include control
11 variables to account for non-PDGM factors that could affect
12 outcomes, such as changes in fee-for-service enrollment,
13 beneficiary characteristics, local market factors, and
14 other influences that could affect home health care.

15 Before I present our results from working with
16 the interrupted time series model, I want to give you an
17 overview of home health utilization, and we shared this
18 last month.

19 In the graph on the left, you can see that from
20 2016 to 2023, the share of fee-for-service Medicare
21 beneficiaries with at least one home health stay declined,
22 with the largest decrease occurring in 2020. Looking at

1 the graph on the right, you can see that the average number
2 of visits per stay decreased in the same period, again with
3 the greatest decline occurring in 2020.

4 One takeaway from this graph is that 2020, the
5 year of the pandemic and the implementation of PDGM, saw
6 the biggest changes in utilization during this period.

7 We are going to turn to the analysis, but before
8 I proceed, I want to again note some cautions about
9 interpreting this data. Many factors can affect
10 utilization. While our models control for measurable
11 factors that we have identified, we cannot be certain they
12 fully account for them. As the previous slide implies,
13 chief among these is the COVID-19 pandemic and the
14 resulting changes in the health care system. In addition,
15 there may be other unmeasured factors that we have not
16 accounted for that could affect our estimates.

17 Second, as I mentioned earlier, PDGM was
18 implemented for all beneficiaries in 2020, and so we cannot
19 rely on a control group. Also, the limits our methods
20 should make us cautious when interpreting small difference.
21 We will have to consider these limitations when presenting
22 results and making conclusions. For these reasons, in

1 general I will frame the results we find as "associated
2 with PDGM" as opposed to caused by it.

3 In the rest of the analysis, I will be presenting
4 results from 2023, the most recent post-implementation year
5 of data and also a year less likely to be affected by the
6 pandemic as prior years. I will also focus on our analysis
7 for all fee-for-service beneficiaries in this presentation,
8 though we will talk about some clinical groups later. Your
9 paper includes analysis for beneficiary subpopulations, and
10 in most cases, results were generally consistent across
11 these groups.

12 In these results, I will present two estimates
13 for our outcomes: a without-PDGM estimate that reflects
14 what we estimate would have happened in 2023 in the absence
15 of PDGM, and a with-PDGM estimate that reflects what
16 actually happened after the BBA. The difference between
17 the two is our estimate of the change associated with PDGM.

18 You can see an example in the figure on the right
19 with hypothetical data, and the orange bar is the
20 counterfactual without-PDGM estimate for the outcome, and
21 the blue is the with-PDGM estimate. As the orange bar is
22 higher in this example, the implementation of PDGM was

1 associated with a lower result relative to the
2 counterfactual.

3 In the following slides, the results are
4 statistically significant with a p-value of .05, unless
5 otherwise noted.

6 Now we turn to our first outcome, which you saw
7 last month. This is the probability of a beneficiary
8 having any home health services in 2023.

9 As you can see from the graph on the left, the
10 overall probability of a fee-for-service beneficiary
11 receiving home health care was slightly lower with PDGM
12 than without. We also noted that PDGM had varying effects
13 depending on the referral source. It was linked to a
14 higher likelihood of a beneficiary having at least one
15 post-hospital home health stay, but a lower likelihood of a
16 community-admitted stay.

17 Our next metric is the average number of visits
18 per stay, and this slide has some minor revisions from what
19 we reviewed before. As you can see from the graph on the
20 left, PDGM was associated with 15.9 visits per stay, or 2.9
21 fewer visit per stay compared to the without-PDGM estimate.
22 The magnitude of the reduction in visits per stay varied

1 for skilled nursing visits and therapy visits, with the
2 latter having a larger drop.

3 PDGM eliminated the therapy thresholds, changing
4 the incentives for these services. The incentives for
5 nursing and aide were not changed by PDGM.

6 The removal of therapy was intended to discourage
7 the provision of care based on financial incentives, and
8 the lower number of therapy visits associated with the PDGM
9 may reflect revised care plans that better align services
10 with patient needs.

11 Our findings indicate fewer visits attributable
12 to PDGM for nursing and therapy, even though PDGM only
13 changed incentives for therapy. This raises the
14 possibility that our results reflect factors other than
15 PDGM despite our efforts to control for them. For example,
16 there have been concerns about tight labor markets for home
17 health agencies, and some of the change in visits we report
18 as associated with PDGM could reflect staffing challenges.

19 We also examined home health aide visits, which
20 are challenging to assess because they are relatively
21 infrequent, and most stays do not have these services. The
22 model indicated that PDGM was associated with more aide

1 visits. But other factors may be at plays as the new
2 payment system did not change the payment incentives for
3 aide services.

4 Turning to quality, this is mostly similar to
5 last month, with the exception that we have a new discharge
6 to community measure in the first row. And as you can see,
7 we have observed a mostly stable rate of discharge, though
8 it was modestly lower. We not that the rate with PDGM is
9 still over 80 percent.

10 For the rate of potentially preventable
11 hospitalization during the stay, we found that the PDGM was
12 associated with a 2.1 percentage point lower rate of
13 hospitalization, indicating improvement. While the
14 improvement in this measure could represent better outcomes
15 for beneficiaries and lower spending, we want to reiterate
16 our earlier cautions about the limitations of our methods
17 for measuring PDGM's impact.

18 For our functional measures, the rate of
19 improvement in self-care and the rate of improvement in
20 mobility, we saw stability, with no substantial difference
21 was associated with PDGM. However, it is notable that the
22 Commission has raised concerns about patient function data

1 that is self-reported by agencies, and the reported results
2 for the functional measures may also reflect agency coding
3 practices.

4 Overall, these measures indicate that PDGM was
5 associated with stable or improving quality of care.

6 Now I turn to a new analysis, a review of our
7 outcomes for the eight conditions common in home health
8 care, and you can see them listed here on the slide. I
9 would note that these were generally relative high use
10 conditions. For example in our sample 12.3 percent of
11 beneficiaries with schizophrenia or major depression used
12 home health, a rate 30-percent higher than the national
13 average, and that the was actually the lowest rate of use
14 across these eight conditions.

15 The effects associated with PDGM for each of
16 these conditions and are outcomes are included in your
17 paper, and I am just going to focus on the ones that showed
18 the most difference.

19 For the likelihood of use, in PDGM was associated with a
20 lower probability for beneficiaries with one of these eight
21 conditions, though in most cases this was a percentage
22 point or less.

1 There could be several factors driving this, but
2 it is notable that many of these conditions we examined are
3 chronic conditions, and as we noted earlier, PDGM was
4 associated with a lower probability of community-admitted
5 stays, and a higher probability of post-hospital stays.
6 Some of the lower probability of use for these conditions
7 may be reflected in the lower rate of community admitted
8 stays I noted earlier.

9 For visits per stay, the magnitude of the
10 difference associated with PDGM was about the same for
11 these eight conditions as the overall difference I
12 reported, indicating that a relatively equal effect across
13 these eight categories.

14 The quality-of-care outcomes for the conditions
15 were also similar for the four measures I mentioned
16 earlier. In general, PDGM was associated with stable or
17 improved quality of care, with the caveats I mentioned
18 about the measures.

19 Finally, we also assessed financial performance
20 by computing the fee-for-service Medicare margins for home
21 health stays in 2023. Across most of the demographic,
22 clinical, and service use categories we examined, and

1 including the overall population, PDGM was not associated
2 with a statistically significant effect, and, in general,
3 the magnitude was small.

4 Separately, it is important to recall that apart
5 from the effects of PDGM, we have found Medicare fee-for-
6 service home health payments were well above costs. As we
7 discussed in the last session, the Medicare margin for
8 free-standing home health agencies in 2024 was 21.2
9 percent.

10 And this brings me to a summary. Overall, we
11 found that PDGM was associated with fewer visits per stay,
12 but little effect on overall use, quality, and
13 profitability. In terms of the effect on fee-for-service
14 beneficiaries' use of care, we saw a 0.2 percentage point
15 lower rate, and we noted that the probability of post-
16 institutional stays increased and the probability of
17 community-admitted stays decreased. We found that total
18 stays decreased by 15.3 percent, though the decline was
19 higher for therapy visits and lower for nursing visits.
20 And we noted that the reduction in therapy visits may
21 reflect the new incentives and have better alignment with
22 patient care needs.

1 We found little effect on most quality measures.
2 The rate of potentially preventable hospitalization was
3 lower, the rate of discharge to community was stable, and
4 we saw no substantial effect on the rates of improvement in
5 self-care vulnerability. In terms of profitability, we saw
6 no statistically significant effect associated with PDGM
7 overall, and we note that the margin for freestanding home
8 health agencies was 21.2 percent in fee-for-service
9 Medicare in 2024.

10 For our next steps, we plan to finalize the draft
11 and put the paper in the March 2026 Report to Congress. I
12 look forward to your conversation, and I'll turn it back to
13 you, Mike.

14 DR. CHERNEW: Great. Evan, thank you. There is
15 so much here. I realize the analytic challenges both
16 because the study design is inherently challenged with the
17 national program. There is COVID in the middle of the
18 program. The quality measures are sometimes problematic.
19 But I think you did a really thoughtful job of presenting
20 the work and thinking through those analytic challenges and
21 giving the appropriate caveats. So kudos to you and the
22 team. Thanks, Betty, as well.

1 We're going to go through the queue, and I think
2 Tamara is first in Round 1.

3 DR. KONETZKA: Thanks, Evan. I want to first
4 just echo what Mike just said, which is it was almost an
5 impossible task you were given here to evaluate this with
6 no sort of control or comparison group built in, and then
7 with this huge confounder of the pandemic. And given that,
8 this is just really a sort of great effort. I couldn't
9 really imagine it, you know, a design that would've been
10 better, given your constraints. So thank you for that.

11 My question is about the community-admitted
12 versus post-hospital. I think you said that the payment is
13 adjusted for whether it's community-admitted. Do you know
14 about how much that differential is, and did that exist
15 before, and did that differential change when PDGM was
16 implemented?

17 MR. CHRISTMAN: Let's see if I can recover all
18 this. I just talked about it in the current system. In
19 the current system, it's a PPS system so it's a system of
20 averages. And when they look at the average number of
21 visits that community-admitted individuals get and post-
22 hospital individuals get, in general the post-hospital

1 crowd is higher. So when you set the payment system that
2 way you wind up with a higher payment, everything else
3 being equal, for a post-hospital person, and it's not any
4 sense of like I'm valuing this over that. It's what I
5 think the average resources use is for a beneficiary with
6 that attribute in a 30-day period of care.

7 But what you said is true. It does result in the
8 fact that, you know, all things being equal, the post-
9 hospital payment is higher. And the exact amount varies,
10 but it's enough, 20, 30 percent or more in some cases. But
11 in theory it's there because that beneficiary is getting
12 more visits.

13 And I think if you look at the profitability
14 table you will see that -- the use was significant because
15 there's a lot of noise -- the margin difference between the
16 community-admit and post-hospital is like 1 or 2 percentage
17 points.

18 So it's true that this sort of shift towards
19 post-hospital does coincide with the new system, and I'd
20 have to think a little bit about what was in place before.
21 There were some things before, but I just can't recover it
22 right now.

1 But when we look at the profitability of a post-
2 hospital stay and a community-admitted stay, they're pretty
3 darn close. And if you'll compare the with and without
4 PDGM estimates, you'll see actually that the delta between
5 post-hospital and community-admitted stays shrank with
6 PDGM. So the difference was like three points before. Now
7 I think it's like one point.

8 But you fairly brought this up at the last
9 session, and in terms of this trend that we've seen of the
10 post-hospital showing some growth and community-admit less
11 so, the I can offer is I think if capacity is constrained
12 in the industry there may be more pressure to make sure
13 that the hospital demand is being met. It's a big referral
14 source for a lot of home health agencies. It's not to say
15 that the other sources aren't important, and I will admit
16 I'm talking a little bit out of my hat. But just sort of
17 thinking about the structure of the industry and what we've
18 seen, that's what I would say.

19 I would say on the financial side I don't see
20 this huge imbalance where it says the community admits have
21 a much higher margin or a much lower margin.

22 MS. KELLEY: Robert, did you have a Round 1

1 question?

2 DR. CHERRY: Yes. Thank you for the excellent
3 report.

4 Just a question. I know this is out of scope for
5 the report, but I was just curious about the functional
6 status that's obtained from the OASIS report. Do you have
7 a sense that the completion of the data is getting better,
8 or do you think that there's still issues with regards to
9 having complete functional data on these patients? Because
10 it's come up in the past. I'm just curious, even though
11 it's not an official part of your report, what your overall
12 sense is.

13 MR. CHRISTMAN: So the functional data is
14 collected for every home health stay. They get an
15 assessment at admission, and they get an assessment at
16 discharge, and the improvement is kind of it's what you see
17 and what you -- and I guess what I would -- I would speak
18 very carefully about this and say that in the past, when
19 MedPAC has looked at it, we've seen indicators that the
20 functional status data is not always consistent with other
21 sources of data about patient function when we can't
22 compare it.

1 I think it's a challenge because, to my
2 knowledge, CMS has never really sort of, for lack of a
3 better word, audited how this is being done, and in
4 general, this data, when these function -- when something
5 like OASIS is developed, they'll do some studies about
6 inter-rater reliability, but once it's out in the field,
7 whether you use training, they have manuals, but I think --
8 and I do believe that people work very hard to code
9 accurately, but I think we see evidence of just -- as any
10 administrative practice, there's a lot of variation.

11 So whether the same patient is being coded the
12 same way, there's nothing, I would say, from the payment
13 system perspective. There's nothing that reinforces the
14 need for consistency. I think the industry wants it, I
15 think, but I think that -- I don't think anybody's really
16 gone down on like full patient records or something like
17 that.

18 DR. CHERRY: Thank you. That's helpful, because
19 it's good to have internal consistency, because it allows
20 for a comparative analysis, and it's all part of -- it's
21 one element of looking at the overall quality, the services
22 being provided.

1 Perhaps at an upcoming report in this topic, we
2 can kind of have a discussion, at least an element of
3 discussion, around how to improve the inconsistencies that
4 we're sometimes seeing, so thanks.

5 MS. KELLEY: That's all I -- oh, I'm sorry.
6 Gina, Round 1?

7 MS. UPCHURCH: Sorry. I keep messing up in the
8 chat.

9 This is also a little bit outside the scope of
10 this chapter, but thank you for the excellent work, and
11 related to something that was brought up a little bit
12 earlier today in reflecting on our December meeting -- and
13 we were talking about skilled facilities and home health
14 across the post-acute setting -- there's so few home health
15 aide visits, social work visits in home health these days.
16 I don't know, as a result of PDGM, or just in the past two
17 decades, it's really shifted.

18 We know we pay a lot more for skilled nursing
19 care, post-acute care, than we do for home health. Do we
20 think they're related in any -- like, we just heard a
21 little bit earlier that when somebody lives alone and
22 they're in a skilled -- they often stay longer in that

1 skilled nursing facility, because there's not this option
2 to go home. If we thought they could get more help in the
3 home with an aide coming, say, two or three times a week,
4 do we have some sense from interviews or anything that that
5 might be a cost-effective way to have people stay in their
6 home?

7 MR. CHRISTMAN: So I guess I would just say that,
8 in general, the skilled -- excuse me -- the social work
9 visits have been relatively rare, and sometimes, some of
10 that might be due to them not being as frequently as would
11 be beneficial.

12 I've also had it described to me as sometimes,
13 you know, as you can imagine this, for patients with
14 challenges like you are mentioning, they are kind of a case
15 manager, and they do a lot of stuff that isn't a visit to
16 the home. You know, they're accessing social services or
17 arranging things or counseling informal caregivers over the
18 phone, those types of things.

19 And so, you know, I don't think -- I think that
20 the -- you know, I would say that the social work and home
21 health aide, I think, have ticked down slightly in recent
22 years. I think the -- you know, from our perspective, you

1 know, it's a little hard to understand that happening from
2 a cost perspective. And so, you know, I'd have to talk to
3 folks to get a better sense of it.

4 MS. UPCHURCH: So just to add on to that, so the
5 work that I'm in, care navigation is huge, and it's such a
6 challenge to stay in the community and get the services you
7 need. If we think health care is confusing, I think social
8 services are equally or more confusing.

9 So I do think some investment in that -- when
10 somebody is -- especially in a very critical time when
11 somebody's leaving the hospital or something, it's such a
12 critical time to connect them with services and such. So I
13 do want us to keep an eye on that, and if it's going down,
14 you know, or people -- I'm just trying to save money at the
15 same time, treat people in a way that, you know, we'd all
16 want to be treated so that we can stay in the home and not
17 have those more costly institutional care.

18 Okay, thanks.

19 DR. CHERNEW: Can I jump in and say something
20 about that? And I do this somewhat at my own peril. So
21 you should feel completely comfortable telling me if I'm
22 completely off base.

1 So to the big picture point, I do think that home
2 care can be much more cost effective and preferable than
3 staying in an institution in a range of ways, and I think
4 there's a bunch of barriers.

5 I think some of it relates to that when we treat
6 these sectors as fragmented, as we tend to do, you don't
7 think about those things. This particular work is on the
8 PDGM, which is a narrower version of that. But I think if
9 you look, for example, at alternative payment models, the
10 post-acute sector has sort of been the ATM for a lot of
11 those models. And that's because they've had the
12 incentives to think about where to make those
13 substitutions, because while it is true that it can be
14 quite cost effective, you can make mistakes in either
15 direction. You could put people into a home when they
16 should stay in an institution, or you could give people
17 home health care that really don't need that level of care
18 if you don't manage it well.

19 And so I think, broadly speaking and
20 holistically, one needs to think about your question in the
21 context of a bunch of sort of general incentive problems.
22 But here, with a focus on what did the PDGM do, it really

1 was not -- it was never designed to exploit or to deal with
2 this. It was really designed to fit in the context of the
3 fee-for-service system and refine it to address this other
4 problem related to therapy that Evan mentioned.

5 So I don't know. Evan, now's when you tell me
6 what I've missed and what I got wrong. I'm used to being
7 told I'm wrong.

8 MR. CHRISTMAN: I'm here to talk about PDGM, man.

9 [Laughter.]

10 DR. CHERNEW: There you go. There you go.
11 That's all perfect. Wonderful.

12 So I think now we're going to get to Round 2,
13 unless someone jumped in while I was rambling.

14 DR. CHERNEW: Oh, Brian.

15 MS. KELLEY: Brian, did you --

16 DR. MILLER: I wasn't going to comment on this
17 chapter, but will comment now. Love the chapter.

18 To Gina's point about people being trapped in a
19 SNF versus going home, I think that the way I think about
20 this is more of a clinical perspective, which is someone
21 spends -- and obviously, we have to account for costs and
22 across the marketplace. If someone spends an extra day in

1 the hospital, they don't need to go to a skilled nursing
2 facility and they can go home, that's a win for the
3 beneficiary.

4 If someone spends an extra day or two in a
5 skilled nursing facility, which allows them to get home
6 without services versus getting home with services, that's
7 also a win for the beneficiary.

8 And so we should think about how the beneficiary
9 -- they have needs, and that there are many ways for us to
10 meet those needs from the mix of sort of -- I call it the
11 end of acute care hospital services and then post-acute
12 care services, which range from IRF, subacute rehab, home
13 health, to nothing funded by Medicare, just you're doing
14 your regular outpatient care going about your life. So that
15 there's an error in that if we hold -- there are errors
16 when we hold someone too long in one type of facility, and
17 that's an error that our Chair has mentioned.

18 The other area which he also -- error which the
19 delivery system and payment can also make, which he
20 mentioned, is arguably actually more harmful, which is
21 sending someone home with -- when they needed the higher
22 level. So if you send someone to home health and they

1 needed subacute rehab after being in the hospital, haven't
2 been on the receiving end of that, that patient ends up
3 right back in the hospital very fast. They're very angry
4 at everybody, understandably so.

5 If someone needs to go to an IRF and they end up
6 in subacute rehab, you might not see them right away, but
7 you'll see them later because they haven't gotten the
8 intensive therapy they needed. So I agree on the consumer
9 protection concern about not trapping the beneficiary in a
10 particular care level too long, but I'm also equally
11 cognizant of if we don't give them enough in post-acute
12 care, it can cause lots of problems, which often end up
13 being dumped on, frankly, the acute care hospital sector,
14 because in the outpatient setting, those patients quickly
15 get shunted to the emergency room. And the emergency room
16 doesn't have the capacity to deal with that, and then they
17 get admitted to the hospital, and then they sit in the
18 hospital while the hospital tries to figure out what to do
19 with them. And that's just -- I mean, that's obviously not
20 great for the beneficiary, and that's certainly not great
21 from a fiscal policy perspective for the Medicare program
22 either. And of course, then it fills hospital beds with

1 people who just really need a better formulation and plan
2 for post-acute care.

3 DR. CHERNEW: Okay. I think we're on to Round 2.
4 Is that right?

5 MS. KELLEY: That is correct.

6 DR. CHERNEW: And that's Robert.

7 MS. KELLEY: Correct.

8 DR. CHERRY: Yeah, thanks again. I just have a
9 brief comment.

10 I was thinking, with these two modest changes,
11 the early indicators are actually encouraging, so really
12 good results so far.

13 I would say that in terms of services like
14 physical therapy, occupational therapy, speech, they are
15 not in abundance in many areas of the country. So I think
16 whatever we could do to reduce unnecessary utilization is
17 great

18 Well, one thing that we don't know is whether
19 they're being redeployed to other patient care areas that
20 may have a great need as well, and hopefully, the
21 distribution of services is improving along with the
22 decreased utilization per patient that we're seeing as

1 well. So they're definitely very encouraged by the results
2 for a very critical area within health care. So thank you.

3 MS. KELLEY: Cheryl.

4 DR. DAMBERG: Again, thank you very much for the
5 work and a plus-one on Tamara and Mike's comments about the
6 challenges of approaching, getting to the answer
7 analytically. Oh, you guys did a great job.

8 So I guess the first thing, it's comforting that
9 the pivot to PDGM didn't really seem to lead to negative
10 effects. So I think that's a positive.

11 But one of the things that I was curious about
12 with this decline in the number of skilled nursing visits
13 per stay, I know in the chapter you provide context that
14 there's potentially other factors going on in the
15 marketplace, which I think is great.

16 But one of the things that I was kind of curious
17 about -- so in Table 14-7, you show the breakout of lower
18 total visits per stay across these categories of
19 beneficiaries. But I was kind of curious how this drop in
20 the skilled nursing might play out by various beneficiary
21 characteristics. So just kind of a footnote, maybe you
22 can't add it for this year, but if you continue to monitor

1 this, I think it would be interesting to look at.

2 MS. KELLEY: I think that's all I have for Round
3 2, unless I've missed someone.

4 Mike?

5 DR. CHERNEW: We can get to a Round 3 if anyone
6 wants to talk broadly. We rarely get to a Round 3, but I
7 am happy to thank Betty and Evan for all the work they've
8 done. I think you were given a very challenging task.

9 And I agree that for the most part, there was a
10 problem we identified. There was a change that was set to
11 address that problem. It seems to have done a reasonably
12 good job of addressing that problem. We haven't seen a lot
13 of other deleterious consequences based at least on my read
14 of this report. So I'm not sure that's the tone in general
15 that you would have, but that's sort of the tone that I
16 took from it.

17 So anyway, I think that's good. What we're going
18 to do now -- so for those of you at home, if you want to
19 get in, please call us or email us at
20 meetingcomments@medpac.gov or otherwise reach out to us.
21 We've already heard from a number of you interested in this
22 sector, and we very much appreciate your voice.

1 And we then are going to take a break for lunch.
2 It has been a lot of material that we've gone through this
3 morning, and I very much appreciate people's time. And
4 we're going to come back refreshed and ready to go, because
5 we have two really interesting chapters on Part D before we
6 do the ASC work that we've done.

7 So again, thank you. Please reach out to us if
8 you're at home, and everyone have a good break. We'll see
9 you at 2:10, I believe.

10 MR. MASI: 2:10?

11 DR. CHERNEW: Yep, 2:10.

12 [Whereupon, at 12:33 p.m., the meeting was
13 recessed, to reconvene at 2:10 p.m. this same day.]

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1 AFTERNOON SESSION

2 [2:10 p.m.]

3 DR. CHERNEW: Hello, everybody, and welcome back.

4 This is our afternoon session of our January meeting, and
5 we are about to embark on a few hours of deep dive into the
6 Medicare Part D program. It will both seem like a lot of
7 time and seem like we did not have enough time.

8 But in any case, we're going to let Betty kick us
9 off. So, Betty, go ahead.

10 DR. FOUT: Good afternoon. Before we start, we'd
11 like to thank Tara Hayes, Pamina Mejia, and Chinmay Amin
12 for their help on this work. And the audience can download
13 a copy of these slides from the right side of the screen.

14 Today we are talking about analyzing the recent
15 increases in Part D bids. We'll start with some background
16 and motivation for this work. We'll present findings from
17 plans' bid data to examine the increases in bid amounts.
18 We'll discuss how beneficiaries' Part D premiums would have
19 been higher if not for Medicare policies that lowered them,
20 and then, lastly, Shinobu will summarize interviews we
21 conducted with Part D actuaries.

22 The Inflation Reduction Act of 2022 introduced

1 major changes to the Part D program. We focused on the
2 benefit redesign starting in 2025. The redesign shifted
3 financing of the benefit, increasing the role of Medicare's
4 capitated direct subsidy payments, and reducing the role of
5 Medicare's cost-based reinsurance. Reinsurance had
6 previously paid for most of the costs of enrollees with
7 high spending. The redesign also further reduced cost
8 sharing for beneficiaries, notably by substantially
9 lowering the out-of-pocket cap on spending.

10 This chart illustrates how the distribution of
11 expected benefit costs for the Part D basic benefit has
12 changed over time.

13 The Medicare program covers the majority of costs
14 through two types of payments, cost-based reinsurance,
15 indicated in the bottom dark blue, and the capitated direct
16 subsidy, which are fixed monthly payments and is indicated
17 in the middle gray section. The remaining orange section
18 of the graph is the enrollees' share, or their premium,
19 referred to as the base beneficiary premium.

20 In 2007, the capitated direct subsidy accounted
21 for the largest share of expected basic benefit costs at 49
22 percent. Reinsurance was 26 percent, and the base

1 beneficiary premium was 26 percent.

2 Over time, the capitated direct subsidy declined
3 substantially to be just 2 percent of the basic benefit
4 costs in 2023. Reinsurance, which pays for actual
5 spending, accounted for 73 percent. This means that by
6 2023, plans assumed relatively little insurance risk for
7 their enrollees' spending, diminishing their incentive to
8 control costs.

9 The redesign in 2025 altered this distribution by
10 restoring the role of the capitated direct subsidy and
11 reducing reinsurance.

12 In addition, IRA provisions lowered the base
13 beneficiary premium by instituting an annual cap on growth.
14 This was done to protect enrollees from expected increases
15 in premiums from the redesign.

16 And consequently, in 2026, shown on the far
17 right-hand side of the chart, enrollees' share of expected
18 basic benefit costs fell to 13 percent, while Medicaid's
19 share increased to 87 percent, primarily consisting of
20 capitated direct subsidy payments.

21 The redesign also significantly reduced
22 beneficiary cost sharing. It eliminated the coverage gap

1 phase of the benefit, which previously required 25 percent
2 cost sharing. It also removed cost sharing beyond the out-
3 of-pocket limit and lowered that limit significantly.

4 In addition, the new true out-of-pocket
5 calculation allows the value of enhanced benefits to count
6 towards limit, enabling more enrollees to reach the
7 threshold with lower personal spending. One study
8 estimated that enrollees reaching the out-of-pocket limit
9 could double between 2023 and 2025.

10 While the reduction in cost improves
11 affordability, especially for the highest-spending
12 beneficiaries, it drives higher demand. This increases the
13 cost of the benefit, which would translate into higher
14 premiums, in the absence of any policies reducing them.

15 Commissioners have expressed interest in learning
16 more about how the redesign affected plans' bids and
17 Medicare's benefit costs. Plans' bids determine the
18 national average monthly bid amount, referred to as NAMBA.
19 It is a measure of plan benefit liability that is used to
20 determine Medicare's capitated payments to plans.

21 In 2025, it increased by 180 percent, and in
22 2026, it increased by an additional 33 percent. At the

1 same time, Medicare's expected total subsidy for the basic
2 benefit also rose by 53 percent in 2025 and 40 percent in
3 2026.

4 Multiple factors contributed to the growth in
5 Part D bids. The chart shows the dollar-level amounts of
6 expected basic benefit costs. As mentioned on the slide
7 before, the average bids across plans, or NAMBA, grew
8 significantly in 2025 and in 2026.

9 Part of this growth is a reduction in expected
10 reinsurance, the bottom dark blue portion of the bar chart.
11 But part of the growth is also higher overall expected
12 basic benefit costs. There are several reasons that I
13 could explain why expected benefit costs grew. First, the
14 Part D benefit became more generous with lower enrollee
15 cost sharing. This makes the benefit more costly and also
16 shifts costs to the premium. Second, benefit costs can
17 increase if the redesign induces greater use, which
18 increases spending, and then lastly, broader trends in the
19 greater use of high-cost drugs also drives up benefit
20 costs.

21 We now review some background on Medicare's
22 payments for Part D. As we showed on an earlier slide,

1 Medicare and enrollees share in covering the cost of the
2 Part D basic benefit. Medicare's share consists of two
3 types of payments that are made to Part D plans to
4 administer the benefit for their enrollees. Reinsurance
5 payments based on enrollees' actual spending above a
6 certain threshold and the capitated direct subsidy, which
7 is a fixed monthly payment per enrollee.

8 Enrollees cover the remaining amount through
9 their portion of the premium, which has historically been
10 25.5 percent. This expected basic benefit cost is the
11 total amount required by plans to administer the Part D
12 benefit, of which Medicare has historically subsidized
13 three-quarters.

14 Plans annually submit bids on their expected
15 liability and costs for administering the benefit. CMS
16 aggregates these bids and computes a risk-standardized
17 nationwide enrollment-weighted average bid amount, referred
18 to as NAMBA. NAMBA is used to determine the amount of the
19 capitated direct subsidy and the base beneficiary premium.

20 The expected amount of reinsurance is also
21 submitted in plans' bids. The NAMBA plus this expected
22 reinsurance amount is used to compute the total expected

1 basic benefit cost and set the base beneficiary premium.

2 Plans intending to participate in Part D in the
3 upcoming year must submit bids that represent their
4 expected liability based on enrollees' historical spending
5 and using guidance and tools from CMS. These bids are
6 prepared using the most recent experience available at the
7 time, which reflects a two-year lag. For example, bids
8 submitted in 2025 are based on plans experienced from 2023.

9 In their bids, plans must provide information on
10 how enrollee spending is expected to be distributed based
11 on the Part D benefit design. Plans project the amount
12 that will be paid for by beneficiary cost-sharing,
13 reinsurance, and manufacturer discounts and rebates.

14 The remaining amount represents the plan's
15 expected liability, or a plan's bid. CMS averages risk-
16 standardized bids to compute the national average bid, or
17 NAMBA. The bid data are available through the 2026 plan
18 year.

19 We use the plans' bid data to decompose the
20 growth in bids. We estimate the relative contribution of
21 shifts in benefit financing versus higher drug spending.
22 Shifts in benefit financing reflect higher plan liability

1 from changes such as lower cost-sharing and the reduction
2 of reinsurance. These changes are expected from the
3 benefit redesign.

4 Higher drug spending can reflect broader trends
5 in the use of high-cost drugs but also induce demand from
6 the lower cost-sharing, and some of the growth in bids may
7 also reflect underpredictions of spending from the prior
8 year.

9 We use unstandardized spending for the
10 decomposition, consistent with how plans construct their
11 bids, and to remove the influence of changes in risk
12 scores.

13 To decompose the bid growth, we applied plans'
14 projected distribution of enrollee spending before and
15 after the redesign, holding overall spending constant. We
16 then summed the changes in the components of enrollee
17 spending. Any residual difference in the bids are then
18 attributed to growth in expected total spending.

19 These bars display unstandardized average bids
20 for 2024 and 2025, showing a \$101 increase in 2025. We
21 estimate that 82 percent of this growth can be explained by
22 shifts in benefit financing that increased plan liability.

1 That is, expected declines in reinsurance, beneficiary
2 cost-sharing, and Medicare's low-income cost-sharing
3 subsidies moved costs towards plan liability. Expected
4 increases in manufacturer discounts in 2025 offset some of
5 this shift.

6 The remaining 18 percent is attributed to plans'
7 projections of higher spending. We estimate an even split
8 of 9 percent projection error in 2024 due to reliance on
9 2022 data and 9 percent expected rise in overall drug
10 spending in 2025.

11 The rise in overall drug spending could be
12 related to overall trends in greater high-cost drug use
13 combined with induced utilization from lower cost-sharing.

14 Shinobu will talk more about how the actuaries we
15 interviewed observed similar trends.

16 We now add 2026 unstandardized bids, which grew
17 by \$49 compared to the prior year. Using the same method
18 to estimate the growth in average bids, we estimate that 72
19 percent of the increase was driven by higher drug spending.
20 This could reflect plans underestimating spending in their
21 2025 bids or anticipating additional growth in 2026. Since
22 2025 actual spending is not yet available, we are not able

1 to separate projection error from expected growth. The
2 remaining 28 percent is attributed to shifts in financing
3 that increased plan liability.

4 The Part D benefit redesign would lead to higher
5 basic benefit premiums, but Medicare policies reduced the
6 portion of the premium that enrollees pay. Had the base
7 beneficiary premium remained at its historical share, it
8 would have grown substantially by 28 percent in 2024 and 44
9 percent in 2025. However, an IRA provision helped mitigate
10 the impact by capping annual base beneficiary premium
11 growth at 6 percent. This effectively reduced enrollees'
12 share of the Part D basic premium to 13 percent and
13 increased Medicare's share to 87 percent.

14 To address high increases in premiums observed
15 among stand-alone PDPs, CMS additionally implemented the
16 Premium Stabilization Demonstration. This three-year
17 demonstration lowered PDP premiums and capped annual growth
18 through greater program spending.

19 For MAPD plans, MA rebate buydowns continue to be
20 a key mechanism for offering low or zero premium plans.
21 Buying down the Part D premium is a common supplemental
22 benefit offered by MA plans.

1 This year, in 2026, the average expected basic
2 premium is \$13 per member per month. However, if the base
3 beneficiary premium were set at its historical share of
4 25.5 percent of expected basic benefit costs, the premium
5 would have been \$75. The difference is financed, in large
6 part, by Medicare through higher direct subsidy payments
7 and the PDP Premium Stabilization Demonstration payments.

8 There was variation in premiums by plan type. In
9 general, MAPD plans tend to have lower premiums than PDPs,
10 in part, because MA rebate buydowns are sizable.

11 And now I turn the presentation over to Shinobu.

12 MS. SUZUKI: Thanks, Betty.

13 We conducted interviews with actuaries to
14 understand how policy changes are affecting Part D bids and
15 market dynamics. We interviewed 11 actuaries with Part D
16 expertise in a semi-structured format between August and
17 December of 2025. The actuaries we spoke with included
18 those with experience working in both PDP and MAPD markets,
19 represented both for-profit and not-for-profit plans, and
20 plans serving single or multiple regions.

21 Discussions focused on topics related to recent
22 trends in bids, the PDP market, LIS benchmark plans, and

1 risk adjustment. While our interviews covered actuaries
2 with diverse backgrounds, the findings may not reflect
3 perspectives of all Part D plans.

4 In the next few slides, we'll provide key
5 insights from our interviews.

6 We consistently heard from our interviewees that
7 plans, on average, likely underbid in 2025, and that 2026
8 bids reflect adjustments for that underbidding. In early
9 2025, plans saw accelerated trends in brand name and
10 specialty drugs, which likely exceeded plan expectations.
11 These accelerated trends were seen more prominently among
12 non-LIS beneficiaries, likely driven by lower out-of-pocket
13 limits and the elimination of cost sharing above that limit
14 and the new true out-of-pocket calculation that Betty
15 mentioned and the underlying utilization trend not directly
16 related to the IRA.

17 In response, plans appear to have corrected
18 upward, contributing to the 33 percent increase in the
19 average bid for 2026. But large variation remained, likely
20 driven by continued uncertainty. For example, for 2026
21 bids, plans did not yet have historical data to understand
22 the full impact of the IRA redesign. There are other IRA

1 policies, like the maximum fair prices for the negotiation
2 program, that are expected to have varying impact across
3 plans.

4 Finally, in the face of greater uncertainty,
5 insurers took different approaches to bidding. For
6 example, some prioritized margins over enrollment, while
7 others focused on keeping premiums low to gain market
8 share.

9 Interviewees also described how policies and plan
10 strategies are shaping the PDP market. Some of the common
11 themes we heard include how insurers now see less value in
12 operating PDPs as a result of changes in the PDP or broader
13 Medicare environment. For example, a few actuaries noted
14 that some insurers are no longer interested in using PDPs
15 as a way to gain enrollees that could be moved into their
16 MA plans.

17 Another theme we heard, repeatedly, is how the
18 IRA redesign commoditized the market by limiting the ways
19 plans can vary cost-sharing and formulary structure to
20 differentiate themselves from other offerings, creating a
21 situation in which competition is primarily focused on
22 having low premiums.

1 We also heard that LIS benchmark plan dynamics
2 may drive both premium competition, which can be beneficial
3 to beneficiaries in Medicare, but also market instability
4 when plans miss the benchmarks and lose substantial portion
5 of their enrollees through CMS's auto-assignment process.

6 Finally, many raised concerns about risk
7 selection within the PDP market, which they noted remains
8 strong and is reinforced by the use of pricing and benefit
9 design to influence enrollee mix and benchmark plans'
10 ability to gain or retain auto-enrollees with lower
11 predictable claims relative to other LIS enrollees.

12 We also heard, consistently, that improving the
13 accuracy of Part D's risk adjustment is crucial for the
14 long-term stability of the PDP market. Actuaries we spoke
15 with generally agreed that the continued uncertainty means
16 that a stable PDP market with predictable utilization and
17 costs is likely still a few years away, and that while the
18 use of separate normalization factors improved the short-
19 term financial prospects for PDPs by increasing their
20 average risk scores and payments, longer term, ensuring the
21 viability of the PDP market would require further
22 refinements of the risk adjustment model to address risk

1 selection, and some suggested potentially other policies,
2 such as temporarily enhancing risk corridor protection to
3 provide some stability as market adjusts to new policies.

4 Shift in drug spending liabilities was the main
5 driver of the NAMBA increase in 2025. In 2026, rising
6 costs and uncertainty in pricing and utilization were the
7 primary factors.

8 Substantial premium buy-downs and temporary
9 subsidies have offset premium increases for enrollees but
10 have led to higher Medicare costs, including higher premium
11 subsidies for LIS enrollees, higher direct subsidies for
12 costs for Part D premium stabilization demonstrations for
13 PDPs.

14 Significant increase in plan bids driven by sharp
15 rise in catastrophic spending, particularly among non-LIS
16 enrollees, as well as the use of diverse strategies by
17 plans highlight the need for policies to address
18 catastrophic spending and ensure balanced competition and
19 market stability.

20 I now would be happy to address your questions
21 and hear any feedback or comments on the material we've
22 presented today. This material will be published as an

1 appendix to the Part D chapter in our March 2026 report to
2 the Congress.

3 Now we'll turn it back to Mike.

4 DR. CHERNEW: Great. And so there's just so much
5 here to wrap your head around, and if any of us can do
6 that, it's going to be Stacie. And she's going to now lead
7 off the Round 1 questions.

8 DR. DUSETZINA: Great. Thank you guys so much
9 for an excellent chapter. I found this chapter to be my
10 favorite reading of the week, by far. I don't know what
11 that says about me or you guys, but that's okay.

12 I just have a quick question about, in the
13 chapter you mentioned that in 2024, CMS had net payments of
14 \$3.6 billion to plans and that was the largest in program
15 history. Those payments to plans aren't really reflected
16 in the figures we're looking at, when you're showing the
17 bid breakdown. So when we're looking at '24, '25, and '26,
18 are those already reflected there or no?

19 MS. SUZUKI: So the risk corridor payments are
20 post actual spending, and what we're looking at here are
21 bids which are expected costs, so it's not --

22 DR. DUSETZINA: Great. That's what I thought.

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

3 MS. UPCHURCH: I did. It might be 1.5, but we'll
4 go with it. When Medicare D began, first of all, I also
5 loved this chapter. Thank you for the work. Really
6 excellent work and super clear. It's confusing, but I
7 think you all made it as clear as possible.

8 When Medicare D began, it was sold to pharmacists
9 as a way for pharmacists to be involved in clinical to
10 improve outcomes for older adults and adults with
11 disabilities. Especially the DIR fees, direct and indirect
12 remuneration fees were sold to pharmacists; to improve
13 quality of care, you get better outcomes, better star
14 ratings. What it's become is an extraction of funding from
15 pharmacies to support the benefit.

16 Can you talk about -- have any of the DIR fees,
17 have the bonuses gone to pharmacies that are doing a better
18 job clinically? Has there been any sort of link there,
19 because that's originally what was supposed to be. That's
20 the first question.

21 Second question, or maybe I'll just stop with
22 that and see if you all have any response, and then I'll go

1 to the next one.

2 MS. SUZUKI: So the pharmacy DIR fees are sort of
3 unique to each plan. They have their own metric to
4 determine how much each pharmacies are paid or are required
5 to pay to plans. So there is no uniform standard that
6 applies, and we don't have insight into exactly how these
7 amounts are determined.

8 MS. UPCHURCH: Right. But overall, it's been a
9 big extraction of funds from the pharmacy to the PBM and
10 the plan. Right. I just want to be clear about that,
11 because it really was sold to pharmacists as something very
12 different from that, that has never come to fruition.

13 The value of enhanced prescription benefits now
14 counts towards the TrOOP. Drug manufacturer discounts do
15 not count towards the TrOOP anymore. That was a big shift
16 with the design. One suggestion I have about that is do we
17 know why that happened? And obviously, the impact, to some
18 degree, keeps folks from the price of very expensive
19 medicines, when there may be alternatives to those. So can
20 you talk a little bit about, do we know why the enhanced Rx
21 benefits, so if you're paying a flat co-pay versus a co-
22 insurance, the co-insurance is more, the co-insurance

1 amount counted towards the true out-of-pocket. So people
2 that take more expensive medicines that have a co-pay are
3 spending less and less and less overall for the year. Can
4 we explain that, why that was put in place?

5 MS. SUZUKI: So I don't think we can talk about
6 why this was included in law. But the way the law is
7 written requires CMS to include the value of the enhanced
8 portion of the benefit in calculating TrOOP. And so CMS,
9 to implement this provision, has used a formula that
10 compares the enhanced plan's benefit, so the co-pays, for
11 example, to the defined standard benefit, let's say 25
12 percent co-insurance, and that difference is considered the
13 supplemental benefit value. And that's how CMS implemented
14 this.

15 MS. UPCHURCH: Yeah. Just so that people know.
16 So if people are on brand-name meds that have a co-pay
17 instead of a co-insurance, the more expensive meds they
18 take, the less they pay for the rest of the year, I mean
19 for the year. So it's perverse. So I just want to point
20 that out.

21 And the last thing, we talked in the past, or I
22 know certain members of Congress have talked about Medicare

1 Advantage plans being there for a year or two, not just
2 every year, having the benefits change and people having to
3 make decisions. Have we done that with Part D, talked
4 about more than a year's enrollment?

5 MS. SUZUKI: Are you talking about tracking the
6 changes in the formulary, or --

7 MS. UPCHURCH: Well, so every year we have to
8 tell people, you have to go through this, you need to
9 compare your medicines, things change dramatically between
10 years potentially. Have we talked about having plans stick
11 with their formularies for more than one year, so that we
12 don't -- you know, it feels a little bit like torture of
13 older adults and people with disabilities to have to
14 constantly go through this.

15 MS. SUZUKI: I'm not aware of a specific policy,
16 but I think that there are a lot of requirements the plans
17 must meet in their coverage. But they're a drug type or
18 drug cost level, and so there are cases where plans,
19 because they negotiated a better rebate, that they may
20 switch from one drug in that class to another. And
21 currently plans are free to change the drugs that are
22 covered preferentially, especially when they negotiate that

1 review once a year.

2 MS. UPCHURCH: Okay. Thank you so much. Again,
3 excellent work.

4 MS. KELLEY: Scott, did you have a Round 1
5 question?

6 DR. SARRAN: Yes. Excellent work for sure. I'm
7 just curious. In your discussion with actuaries, what was
8 your sense of their overall level of concern about their
9 ability to continue to deploy products? I don't know if
10 this is sort of a qualitative kind of feel. Are they in
11 panic mode or just concerned, we'll have to make some
12 changes to make this work?

13 MS. SUZUKI: So in our interviews we definitely
14 did not hear panic. We did hear about there being greater
15 uncertainty. And I think part of this is when they're
16 preparing bids, they do need the historical to reflect the
17 current design, and with the redesign taking place in 2025,
18 they hadn't yet experienced the whole impact of the IRA.

19 I think the other part is there are new policies
20 that are being implemented as we speak. This year it's the
21 maximum fair price. And a lot of plans are still waiting
22 to understand how that affects the benefit cost.

1 MS. KELLEY: Lynn.

2 MS. BARR: I was curious. What do we know about
3 the profitability of the plans? You know, and again it's
4 really complicated with the MA PDPs because they've got so
5 many overlying interacting incentives. But what was the
6 profitability of the plans before the old rules and the
7 projected profitability of these plans under the new rules?

8 MS. SUZUKI: So you're talking about the
9 redesign's effect on their profitability?

10 MS. BARR: Yeah.

11 MS. SUZUKI: I think it's difficult to say for
12 the redesign. We don't have the data yet. But in 2024, in
13 our other report, we do talk about how we saw more risk
14 corridor losses that CMS then had to pay plays. So in
15 2024, the biggest driver, we think, was related to the
16 catastrophic spending growing much faster than in other
17 years, likely due to the out-of-pocket going down,
18 especially for non-LIS beneficiaries, with the zero-dollar
19 cost sharing at the out-of-pocket limit.

20 MS. BARR: Do you have a sense of, like, were
21 they aggregately profitable or not profitable? Was it 5
22 percent? 10 percent? I mean, like any sort of -- do we

1 have any of that information?

2 MS. SUZUKI: Not directly. But I will say that
3 plan bids, which we talked about, that includes margin in
4 there. So when we talk about losses in the risk corridor
5 it is separate from the margins that are included in their
6 bids.

7 MS. BARR: And so like, for example, when there
8 was really no kind of plan liability before, right, it was
9 like everyone was paying but them. Are they still limited
10 by the 15 percent? I mean, what kind of margins were they
11 building in? I'm just really curious about, how much money
12 were they making before? How much money are they making
13 now? How does that all play out, if anyone knows.

14 DR. FOUT: Like Shinobu said, we don't have the
15 2025 actuals. We have the prior years' actuals from their
16 bid data. And the margins that they build in there are
17 very small. It's probably complicated to really assess
18 that margin, but they are not large.

19 DR. CHERNEW: I want to say one other thing
20 related to this, which is one of the challenges, which will
21 maybe come up in the status chapter, is the vertical
22 integration between these organizations and a bunch of

1 other parts of the organizations make thinking through
2 profitability challenging, in the accounting sense. So as
3 you go through the status chapter, I think there is a lot
4 of what an economist would call preference orientation of
5 what they're doing to figure out what's happening. So the
6 question about are they panicked -- because there's a lot
7 of things going on in here that make it hard to infer, at
8 least to my simple mind.

9 MS. BARR: That's why I was thinking about the
10 standalone PDPs might have a clearer look. But when you
11 say small, is that like 5 percent? I don't know.

12 DR. CHERNEW: Standalone PDPs are often offered
13 by the same companies that are offering MA things, and they
14 also have PBMs that are integrated. So they're standing
15 alone in the sense that they're not MA, but they're not
16 alone.

17 MS. BARR: Thank you.

18 MS. SUZUKI: One thing I will add is that the
19 margins are calculated as a percentage of their bid. So
20 before 2025, plan bids, which is the portion of the benefit
21 that they are at risk for, that was a relatively small
22 share. Now that the plan liability has grown, those

1 margins are now on the bigger number. So we did hear from
2 some stakeholders that this does provide for some more
3 margin to be built into the bid.

4 MR. MASI: And just to add, I think we're hearing
5 strong interest in additional work of this type, and
6 providing what information we can about the financials of
7 the sector. As Mike pointed out, and as Shinobu pointed
8 out, there are some real complications, whether it's
9 vertical integration or just how margins are calculated as
10 a share of plan liability, that will make that a
11 challenging exercise. But we'll certainly keep this in
12 mind and try to provide what we can in the future.

13 MS. KELLEY: So I think that's all we have for
14 Round 1, unless I've missed anyone.

15 DR. CHERNEW: I think that's good, because I'm
16 sure we're going to start Round 2. Stacie.

17 MS. KELLEY: Stacie.

18 DR. DUSETZINA: All right. This is incredibly
19 well done, and I think a couple of things that are on my
20 maybe wish list or thinking about how this information
21 might be received when you see the big jump, like the
22 percentage jump from 2024 to 2025 and 2025 to 2026. You do

1 a great job of decomposing what you think those are related
2 to, the changing in the way that plans bid for their cost
3 of the benefit.

4 But I keep wondering, is there a way to replicate
5 Figures 13(a) in the chapter with actual spending once
6 you've taken into account the risk corridor payments, just
7 so that you can get a sense that 2023, '24, '25, you know,
8 they're going to be different from one another, but maybe
9 they won't look quite as shockingly different as they do
10 when you're just looking at the bid data.

11 That seems like it would be potentially helpful
12 for just thinking through that, you know, before the change
13 I don't think plans had a great incentive to bid accurately
14 for the upfront payment portion. So like they're bidding
15 low relative to what the benefit is going to cost, and they
16 know that reinsurance is going to pick up the tab.

17 So I just think that with this need to have the
18 bid better reflect the actual cost of the plan, it might
19 just give the impression that it's gotten so much more
20 expensive. It has gotten more expensive, and you do a good
21 job of showing that. But I think it would help readers to
22 understand if there is some way to incorporate, even for

1 the older years, what happened with the risk corridor
2 payments, to try to better understand the total cost of the
3 benefit, I think that could be helpful.

4 Gina brought up the issue around the way that the
5 enhanced plans count TrOOP. I think this is an incredibly
6 important issue and one that we really need to get more
7 information on. It's not totally clear to me that that was
8 like super strategic. It's like as it was being
9 implemented it's like, okay, this is how we're going to
10 count the dollars towards getting people to the cap. But
11 it does have a couple of really potentially bad incentives,
12 like incentivizing higher drug prices if you can get them
13 under a co-pay, that I don't think we want.

14 And one of the things that I've wondered about,
15 and I think if you have the opportunity to talk to the key
16 informants, again, the actuaries from plans, is are plans
17 strategically responding to this change and making their
18 insurance benefits kind of like a little bit worse, on
19 average. What we've seen more broadly is a big jump in the
20 proportion of plans that require co-insurance for Tier 3
21 preferred brands. We also see more use of deductibles,
22 higher deductibles. And I think that those are important

1 potential consequences of this policy change, but it would
2 be great to know a little bit more about how much was that
3 the motivation for some of these changes versus something
4 else, and is that what's best for beneficiaries and
5 improving access to drugs that are really important for our
6 beneficiaries.

7 The other things, just kind of briefly, the
8 premium differences for MAPD and PDP, first off, every time
9 I start writing down a comment about, oh, it would be nice
10 to see this broken out, and then the next page you had
11 anticipated my data and had broken it out. So thank you
12 very much for all of that great work.

13 But I worry so much about PDPs for beneficiaries
14 and their ability to stay in the fee-for-service program
15 and have options that are truly affordable to them. The
16 premiums on those are going up quite a bit, and I'm not
17 sure how affordable it would be, especially once you take
18 away the demonstration project that lowers the premiums for
19 the next couple of years.

20 I also don't know if zero dollar premiums for the
21 MAPD market is a good reflection of the cost of those
22 benefits. You know, that's still the mean and medium

1 premium in those markets, and I'm not sure that zero
2 dollars is the right price for a benefit that actually does
3 have a lot of spending implications.

4 I wanted to call out just a couple of things from
5 your interviews, because again, this was like one of my
6 favorite parts is some of these quotes you got from the
7 actuaries about bidding behavior. One of them had made a
8 comment about, if you think you're going to be above the
9 benchmark you're going to bid incredibly high because you
10 might as well make a margin and be way above the benchmark.
11 Well, that's not great.

12 There's also a comment, and I think you alluded
13 to this too, about there being incentives for plans to have
14 a pool of enrollees who they could move into their MAPD
15 plan. This again is something I've worried a lot about,
16 about the concentration of plan sponsors, a small number of
17 companies who have both PDP and MAPD, and we know MAPDs are
18 more profitable. So I think it just creates -- I can't
19 believe that they said that out loud and you got this as a
20 quote. It was like one of those things where I read it and
21 I was like, oh, I thought that's what was happening but I
22 haven't been able to have somebody say that before.

1 I'm sorry -- and this is why I didn't talk all
2 morning was I was saving up all my time. The last thing, I
3 think, was you had a couple of quotes, and I really
4 appreciated how you talked to the actuaries about the
5 potential changes to the PDP market that might be needed to
6 keep it to be an attractive market for them. And I thought
7 some of the issues that they raised about like when they
8 were off of the benchmark and then they lost all of their
9 enrollees, it's like really hard to get those enrollees
10 back into the plan.

11 It made me think about how, at least in the MAPD
12 market, there seemed to be, at least, a little bit of an
13 ability to respond if you aren't going to be below the
14 benchmark, that you could do a little bit more to get your
15 premium to that space, and the PDP market doesn't have that
16 same flexibility. So that made me wonder is there any kind
17 of envisioning of a policy opportunity there or some sort
18 of flexibility to allow the PDP market, if they could and
19 wanted to get below the benchmark, how could they do that.

20 And then the other one was being locked out of a
21 region for two years if you left a region. And I know
22 that's to safeguard people's access and not have plans

1 leave, but it did make it seem that it would be hard for
2 them to update their benefits. So I felt like those were
3 two really important places to think about where we might
4 need a little more flexibility on the PDP standalone plan
5 side to make that market as attractive as we can.

6 Absolutely fantastic work.

7 MS. KELLEY: Brian?

8 DR. MILLER: So a couple thoughts. Historically,
9 I don't think necessarily standalone PDPs underbid.
10 Rather, at least when I've talked with plant executives,
11 they saw standalone PDPs as a commodity product to build a
12 brand relationship with the fee-for-service beneficiary and
13 then try and lure them into the MAPD market. So, if
14 anything, historically, it's been over-competition on
15 price, less non-price competition, and McKinsey actually
16 had some industry-oriented research that they published to
17 try and sell consulting services to standalone PDP plans.

18 I really liked this chapter and thought it was
19 very thoughtfully balanced in how it was executed and that,
20 you know, undertaking an 11 actuary survey, it's not easy
21 to find those folks, schedule that, and get that done. So
22 this is probably the only place we will ever see that.

1 I do think there are some interesting sort of
2 takeaways I had from this chapter, which I want to share,
3 because there was a lot of detail and it took me a while to
4 sort of step back a level, and the detail was very welcome.

5 One is, you know, I think we all agreed that the
6 Part D benefit redesign needed to happen, and what we
7 highlighted in this chapter is that there are challenges
8 when we don't have adequate transition periods. And so the
9 Part D design was desperately needed.

10 The donut hole was silly and harmful. So what we
11 saw from 2023 to 2024 to 2025 onwards is that the maximum
12 out-of-pocket for the MOOP dropped by over \$1,000. The
13 donut hole closed, all things that need to happen. And
14 then Part D plan responsibility grew from 20 to 60 percent
15 above the cap which, again, sounds reasonable and is
16 reasonable, just that the timeline was compressed.

17 Because of that compressed statutory timeline,
18 there was a price shock that drove up the standalone Part D
19 plan bids and drove plan exit, and I was looking at the
20 table in there, and it said the standalone PDPs declined
21 from 814 in 2023 to 367 in 2026. And the market is still
22 not what I would call stable or most of us would call

1 stable. So I'm worried about the stability of the
2 standalone PDP market, and that's what I would call robust
3 access to fee-for-service as an option for beneficiaries.

4 If we look at the spending data that we crunched,
5 I think, on a subsequent page, the plan liability went from
6 10 percent to 52 percent to 57 percent, and that's a pretty
7 aggressive change in an insurance market, whether it's auto
8 insurance, disability insurance, life insurance; in this
9 case, prescription -- outpatient prescription drug
10 insurance. We did that transition to ourselves, and that
11 was too fast. So it was the right change, but it occurred
12 over a short period of time, and so I think we're eating
13 the consequences of that.

14 Another theme that I saw in here, which we noted
15 explicitly, is that we gave managed care more
16 responsibility for costs without more tools, and I thought
17 that that was a perfect description. So bids ran up. They
18 ran up in a short period, which we would all have expected,
19 and then plan said, okay, I had an aggressive price
20 competition marketplace. How am I going to deal with these
21 massive increasing costs? I'm going to drive up co-pays,
22 co-insurance. The MOOP went down.

1 And so those tools were used. They probably
2 dumped some pharmacies out of network that they probably
3 shouldn't have and other tools, and then they ran out of
4 tools because they only have so many tools, and they broke.
5 So then premiums went up a lot. So it's sort of like you
6 can decrease costs, you can transfer costs, and then at a
7 certain point, you transfer costs to the consumer. So we
8 should probably think about giving them more tools. I
9 don't know what the right answer to those tools are.

10 Policy options, I would say -- and this is not my
11 personal opinion, but policy options I think about are
12 addressing protected classes. As a clinician, I'm
13 obviously a fan of protected classes, but from a policy
14 analyst angle, perhaps readdressing those is something that
15 we should think about.

16 The other thing we could think about is price
17 transparency at the point of service with net costs in the
18 electronic health record, so that at the point of
19 prescribing, the patient and the clinician are fully
20 informed of the price with real-time benefits. And that
21 could potentially change consumer choice.

22 I know that the Trump administration, the Biden

1 administration, and now the Trump administration, and
2 hopefully a future administration will continue this push
3 towards price transparency. So that's a pretty good
4 option, I think.

5 As a non-actuary, my read of the actuarial
6 interviews is that the risk model for Part D is failing,
7 and that was very clear to me as someone who's a clinician.
8 So, if I can figure it out, that means it's pretty bad.

9 And then I think the thing that really struck me
10 -- and this is related, but not entirely in our space, but
11 worth, I think, noodling on, just all of us collectively in
12 our spare time, which we don't have any of -- is that we
13 really lack -- and the fundamental problem with a lot of
14 drug costs is that we lack biologic market price
15 competition. So the biologics market doesn't have price
16 competition, and you have a lot of old, very expensive
17 drugs. And I'm not saying that small molecule generics or
18 that branded small molecules or branded biologics -- I'm
19 not saying that those don't have their own pricing issues,
20 but a lot of the burden to the beneficiary is from old
21 biologic drugs for which we don't have price competition.
22 So we probably need non-Medicare tools, which are

1 definitely outside of our scope, thinking about IP patent
2 fixes and then thinking about our own version of Hatch-
3 Waxman for the biologics marketplace and an abbreviated
4 biologics license application pathway.

5 Now, that's definitely outside of our scope, but
6 I think we should just be cognizant of the fact that part
7 of the Part D problems are created by lack of biologic
8 drugs market competition.

9 MS. KELLEY: Robert?

10 DR. CHERRY: Yeah, thank you for an excellent
11 report. This is certainly one of the more challenging
12 topics in health care, and I think you've packaged the
13 information, you know, quite nicely together.

14 I'll just mention that I think that in terms of
15 the Part D benefit redesign that's been done so far under
16 the IRA, it seems like in the very, very short term, it's
17 accomplished at least some reasonable goals that we can
18 see. You know, the reinsurance rates have gone down.
19 There are fewer out-of-pockets, and the cost-sharing model
20 is more optimized.

21 I think I would also put myself in a category of
22 uncertainty regarding the long-term future in terms of

1 what's been done and whether it's actually a sustainable
2 model, and while I do agree that the trend is towards
3 higher pharmacy costs, I think the assumptions here do need
4 to be revisited about, you know, what this looks like, you
5 know, on a go-forward basis.

6 So I'm not an actuarial scientist, of course, but
7 I do know that assumptions, you know, can make or break the
8 ultimate outcome that we're trying to make, you know,
9 judgments on.

10 I'll just mention just a few areas to highlight,
11 you know, two assumptions that I don't think were really
12 mentioned in the report, one that was mentioned, but I'm
13 not sure entirely in agreement with.

14 One has to do with -- and this was mentioned, is
15 the increased costs related to GLP-1s, and I think there is
16 an urban legend out there that basically says that these
17 are going to increase pharmacy costs, and I do agree with
18 that.

19 However, when you look at, you know, health plan
20 formularies, hospital system formularies, they're taking a
21 closer look at these GLP-1s and starting to think about
22 which patients actually would benefit from them. So they're

1 applying BMI criteria and comorbidity criteria, and I think
2 that is going to change the trajectory of the cost model
3 and the projections moving forward. So I do think that
4 that's worth kind of, you know, relooking at.

5 The other two areas that were not mentioned but
6 we've mentioned in, you know, in this group has to do with,
7 I think, the explosive growth that we'll see with cellular
8 and gene therapy drugs between now and 2030. And I didn't
9 see a mention of, you know, how that particular category of
10 drugs will upend, you know, the current model.

11 And then, finally -- and it's difficult to
12 probably, you know, wrap, you know, reasonable assumptions
13 around this, but I think it's probably safe to say that
14 over the next couple of years, there's going to be ongoing
15 pressures and disruptions around global supply chain with
16 regards to pharmaceutical drugs in terms of just access,
17 availability, and perhaps pricing as well.

18 S, I think as we, you know, continue to think
19 about this, I think we have to keep revisiting the models
20 to see what works, and, you know, I do agree with Brian,
21 you know, we need more tools in our toolkit as we start to
22 identify more issues, whether it's price transparency or

1 improved competition. But at the end of the day, this is
2 kind of like playing whack-a-mole, and we have to, you
3 know, look at the models critically and continue to revisit
4 the tools that are available.

5 But thank you for a great report.

6 MS. KELLEY: Cheryl?

7 DR. DAMBERG: This is really a fantastic chapter.
8 I certainly learned a lot reading through it, and once the
9 public gets to see it, I think they will enjoy the work as
10 well.

11 So this is a really huge set of policy changes,
12 and, you know, as with -- you know, I don't know whether
13 it's the Affordable Care Act or name any big policy change,
14 you rarely get everything right coming out of the gate. So
15 I think this really underscores the importance of
16 continuing to monitor what's happening in the space and
17 thinking about what types of adjustments or mid-course
18 corrections might be needed to shore up different pieces of
19 it.

20 So I certainly look forward to the future work
21 that the Commission is going to do in this space, because
22 there's a lot of different actors in this space and kind of

1 what their behavioral responses to all these changes are
2 will be interesting to play out.

3 I want to plus-one on Stacie's comment related to
4 Figure 13(a).1 about looking at the total cost of the
5 benefit, because I think my initial read of it was like,
6 wow, you know, the cost has gone up. But, you know, once
7 you factor in the reinsurance piece, maybe it's not so
8 shocking. But maybe it is, but it would be helpful to see
9 that.

10 And I think related to that -- and this gets into
11 the Part D standalone plans and the premium stabilization,
12 which is a temporary program, and I don't know whether CMS
13 is going to continue it, but at some point, I'm assuming,
14 you know, there's a transition out, and so you're going to
15 have to rip off the bandage, right?

16 And I think right now consumers, meaning
17 beneficiaries, don't really have any awareness of the
18 degree of subsidization that's going on to prevent that big
19 price increase and what the true cost of their prescription
20 drugs are, and so they may end up paying more up front but
21 sort of saving on the back end.

22 And so I think as we, you know, try to explain

1 this to the public, just having a better sense of, you
2 know, where that policy making is going and at what point
3 consumers are going to face this additional cost would be
4 helpful. I realize you don't sort of have the crystal ball
5 to know what CMS is going to do in terms of extending that
6 policy.

7 And then I, too, am very concerned about the
8 shrinking standalone PDP market and the long-term viability
9 of it. So I do think we need to be thinking harder about
10 the risk model to ensure, you know, correct pricing in that
11 space.

12 And I agree with Brian and, you know, the
13 comments in the paper about, you know, effectively the
14 plans do need tools to manage utilization and spending.
15 Again, I'm not sure what those tools are, but I do think
16 that we're going to have to think harder about that.

17 MS. KELLEY: Gina.

18 MS. UPCHURCH: Again, thanks so much for this
19 work.

20 This raised a lot of concerns for me. First of
21 all, I think the redesign was tremendous and has done a lot
22 of good for a lot of people. I do think we've got to keep

1 our eyes on a couple of things, one of them being the
2 overall costs and the prices. So, in order to stabilize
3 the market between standalone drug plans and Medicare
4 Advantage plans, if we think we're overpaying Medicare
5 Advantage plans anywhere from 14, 20, 22 percent, whatever
6 year we're talking about, does that mean we have to overpay
7 for the standalone drug plans that amount? You know, I
8 mean, because they're using some of that money to buy down
9 the drug benefit. So I don't think overpaying for
10 everything is really going to -- I don't think that's how
11 we want to stabilize the market. So I just want to point,
12 you know, it's not the best alternative. So I'm very
13 concerned about the prices.

14 In particular, the amount of administrative work
15 that has to go into administering the Part D benefit, I'm
16 just going to name a few things. Maximum fair price. We
17 know a lot goes -- and this affects not only the plans, but
18 pharmacies. Pharmacies. The maximum fair price, you know,
19 all the work that goes into pharmacies of signing up for
20 the facilitator of this maximum fair price, the MP3
21 program, which is the prescription payment plan, you know,
22 very few people have taken advantage of it, but plans have

1 to create a whole section of people to deal with MP3. What
2 if somebody doesn't pay? And this is where you can just
3 not pay anything at the pharmacy counter and pay the
4 insurance company on the back end. What if people don't
5 pay? What's the administrative burden of that? What's
6 happening to those people who don't pay when their prices
7 start skyrocketing in October, November, December? I want
8 us to keep following that, not only administrative burden,
9 but what it means for consumers who didn't really
10 understand what they were getting into.

11 You know, obviously, the stabilization program is
12 administrative overhead. The bid teams that these plans
13 have to get to understand the bids and how they work and
14 the risk assessment and how they can, you know, manipulate
15 that situation for their company, I agree with Stacie. She
16 made a comment, you know, basically somebody said, you
17 either go -- if you're going to bid, you go big or you go
18 home because you get paid more the more you're off target.

19 And then lastly, formulary management. It's
20 tremendously administratively burdensome for everybody. So
21 there's so many administrative costs into the drug benefit
22 we have now.

1 Which leads me to Robert's, you know, talking
2 about we need tools in the toolkit, and in our previous
3 meetings, I know Greg has talked about, and many of us have
4 supported, the idea of how we pay for medications in
5 Medicare. There's A payments, B payments, C combination,
6 and D payments. So looking that across the board, I think,
7 would be very helpful.

8 And lastly -- and you all have gotten an email
9 from me about this -- I would love to know the total cost
10 of the drug benefit; in other words, not only what the
11 plans or the manufacturers are contributing, but what the
12 consumer is paying, not only in premiums, but in cost
13 sharing as well. You know, so what is the total amount
14 that's going towards the drug benefit, and including their
15 cost sharing for enhanced benefits, but just other cost
16 sharing, co-pays and co-insurance that they have?

17 Again, a tremendous job. I have lots of other
18 comments, but I'll save it for the update chapter. Thank
19 you.

20 MS. KELLEY: Okay. I have a comment from Kenny.
21 Kenny says that he loves this chapter enthusiastically.
22 While the 2025 update note warned of standalone Part D

1 instability, 2026 documented its emergence. The IRA
2 resulted in huge costs shifted over to health plans due to
3 significantly lower beneficiary MOOP and associated induced
4 utilization and expensive drugs such as GLP-1.

5 The IRA has resulted in the Part D risk model
6 being the keystone of sustainable standalone Part D
7 financing. The future is highly uncertain.

8 He believes the weakness of the current Part D
9 risk model is being masked by temporary financing fixes and
10 risk corridors. Medicare needs a much more accurate risk
11 model, or this will undermine standalone PDP competition,
12 premium stability, and ultimately fee-for-service program
13 sustainability.

14 He implores MedPAC to work closely with CMS and
15 the industry to monitor the situation to ensure a
16 sustainable standalone Part D program for the long term.

17 And I have Lynn next.

18 MS. BARR: Thank you.

19 You know, when we talk about Medicare Advantage,
20 it's pretty clear what MA plans do and how they interact
21 with the beneficiaries. What is the value that the plans
22 are bringing to the Part D program? Can you help me

1 understand what is it? Why are they in the middle of this?
2 I guess is my question. I mean, why don't we have a fee-
3 for-service Part D? What are they doing that is bringing
4 value to the program?

5 That's a part -- I know it's a one question, but
6 yeah, that's for you.

7 UNIDENTIFIED SPEAKER: That is three questions.

8 MS. BARR: No, it's a question because I don't
9 understand it. I'm like, what are they -- are they doing
10 prior auth? What are they doing?

11 DR. CHERNEW: Well, I think the answer is the
12 Part D plans do a lot. They do formulary management. They
13 do a lot of the negotiation stuff. All the other detail
14 benefits, pharmacy network stuff, all that stuff is what
15 they do.

16 One could have a debate about how the law was set
17 up and the role of private plans in general, which by the
18 way, I don't want to have.

19 MS. BARR: I don't want to have. But when you
20 say they do -- I mean, formulary management is sort of like
21 a rebate game, right? I mean, does that make it less
22 expensive for --

1 DR. CHERNEW: For time reasons, we can have a
2 longer discussion here, but I think the point is there's a
3 lot of ways you can innovate on aspects of formulary in a
4 whole bunch of ways, a lot of ways you can engage
5 beneficiaries. There's a lot of, I think, pathways to
6 value of what they can do. Whether it could be replicated
7 elsewhere besides the point.

8 I think the key point here is we're working
9 within a much, much narrower construct, which is it was set
10 up before my time, at least my time here, to rely on
11 private-sector plans under the belief that the competition
12 amongst the private-sector plans would provide innovation
13 and cost savings.

14 Without going through the merits of that
15 argument, I think there were some concerns with the way it
16 was designed before they did the redesign, and so we're
17 doing a much more limited exercise here just to understand
18 what we can learn about how that's working and doing it
19 with the data we're getting from the bids, which I think is
20 quite unique data combined with the qualitative work we've
21 done.

22 So I think we should say for a future discussion

1 -- notice I say that knowing I won't be chair. I think we
2 should say for the next Chair to decide, the extent you
3 want -- we want to have a bigger philosophical discussion,
4 about how to manage drug costs and focus now on --

5 MS. BARR: I'm not asking for that. I was just
6 wondering, do we have evidence that they're actually
7 reducing -- that the plans are reducing the cost versus if
8 it was just a fee-for-service? I'm just asking if there's
9 evidence. If we just did fee-for-service on drugs, like we
10 do, would it be different? Would it be more expensive? Is
11 there evidence that what they're doing is actually
12 benefitting the beneficiaries? That's all I'm asking.
13 It's not a philosophical question. It's like a data
14 question.

15 DR. CHERNEW: I think the short answer, because I
16 do want to move on, is since we haven't done it the other
17 way, we don't have evidence comparing it to the other way.
18 It obviously would depend on how the government set their
19 formularies, their prices, and all the other sorts of
20 things the government did. So we will see how that plays
21 out, but there's -- to sort of answer directly, it's not a
22 comparison if we did it a different way because we haven't

1 done it a different way.

2 MS. KELLEY: Greg.

3 MR. POULSEN: I'm terrified to ask this because
4 it was a permutation of what Lynn just said.

5 [Laughter.]

6 MR. POULSEN: Robert mentioned we're going to see
7 an explosion of gene therapy capabilities and potentially
8 at enormous cost. I think if we combine that with
9 monoclonal antibody breakthroughs and messenger RNA
10 breakthroughs, there are very few diseases that aren't at
11 risk here, folks. I mean, if I was a disease, I'd be
12 nervous.

13 But the issue that goes with that is that the
14 costs of all these are extraordinary, and we've started to
15 recognize that. As a country, we're looking at things like
16 most-favored-nation discussions for major drugs. We're
17 looking at a whole bunch of things, all of which raises, I
18 think in a very serious way, the point that Lynn's making,
19 which is some of the things that we have historically hoped
20 that the market would do, we're now saying the market
21 failed us. We're way more expensive than every other
22 country in the world in terms of the drugs that we buy, not

1 just on a utilization basis, but on a per-unit basis. And
2 we're seeing some things that are really, really
3 interesting here.

4 And again, at the risk of heading down Lynn's
5 path, which I think we probably need to at some point,
6 because this is such a big, big percentage of our spend
7 these days, and it's going to get way, way bigger in the
8 absence of a trajectory change, I just think the data that
9 you all put together is brilliant and very, very helpful,
10 but I think the implications of it are far broader than the
11 discussion that we're having here.

12 I know we're not going to do that in the next
13 three and a half minutes. So I just want to put a place
14 marker that I think this is a huge deal that we're going to
15 have to embrace if we want to control health care costs.

16 DR. CHERNEW: That was the end of Round 2 from
17 what I had.

18 MS. KELLEY: Yes.

19 DR. CHERNEW: Perfect. So I want to say a few
20 things before we go on to talk about a complicated topic,
21 Part D.

22 So the first thing is, I just want to point out

1 that what I liked a lot about the chapter is acknowledging
2 that a lot of the premium increase is a financing shift
3 from out-of-pocket to premiums, and there's a portion that
4 is actually added use, because when you do that, you get
5 added use.

6 When you shift from out-of-pocket to premiums,
7 you're spreading the cost in a certain way. So some people
8 benefit quite a lot, and then other people are paying a
9 premium that's just gone up a lot, and they aren't
10 benefitting as much. And so I think the distributional
11 issues of that shift are important, and I think the
12 chapter, by highlighting what's going on, actually did a
13 quite good job, because as soon as you say, that's kind of
14 simple, but there's also the low-income subsidy part and
15 all these other things, net, because of some of the rules,
16 particularly the 6 percent cap on premiums, in fact, the
17 government is paying more. This is, of the total spend,
18 collectively, the taxpayer is shouldering a higher degree,
19 a higher share than they otherwise might. It's just being
20 pushed more onto the premium and away from out-of-pocket,
21 and of course, the total pie is bigger, because of the lack
22 of cost-sharing incentives. And I think that is useful to

1 note, and I think the chapter does a good job. I encourage
2 people, when the chapter comes out, to look at all of that
3 work.

4 The other thing I'll say, in response to what you
5 said, Greg, and to Lynn, I think maybe I'll revise a little
6 bit of my answer before. We do have Part B drugs, which
7 are not dealt with in exactly this way, although they are -
8 - they're often managed by plans in a whole other way. So
9 they're not really working exactly analogous to A and D,
10 but they're Part B. And there's complicated issues of how
11 those -- how Part B stuff works.

12 I'm not -- I don't want to belabor all the work
13 we've done on Part B, but it is not working perfectly, for
14 a range of reasons, and many of the things, I think, Greg,
15 that you were talking about -- actually, I don't know
16 clinically enough; I'd defer to others -- are probably
17 actually Part B issues that we have to deal with. And
18 that's sort of separate from the Part D redesign, bidding
19 process stuff that we do, and I think the core issue is how
20 you think about the prices there. And so I'm going to sum
21 up by saying the fundamental challenge in any
22 administrative pricing system, like Part B, is -- or drugs

1 in general, even including what Brian was talking before is
2 there is a complicated trade-off between spending a lot,
3 certainly more than other places, and how you think about
4 the innovation incentives, and what you're getting.

5 And a lot of these new drugs, not all of them,
6 but a lot of these drugs are actually drugs that we're
7 really glad that we have access to, and the question is how
8 to get access to those drugs at a price we can afford
9 without deterring innovation. And we've tried to do some
10 of that stuff, I think going forward. Other people will do
11 some of that stuff, and I think it's certainly the case
12 that we want incentives to make sure that people don't use
13 those drugs in situations when they shouldn't. And there's
14 a lot of stuff we've done, particularly in Part B, where
15 we're saying, you know, we have a lot of incentives to not
16 have people use, say, the most cost-effective type of care.

17 So we will get there, I will be mortified when I
18 read that comment on the transcript. I discourage anybody
19 from looking at the transcripts. But in any case, this has
20 been a really rich discussion, I imagine a lot of people
21 have more things to say.

22 Let's take -- since Shinobu's coming back -- oh,

1 Paul wants to say something.

2 MR. MASI: I agree with all that, Mike.

3 Just to acknowledge very quickly, one challenge
4 when we have a conversation focused on problems is we talk
5 a lot about problems, which is a very -- this is a very
6 productive conversation and very helpful. Because it got
7 triggered a few times, I do think it's worth acknowledging
8 that kind of stepping back from the experience of the last
9 few years, which is, of course, very important to focus on
10 -- that's what we're doing here -- I did want to just note
11 that kind of over the broad experiment of project of Part
12 D, you know, we have seen, you know, high and consistently
13 growing rates of generic dispensing and beneficiaries'
14 reports, you know, very favorable marks in terms of patient
15 experience. And that's something we hear in our focus
16 groups. So I just wanted to make sure that was also
17 acknowledged kind of in our discussion.

18 DR. CHERNEW: If only we could invite Shinobu
19 back to talk about the status of the Part D program, we'd
20 be able to expand on that comment, but I think maybe we
21 will. If we have a motion to invite Shinobu back to talk
22 about this part -- there you go.

1 So let's take a break for about maybe a little
2 more than five minutes or so, because we're a little bit
3 behind, and then we are going to invite Shinobu back to
4 talk about the status part, and maybe -- I don't know,
5 Betty, if you're joining or whoever else is joining, but in
6 any case, thank you both. This is so complicated of a
7 topic. We really appreciate your work on this.

8 [Recess.]

9 DR. CHERNEW: Hello, everybody. We're live. I'm
10 sorry you can't see me. There's an issue with my camera,
11 but I am indeed here. And as I promised, it would be a
12 great thing to follow up the discussion we just had with a
13 discussion on the Part D status, the status of the Part D
14 program, and who better to kick us off than Shinobu. Oh,
15 I'm sorry. I take it back. Go ahead.

16 MS. DEWAN: Good afternoon. We are here to
17 present the annual status report on Part D, Medicare's
18 outpatient drug benefit. Tara Hayes, who worked on this
19 report, could not come to the meeting today. This material
20 will be a chapter in the Commission's upcoming March
21 report. As a reminder to the audience, a PDF of these
22 slides is available at the top right corner of your screen.

1 First, we will provide some background on the
2 Part D program, followed by an update on enrollment trends,
3 changes in plan offerings, premiums, and program spending.
4 Then we will discuss Part D prices. Finally, we will
5 discuss beneficiary access and analysis related to the
6 accuracy of drug prices on Medicare Plan Finder.

7 The Part D program provides Medicare
8 beneficiaries with access to prescription drug coverage by
9 using private insurers that compete to deliver pharmacy
10 benefits. Plans may be standalone prescription drug plans,
11 referred to as PDPs, available to beneficiaries using fee-
12 for-service Medicare, or part of a Medicare Advantage plan,
13 known as an MAPD, which offers both medical and
14 prescription drug coverage. There are two types of MAPDs,
15 conventional plans, open to all MA enrollees, and Special
16 Needs Plans, referred to as SNPs, which are available only
17 to certain qualifying individuals.

18 Plan sponsors and their Pharmacy Benefit
19 Managers, or PBMs, take part in a couple of sets of
20 negotiations. One is with pharmacies, to set up networks
21 and agree on payment rates for prescriptions and pharmacy
22 fees. The other negotiation is with pharmaceutical

1 manufacturers over formulary placement and post-sale
2 rebates.

3 Medicare's payments to plans cover a substantial
4 portion of basic benefit costs. Enrollees pay their share
5 of the premiums plus any cost-sharing required for their
6 medicines.

7 While plans bear financial risk for enrollee
8 spending, which provides incentives to manage benefits,
9 Medicare does share in that risk through reinsurance and
10 risk corridors that limit plan losses and profits. In
11 addition, payments to plans are risk-adjusted to account
12 for variation in spending due to health status.

13 In 2026, the standard benefit has an annual
14 deductible of \$615 and an out-of-pocket cap of \$2,100.

15 The new benefit structure took effect in 2025,
16 and increased plan liability, reduced Medicare's
17 reinsurance liability, provided beneficiaries a \$2,000 out-
18 of-pocket cap, and changed drug manufacturers' liability
19 for costs. The out-of-pocket cap, like the deductible,
20 grows each year in accordance with growth in Part D
21 spending.

22 Before diving into the details, here's a snapshot

1 of the program. Note that we use the most recent available
2 data for each parameter discussed, which means the years
3 vary.

4 In 2025, enrollment reached nearly 56 million.
5 Low-income subsidy enrollment declined for the first time
6 in 2025 to 13.6 million. Across plan types, enrollment
7 continued to shift to MAPDs, driven by SNP enrollment.

8 Across the country, there are more than 5,000
9 plans offering Part D coverage. There was a slight drop in
10 overall plan counts from 2025. PDP plans again declined
11 significantly, which will be discussed more later. But
12 across the 34 PDP regions, there are an average of 11 plans
13 per region. The number of conventional plans declined by 9
14 percent, but the average Medicare Advantage beneficiary
15 still has 32 plans from which to choose. In contrast, the
16 number of SNPs increased 20 percent.

17 Medicare's program spending in 2024 totaled \$132
18 billion, up 18 percent from the prior year. Note that 2024
19 spending is before the benefit redesign that went into
20 effect last year.

21 Beneficiaries paid \$34 billion between their
22 premiums and cost sharing paid out-of-pocket, a slight

1 decline from 2023 driven by a drop in enrollee cost sharing
2 as a result the elimination of cost sharing above the out-
3 of-pocket cap that went into effect in 2024.

4 The Part D program has historically enjoyed high
5 levels of beneficiary satisfaction, and while star ratings
6 declined again, CAHPS scores related to enrollees' drug
7 plan ratings and access to needed medications remained
8 above 80 on a 100-point scale for both PDPs and MAPDs.

9 I will now hand over to Betty.

10 DR. FOUT: We will now talk about enrollment,
11 plan offerings, and spending.

12 Over the past decade, Part D enrollment grew from
13 73 percent to 80 percent of Medicare beneficiaries. PDP
14 enrollment fell to 42 percent of Part D enrollees in 2025,
15 though there has been a slight increase in PDP enrollment
16 the past two years after a period of decline.

17 MAPD enrollment continued to grow steadily, with
18 recent growth driven by SNPs. Chronic condition SNPs, or
19 C-SNPs, in particular, have been growing rapidly,
20 especially among non-LIS beneficiaries. Such beneficiaries
21 accounted for roughly 12 percent of SNP enrollees in 2025.

22 The number of PDPs continued to decline, with

1 roughly half as many PDPs available in 2026 as there were
2 two years ago. However, the drop in 2026 is mostly due to
3 a 34 percent decrease in the number of enhanced plans, as
4 most plan sponsors now offer just one enhanced plan instead
5 of two. Because some sponsors offer just basic plans, for
6 the first time since 2012, fewer than half the PDPs
7 available are enhanced.

8 After steady growth for most of the past decade,
9 the number of conventional MAPDs declined slightly.

10 SNPs, on the other hand, grew 20 percent, and
11 nearly 75 percent of SNP enrollees are now in enhanced
12 plans, a reversal from the historical trend. This is likely
13 due to the end of the VBID model, which previously allowed
14 plans to offer many supplemental benefits under a basic
15 plan.

16 Despite the decreases among PDPs and conventional
17 MAPDs, there are still an average of 11 PDPs available
18 across the 34 regions in the country, and the average
19 beneficiary has 32 MAPDs from which to choose. Every PDP
20 region has at least 1 benchmark plan. and most enrollees
21 have a choice of a premium-free MAPD.

22 With the benefit redesign substantially

1 increasing the amount of spending that would fall under
2 plan liability, as we discussed in the last presentation,
3 it was expected that premiums would also increase
4 substantially. And that is in fact what you see in the
5 dotted top lines at the top of these two graphs, charting
6 average total basic and supplemental beneficiary premiums
7 for PDPs on the left and MAPDs on the right.

8 However, the IRA included a provision to limit
9 annual increases in the base beneficiary premium, the share
10 of average expected costs that will be paid by enrollees,
11 to no more than 6 percent. The application of this limit
12 on premium increases brought average premiums down to the
13 amounts shown by the dashed line in the middle of these two
14 charts.

15 But the average premiums beneficiaries would
16 actually pay are shown by the solid line at the bottom of
17 each graph.

18 For PDPs, in 2025, after analyzing bid
19 submissions, CMS implemented a demonstration further
20 reducing beneficiary premiums, noting their concerns that
21 large premium increases and variations could cause
22 instability in the PDP market. This demonstration lowered

1 the actual premiums for PDPs in 2025 and 2026, so that they
2 are very close to recent historical averages.

3 MAPDs have their own mechanism -- the ability use
4 Part C rebates -- to reduce the premiums actually paid by
5 beneficiaries below what the 6 percent cap would have
6 required. In fact, because of the 6 percent cap, MAPDs
7 were able to use fewer rebates to lower premiums below the
8 average of the year prior to the IRA's provisions taking
9 effect, as you can see by the gap in the bottom two lines
10 of the right-hand chart.

11 While the benefit redesign is intended to correct
12 misaligned financial incentives the Commission was
13 concerned about, additional trends raise concern about the
14 long-term stability of the PDP market, as the MAPD market
15 continues to grow.

16 As we just showed, average PDP premiums are
17 consistently higher than those of MAPDs, and the premium
18 stabilization demonstration is set to end in 2027, and the
19 6 percent cap on annual increases in the base beneficiary
20 premium will also end in 2029, which may result in this gap
21 widening further.

22 The number of PDPs continues to decline. There

1 are now half as many PDPs across the country as there were
2 just 2 years ago, though the most recent decrease was
3 primarily due to a decline in enhanced plans, which may be
4 because redesign limits plans' ability to differentiate
5 their products.

6 As for benchmark plans, 18 out of 34 regions have
7 just one or two premium-free plans for fee-for-service LIS
8 enrollees.

9 PDPs also, on average, have had higher gross
10 costs but lower risk scores than MAPDs. In 2025, CMS began
11 applying separate normalization factors for PDPs and MAPDs
12 to account for the divergent risk score trends in the two
13 markets.

14 Finally, PDPs have been more likely to incur
15 losses, which is, at least in part, related to the
16 differences in risk score trends in the two markets. We
17 plan to continue to monitor these trends.

18 And now I will turn it over to Shinobu for
19 discussion of Part D spending and drug prices.

20 MS. SUZUKI: So we will now talk about spending
21 and prices in Part D.

22 The table here shows the components of Medicare's

1 Part D program spending, and separately, the share of drug
2 spending paid by Part D enrollees in premiums and cost
3 sharing. The first row shows that, in 2024, Medicare's
4 spending for Part D grew by 18 percent, and we can see that
5 the largest driver was the increase in capitated direct
6 subsidy just below which grew by 389 percent.

7 The increase reflects IRA changes that took
8 effect in 2024: the increase in plan liability in the
9 catastrophic phase of the benefit as the IRA eliminated the
10 5 percent cost sharing, which lowered both cost sharing
11 paid by enrollees and by Medicare's low-income cost-sharing
12 subsidy, and the 6 percent cap on the annual increase in
13 enrollee premiums.

14 As we described during the bid presentation, both
15 the increase in catastrophic plan liability and the 6
16 percent cap increased direct subsidy payments. As a
17 result, Medicare's basic benefit costs, shown as a subtotal
18 for basic benefits, grew by 34 percent in 2024. Premiums
19 paid by enrollees grew by 6 percent, consistent with the
20 cap, and cost sharing paid by enrollees decreased by 6
21 percent. On net, enrollees' costs totaled \$34.4 billion in
22 2024, a slight decline from \$34.5 billion in 2023.

1 In 2024, there were two opposing trends that
2 affected spending in the catastrophic phase. First, a
3 policy requiring pharmacy fees to be reflected at the point
4 of sale lowered point of sale prices, which in turn,
5 resulted in fewer enrollees reaching the out-of-pocket
6 threshold. However, once an individual reached the
7 threshold, spending increased, particularly among non-LIS
8 enrollees, who no longer paid cost sharing.

9 We will discuss how this may have contributed to
10 more plans incurring losses next.

11 Part D's risk corridors protect plans from large
12 losses and limit excess profits when actual experiences
13 diverge from plan bids. You may recall from our bid
14 presentation that plan bids represent the revenue required
15 for the portion of benefit costs for which plans bear risk,
16 and are funded by Medicare's direct subsidy and enrollee
17 premiums.

18 Because plan liability includes some of the
19 catastrophic costs, higher than expected catastrophic
20 spending can contribute to losses, that is, actual plan
21 costs exceeding the amounts they assumed in their bids. In
22 2024, Medicare's net risk corridor payments to plans

1 totaled \$3.6 billion, representing the largest payments
2 since the program began. About 75 percent of the payments
3 were to PDPs, shown in blue, continuing a concerning trend
4 that PDP has been more likely to incur losses.

5 While generic drugs have accounted for 90 percent
6 of all Part D prescriptions since 2017, most recent data
7 suggest that catastrophic spending continues to be driven
8 largely by increased use of single-source drugs, which are
9 typically high-priced brand-name drugs and biologics, with
10 no generic or biosimilar alternatives.

11 Our analysis of the 2024 data found that single
12 source drugs accounted for just 10 percent of prescriptions
13 but over 83 percent of gross Part D spending, up from 70
14 percent in 2014.

15 Since 2019, point of sale prices for single-
16 source drugs have increased by an average of between 5
17 percent and 7 percent. The exception was in 2024, when
18 point of sale prices decreased as the new policy requiring
19 pharmacy fees to be reflected at the point of sale went
20 into effect.

21 Between 2014 and 2024, post-sale manufacturer
22 rebates increased from about \$16 billion to \$77 billion.

1 This represents an average annual growth of about 17
2 percent. Yet, prices of single-source drugs, net of
3 rebates, still increased by about 4 percent per year during
4 the same period. Given their high prices, this growth has
5 significant cost implications.

6 To address high prices that drive spending,
7 Medicare now negotiates prices of selected drugs with the
8 highest expenditures under the Medicare Drug Negotiation
9 Program. Beginning this year, negotiated prices referred
10 to as Maximum Fair Price, or MFP, applies to selected
11 single-source drugs.

12 In 2024, selected drugs accounted for large
13 shares of spending and rebates for single-source drugs.
14 For the 10 applicable year 2026 drugs, spending totaled \$61
15 billion, or over a quarter of total spending on single-
16 source drugs, while rebates totaled \$28 billion, or about
17 40 percent of all rebates for single-source drugs. For the
18 15 applicable year 2027 drugs, spending totaled \$42
19 billion, or about 18 percent of spending on single-source
20 drugs, and rebates totaled \$14 billion, or about 20 percent
21 of all rebates for single-source drugs.

22 Nearly all selected drugs have high point of sale

1 prices, often \$500 or more per month, with some in the tens
2 of thousands of dollars.

3 Given the concentration of spending and rebates
4 among the selected drugs, the application of MFPs are
5 expected to have material impact on plans' and Medicare's
6 costs. CMS estimated that MFPs represented an average
7 discounts of low to mid-60 percent relative to list prices
8 for both 2026 and 2027 applicable year drugs, but somewhat
9 different discounts relative to net prices, 22 percent and
10 36 percent, respectively for 2026 and 2027 drugs.

11 Differences in discount relative to net prices
12 are driven primarily by rebates. The 2027 cohort included
13 more protected-class and specialty drugs, where rebates
14 have tended to be limited than for other drug classes, and
15 as a result, there may have been more room for negotiation
16 to lower prices.

17 However, there is considerable uncertainty in
18 estimating impact on Medicare spending. For example,
19 prices and utilization of selected drugs may change between
20 the time MFPs are negotiated and when they become
21 effective. Medicare will also incur higher reinsurance and
22 subsidy costs for selected drugs as these drugs are exempt

1 from Part D's mandatory discounts of 10 percent in the
2 initial coverage phase and 20 percent in the catastrophic
3 phase of the benefit.

4 In addition, a shift from rebates to lower point
5 of sale prices creates both downward and upward pressure on
6 premiums and costs, complicating measuring the net impact
7 on Medicare costs.

8 Now, I will turn it over to Pamina for
9 discussions about beneficiary access.

10 MS. MEJIA: Thanks, Shinobu. I will now discuss
11 beneficiary access and findings from our Medicare Plan
12 Finder analysis.

13 Part D plans use different levers to manage
14 benefit spending. These levers include formularies, cost-
15 sharing, and pharmacy networks. Plan sponsors contract
16 with pharmacies to create plan-specific networks which can
17 be used to direct beneficiaries to higher value pharmacies
18 or offer lower cost-sharing. Medicare beneficiaries can
19 use the Medicare Plan Finder tool to compare and select
20 Part D plans available to them in their geographic area.

21 Part D plan pharmacy networks must meet the
22 standards for convenient access to network pharmacies.

1 According to the standards, for each plan, 90 percent of
2 urban beneficiaries must live within 2 miles of a network
3 pharmacy, 90 percent of suburban beneficiaries must live
4 within 5 miles of a network pharmacy, and 70 percent of
5 rural beneficiaries must live within 15 miles of a network
6 pharmacy.

7 Recent reports of pharmacy closures raise
8 concerns about potentially reduced beneficiary access to
9 pharmacies and the reduction of plan capacity to meet the
10 access requirement, although there has been no evidence of
11 this to date and surveys indicate high levels of
12 beneficiary satisfaction.

13 Pharmacy closures may be driven by lower
14 reimbursement of prescriptions, pressure from pharmacy
15 benefit managers, rising operating costs and staffing
16 shortages. We plan to analyze how these evolving
17 incentives may influence pharmacy participation in Part D
18 networks and beneficiary access to pharmacies.

19 Medicare Plan Finder allows beneficiaries to
20 estimate their total annual costs by displaying drug prices
21 and out-of-pocket cost estimates. These displayed cost
22 estimates may be personalized to a beneficiary's current

1 prescription drug regimen and their pharmacies of choice,
2 if beneficiaries choose to input this information.

3 Plan selection is often driven by expected out-
4 of-pocket costs. Therefore, accurate Plan Finder prices
5 are essential for beneficiaries to make informed decisions
6 when choosing a Part D plan.

7 In 2024, CMS raised concerns that some Part D
8 plans may be engaging in "pricing tactics" during the
9 Annual Enrollment Period. Specifically, CMS noted that
10 some plans may be "submitting artificially high or low
11 prices" for display on Plan Finder.

12 To analyze the accuracy of displayed drug prices
13 on Plan Finder, we used Medicare Plan Finder data for the
14 2024 benefit year at Annual Enrollment Period (October
15 2023), January 2024, and August 2024.

16 Our analysis was limited to unit prices of solid
17 oral drugs at the National Drug Code, or NDC, level. The
18 extent of variation in prices across network pharmacies
19 varies by contract and by NDC. Therefore, we used a simple
20 average to assign a single unit cost for each contract-NDC
21 combination. Results were weighted by contract-level
22 enrollment and volume, measured by prescriptions

1 standardized to a 30-day supply. Our analysis included
2 just under 800 contracts, and about 3,700 NDCs.

3 Price at the AEP, averaged at about \$5, which is
4 equivalent to \$150 per month for an oral medicine taken
5 once daily. Prices ranged from 6 cents to about 12 dollars
6 at the 10th percentile to the 90th percentile.

7 Between the AEP and January 2024, most solid oral
8 drug products experienced very small price changes. Just
9 under half of oral products increased in price, with an
10 average increase of 14 cents, or about 3 percent. A
11 comparable share of products decreased in price, with an
12 average decrease of 3 cents, or less than 1 percent. For
13 example, from the AEP to January, 90 percent of oral
14 products with price increases changed by 10 cents or less.

15 Price increases were more common and slightly
16 larger in August compared to price increases from AEP to
17 January.

18 While our analysis for the 2024 benefit year did
19 not raise concerns about the overall accuracy of Plan
20 Finder prices, a small number of solid oral drug products
21 with large price changes may warrant further analysis.

22 That brings us to our discussion. We'll be happy

1 to answer any questions about the material in this
2 presentation, and we are interested in your feedback on the
3 draft chapter for the March 2026 Report to the Congress.

4 We also have more work planned on LIS benchmarks
5 and pharmacy networks.

6 That concludes the presentation, and we'll now
7 turn it back to Mike.

8 DR. CHERNEW: That needed four people, and you're
9 all outstanding, so terrific.

10 I think we should jump right in. And, Cheryl, I
11 think you have the first Round 1 question; is that right?

12 DR. DAMBERG: Yeah.

13 Thank you, you guys. Great work.

14 This is sort of a leftover question from the last
15 session. So when you were showing the share paid by
16 beneficiaries versus the Medicare program, it was that 13
17 percent versus 87 percent split. My question is, given
18 that sort of the desired split was more 25/75, is the
19 ultimate goal here to move toward that, and sort of what's
20 the path to getting there?

21 MS. SUZUKI: So the law sunsets the 6 percent cap
22 after 2029, and instead of the 6 percent cap, it will then

1 be 20 percent lower. So the premium beneficiary share
2 cannot be lower than 20 percent. So that will happen then,
3 and the demo, we think, will end after 2027. And we don't
4 know the parameters of the demonstration next year. So
5 there may also be another sort of change after the demo
6 ends.

7 What we have been looking at is what has been the
8 impact of the BBP cap, and so in the initial -- this is a
9 cumulative effect, and so the amounts get larger every
10 year. For example, in the initial year, we think that the
11 BBP cap probably had, you know, 2- to \$3 billion impact on
12 the program spending by shifting that amount to the direct
13 subsidy payment. By 2026, we think the amounts are closer
14 to \$20 billion.

15 DR. DAMBERG: Yeah. So I really liked your Slide
16 9. That sort of breaks down what the cost to the consumer
17 would have been, absent some of these, what I call patches
18 to try to smooth the transition into this. But I still
19 assert that it's going to be sort of a big wake-up call for
20 beneficiaries across the country once they're bearing that
21 20 percent.

22 I had a couple of other questions. What share of

1 manufacturers had to pay rebates when the price of the drug
2 rose faster than inflation? Do you know that?

3 MS. SUZUKI: We have not tracked exactly. I know
4 that the bill for the inflation rebates likely have gone
5 out around December of last year. I haven't seen the exact
6 amount or how many manufacturers had to pay.

7 DR. DAMBERG: Okay. Thanks for that.

8 And then in terms of -- this is on page 14. You
9 talk about the out-of-pocket threshold is \$2,100, and it's
10 expected to be reached after a beneficiary incurs
11 approximately \$6,500 worth of spending. I was curious, and
12 this might be helpful context for this chapter. Can you
13 show like the distribution of beneficiaries who actually
14 hit that? I don't think I saw that in the chapter.

15 MS. SUZUKI: We can certainly look into the
16 distribution.

17 MS. KELLEY: Robert, did you have a Round 1
18 question?

19 DR. CHERRY: Yes, thank you. Probably more of a
20 request and less of a question.

21 And terrific job with the presentation.

22 You know, in the pre-read materials, there's a

1 lot of information there. There's one paragraph there that
2 kind of caught my attention, and I wonder in the future we
3 should expand upon this. There was a small paragraph
4 related to the threats of the business model for both
5 large-chain retail pharmacies, but also small independent
6 community pharmacies as well. We do talk a lot about, you
7 know, PBM strategy and those types of issues and pricing
8 issues, but there are probably some very real threats to
9 pharmacies as we know it and access to pharmacies in the
10 future.

11 It may be a topic for, you know, for later on to
12 really kind of discuss what does the access to pharmacies
13 look like five, ten years from now? Is this going to be a
14 growing threat where more and more pharmacies are going to
15 be, you know, closing down and beneficiaries are going to
16 have to travel further and further in order to get their
17 medications? So just a suggestion for a future topic.

18 Thank you.

19 MS. KELLEY: Gina?

20 MS. UPCHURCH: Wasn't going to be part of one of
21 my questions, but to build off what Robert just said -- and
22 I really appreciate -- is what we found is often the

1 preferred pharmacy is the vertically integrated pharmacy,
2 and it actually costs the consumer more to use the
3 preferred pharmacy. Especially this past year, we saw
4 that a lot.

5 So I really want us to dig into this, because we
6 are seeing -- I mean, just in Durham alone, half the
7 independents have closed. So we know it's a problem. So
8 thank you for that.

9 On page 4, we mentioned that the maximum fair
10 price has led to lower point of sale costs for the
11 consumer. We really thought that was going to happen, but
12 it really wasn't evident. They still had high copays, you
13 know, the \$47, the \$50. So even though the price of them -
14 - I'm just giving Eliquis as an example. The price of
15 Eliquis went down, but what the consumer is paying did not
16 go down. I mean, it will when you hit the cap, but we did
17 not see a lot of evidence at point of sale, the price is
18 going down for those 10 meds. It would be interesting just
19 to follow that, because we're just not seeing it.

20 The other thing that I learned during this open
21 enrollment period is a lot of agents and brokers were being
22 told they would not be reimbursed to sell standalone drug

1 plans or PPOs, right? So just following agents and brokers
2 and what they're being told and not told to sell, because
3 that has huge influence in this market. I don't know if
4 you all heard anything about that or it's something we can
5 pursue.

6 And then related to what Cheryl just asked about
7 the inflationary rebates, is that -- so it's when drug
8 manufacturers, certain ones, raise, you know, more than
9 inflation. They have to give the money back to Medicare.
10 Is that earmarked for Part D benefit, or do we know?

11 MS. SUZUKI: I think it goes into the trust
12 fund, the Part D accounts of the trust fund, but we can
13 double check.

14 MS. UPCHURCH: Part D?

15 MR. MASI: That's right. It would go into the
16 Part D account of the SMI Trust Fund.

17 MS. UPCHURCH: Okay, okay. I was wondering about
18 that.

19 And then you mentioned that 5 percent of consumer
20 beneficiaries had entered their prescription payment plan,
21 so 5 percent of them, and it helped them a lot. And I
22 understand that. It can spread your costs. Even though it

1 may be confusing to understand, it's spread the cost of a
2 year. But I guess my question is, at what cost? What did
3 it cost to implement that program, if we have any sense of
4 that?

5 I know for our sake, we have to tell people low-
6 income subsidy, no, no, no, don't sign up for that. You're
7 relying on the state pharmacy assistance program in North
8 Carolina. No, no, no, don't sign up for that. So, you
9 know, we're constantly telling people not to sign up for
10 something. So I'm just wondering about the cost to
11 administer the benefit, and there are many reasons that
12 somebody would not want to sign up for that, because it
13 could hurt.

14 And then my last question is on Table 13.5. We
15 mentioned -- and this is very concerning. Obviously, if
16 the plan finder, you know, is not getting accurate prices,
17 but we mentioned that price is going up, I guess my
18 question is, if the prices are going up across all of the
19 plans, it's just the manufacturers charging more, right?
20 So it sort of evens out, but if it's only going up on
21 certain plans and not other plans, that's more of a problem
22 with the plan finder tool.

1 But, you know, every two weeks, medication prices
2 can change. So, if it's consistently going up -- so if
3 this drug went up and it went across, you know, every one
4 of the insurance plans -- that seems less of a problem to
5 me than if it just was certain plans, because that does
6 feel like smoke and mirrors there.

7 Thank you. Thanks so much for this work, and
8 really excited we're going to look into pharmacy networks.

9 MS. KELLEY: Okay. That's all I have for Round
10 1, unless I've missed anyone.

11 DR. SARRAN: I think Scott.

12 MS. KELLEY: Oh, I'm sorry. Scott, go right
13 ahead.

14 DR. SARRAN: I just want to make sure I'm clear
15 on something in my head. When the PDP premium
16 stabilization and beneficiary premium growth cap, when all
17 that expires, absent there being some other action taken by
18 Congress, beneficiary premiums for PDPs would go up
19 dramatically, correct?

20 MS. SUZUKI: That would be -- I guess compared to
21 without the demo, the premiums would be higher. I think
22 how much of an increase it would be is a separate story.

1 DR. SARRAN: But assuming cost increases are
2 continuing to go much faster than inflation, those premium
3 increases would be very significant.

4 MS. KELLEY: Okay. Round 2, Mike?

5 DR. CHERNEW: Yes.

6 MS. KELLEY: Brian, you're first.

7 DR. MILLER: I feel guilty. I thought Stacie had
8 already put her name in the queue. Sorry about that.

9 So really appreciate you all doing this. That
10 broke my brain a bit to read it because it was so well done
11 and detailed and jam-packed, and I know that's not easy.

12 The research around the accuracy of the plan
13 finder and the note for CMS to continue monitoring I think
14 is a helpful reminder to the market regulator. I also
15 agree on doing more work on pharmacy networks and would
16 sort of echo Greg's point that we should think about
17 segmenting the pharmacist and pharmacy marketplaces by
18 ownership model. When we do that, recognizing that large
19 chains, regional chains, and independent community
20 pharmacists probably serve a different population, and we
21 might not have the data about what those populations are
22 and how they're different. But it's important for us to

1 know that there are those different marketplaces because
2 they offer a different service, noting that the small
3 independent community pharmacist is often more customized.

4 I think something else that we could sort of
5 shoehorn into here, which I know that our Vice Chair has
6 thankfully shoehorned into the physician fee schedule with
7 nurse practitioners and PAs and their role in the Medicare
8 program, perhaps we could shoehorn some more work about the
9 role of the pharmacist in caring for the Medicare
10 beneficiary and the opportunity to expand or grow sort of
11 MTM as a book of services. That's sort of an -- I would
12 say under, but I think it's more accurate to say it's an
13 unutilized part, Part D.

14 Just sort of stepping back, thinking about
15 philosophies of drug pricing, because that's fundamentally
16 what we're dealing with when we address part D, the IRA
17 drug price-setting program, I think made a philosophical
18 mistake and undermined our drug markets because we built on
19 the premise that centralized administrative pricing is the
20 solution. I'm in full agreement that we need lower prices
21 for a lot of drugs.

22 I point out that we don't regulate the cost of

1 the filling for the cavity they had, which was covered by
2 insurance, the glasses that I'm using, which are also
3 covered by insurance, the laptop that I'm typing and logged
4 in on, which I have paid for, or the cheap small-molecule
5 generic that I take for blood pressure because people drive
6 slowly. Right? That's not a regulated price.

7 And so price regulation might work well in the
8 short term, and we've already seen some evidence that the
9 IRA has been effective at reducing prices, but not reducing
10 prices as much as we thought it would, which to me was an
11 interesting signal.

12 We have also tried a lot of sort of static, rigid
13 interventions built upon centralized price regulation in
14 other markets. We have the Medicaid drug rebate program.
15 We have 340B. There's a long list of drug price regulation
16 that we have, and every couple years, we do another
17 legislative version of drug price regulation. And then a
18 couple years later, we come back and point out that drug
19 prices are still going up really high and it doesn't work
20 and hasn't worked or is broken because of X, Y, Z.

21 And that's because we're creating sort of a
22 command and control system for drug pricing, and then when

1 that breaks, who's left picking up the pieces? The people
2 left picking up the pieces are the plans, but most
3 importantly, the beneficiaries.

4 And so when I look at the Part D market, I see
5 that MAPD plans, because it's an integrated benefit, has
6 the flexibility to compensate for a lack of competition in
7 drug markets, and that standalone PDPs don't. And that's
8 sort of what's been happening.

9 And that particular market that I've been focused
10 on is the biologics market, and a lot of the old drugs that
11 we have that are very expensive that are sort of disrupting
12 the drug market in Part D are old biologic drugs. If we
13 look at what the Department of Justice Antitrust Division
14 and the Federal Trade Commission have said is they've said
15 that for decades in other markets and in health care, that
16 regulation can't replace competition.

17 So I think that, fundamentally, we need to return
18 to a competition model for drug pricing to create a dynamic
19 market system with lower prices to drive value. The last
20 big time we did this was 1984 with Hatch-Waxman, which
21 created a viable small-molecule generics marketplace and
22 massively drove down prices. Hypertension drugs are cheap,

1 diabetes drugs are cheap, statins are cheap. We have lots
2 of cheap copycat drugs, which is a good thing.

3 And then in the branded-small molecule market,
4 you have a lot of non-price competition around
5 pharmacokinetics and efficacy, right, marginal efficacy
6 amongst the angiotensin receptor blockers, frequency of
7 administration.

8 We don't have that in the biologics market, and
9 then you end up with massive specialty drug costs. So I
10 actually think that we need a competitive biologics market
11 to fix the Part D marketplace because I don't think that
12 the tools that we have in payment world are actually going
13 to help us fix the Part D marketplace. We're going to just
14 continue to do repairs on a car that has already hit a
15 wall, and so I think we need an abbreviated biologics
16 license application, which I recognize is outside of scope
17 for us.

18 MS. KELLEY: Stacie?

19 DR. DUSETZINA: Thank you so much. I know I say
20 this just about every year. This is one of my favorite
21 things to read before I was on MedPAC and through MedPAC,
22 and it will be after I have left, begrudgingly left, I'll

1 say.

2 I apologize. These are not in any particular
3 order, because I was working so hard to put my last session
4 comments in order. So just an absolutely fantastic chapter
5 throughout. I think that the work that you've done is
6 great.

7 I just have a couple of suggestions for things
8 that I think might be helpful, small things to add to this
9 chapter, but also some forward-looking things for future
10 chapters.

11 So one might be considering adding a text box
12 somewhere that talks about the balance model and the GLP-1s
13 and potential for adding that spending in Medicare. I
14 realize that that was just announced on December 23rd, so
15 not a lot of people have been able to digest and that
16 there's not a ton of information, but it is very
17 potentially impactful in the very short term for Medicare
18 Part D plans.

19 And I think especially when you look into the
20 details there, there's some comments about the
21 administration and CMMI incentivizing plans to join by
22 offering more reinsurance coverage for these drugs and also

1 potentially providing higher capitated payments or
2 adjusting risk scores. So I think it's very important to
3 maybe at least just mention it given the spending
4 implications.

5 Looking at the parts around the IRA drug
6 negotiation that were in there, I found it was like, wow,
7 it is absolutely shocking. The first two years, it's 36
8 percent of gross spending and 60 percent of rebates. Like,
9 I think the way that you captured what has already been
10 included, very well done. So just compliments. No change
11 is needed.

12 You know, I'm going to worry about this forever,
13 I think, but the diverging premiums, I just want to say it
14 again, is like between the MA market and the PDP market,
15 and then also what's going to happen when we lose the
16 demonstration stabilization, when that cap is lifted off
17 that 6 percent? You know, that is highly concerning to me
18 for thinking about people's access.

19 One just minor note for edits for this and the
20 prior chapter is when you talk about the premiums, maybe
21 emphasizing monthly when you're talking about some of
22 those, because the amounts are getting so high that they

1 actually look like annual premiums for MAPDs. And I think
2 just that would be helpful to keep clear.

3 A couple of qualitative interview wishes for --
4 you know, in the future. I think that, again, going back
5 to this issue about the way that the troop is calculated
6 for enhanced plans and how that's changing how plans are
7 thinking about offering the benefit and what those costs
8 look like, especially considering the trade offs between
9 the premiums that are being paid and then the cost-sharing
10 arrangements like the deductibles, just I personally have
11 been looking at this for the 2026 plans in my research, and
12 it does not look good, you know, like when you're thinking
13 about tier three preferred drug cost sharing. It seems
14 like a smaller and smaller number of plans available where
15 people can get into plans that offer their drugs at co-
16 pays.

17 For better or worse, you know, like as Gina had
18 alluded to, the people taking negotiated drugs might be
19 better off with co-insurance in the future versus co-pays.
20 But it also makes the price at the pharmacy less consistent
21 for patients and less predictable, which I think is not
22 good.

1 I also would love to know more about how the
2 Medicare prescription payment plan is going from pharmacist
3 perspectives, because I think it seems that it's being
4 dramatically underused by patients. But I've also heard
5 from -- my perception was that like, you know, if you were
6 an oncology patient, that you might really benefit from
7 being enrolled in that plan. But then talking with
8 specialty pharmacists, they're like, no, it's actually
9 better if they're not, because of the way patients
10 assistance works and things like that, that it actually can
11 be a lot better for them to have people not be in the plan.
12 So I think some interviews with pharmacists about how
13 that's going and potentially with patients and plans about
14 how the payback is going would be helpful.

15 The last is just a comment around -- oh, and
16 pharmacies also about the point-of-sale DIR and the
17 negotiated drugs and how they're impacting pharmacies, I
18 think we need to know and monitor very closely for just
19 access to pharmacies.

20 All right. The last ones are kind of as we keep
21 getting a little bit further into the IRAs' full
22 implementation for thinking about what happened to

1 beneficiaries.

2 I think that looking and decomposing what's
3 happening by the types of drugs people use is going to be
4 super important. So the specialty drug users, the
5 preferred brand -- like, I use one preferred brand user --
6 and the generic drug users, and kind of what's the total
7 cost of the benefit to them over time when we take into
8 account premiums and their spending? That's a couple years
9 off because I know it'll take a while for the data to catch
10 up.

11 And then the last thing is just like the great
12 work on the issues around the plan finder. I think that,
13 you know, CMS's note about potentially having plans try to
14 encourage or discourage certain types of beneficiaries,
15 that's like highly offensive to me, the idea that you would
16 put in information that is misleading to get certain types
17 of customers.

18 I'll note that, at one point, a group of five of
19 us Commissioners were trying to troubleshoot a problem with
20 plan finder during open enrollment where it would just
21 completely break when you change the frequency of a drug
22 from once a month to like anything that was different than

1 that, and it would just show up as not covered at all. And
2 so I think -- we reached out to CMS to kind of say, hey,
3 here's a problem with the plan finder.

4 But, you know, I think these are things that are
5 critically important for beneficiaries. It's a tool that
6 we rely on for getting accurate information on the types of
7 plans people are in, so important to keep that monitored.

8 But absolutely outstanding work to all of you.
9 Thank you.

10 MS. KELLEY: Scott.

11 DR. SARRAN: Yeah, again, excellent work. And
12 boy, I have really struggled to wrap my head around what
13 are the real issues that we need to continue to focus on
14 and solve. So here's as best as I could sort them and
15 categorize them in my take-homes.

16 So first, as far as beneficiaries, in the scheme
17 of things, I think today -- not necessarily a few years
18 from now, but today, net of the IRA-driven changes in MOOP
19 and with the current protections against a beneficiary
20 being denied a potentially beneficial class of drugs. some
21 of those protections are explicit in the protected classes.
22 Some of them are implicit to basically our social contract

1 that we're not going to fail to bring to market and cover
2 across all payers, essentially any drug that offers any
3 degree -- any degree of incremental clinical improvement
4 for a serious disease. So that gives actually a lot of
5 beneficiary protection.

6 So net of that, the Part D programs overall, I
7 think, is fulfilling a lot of its original intended promise
8 for beneficiaries. Yeah, there are things with plan finder
9 absolutely need to be improved. But, I mean, beneficiaries
10 are getting a lot of drug access to a lot of necessary
11 drugs.

12 The problems, I think, are, number one,
13 pharmacies, as Gina keeps reminding us, we're just driving
14 out small pharmacies, and that's not what anybody would say
15 is desirable. So I think we got to keep that front and
16 center.

17 Number two, the PDP market, absent some miracle,
18 I think is just going to continue to need to be hugely
19 subsidized or it will collapse. And maybe that's okay.
20 You know, maybe that's okay because we want to keep some
21 parity at a macro level between beneficiaries who want to
22 stay fee-for-service versus MA. So maybe that's not a huge

1 problem. Maybe it just will require a renewal of the
2 subsidies to keep the PDP market viable. So that may or
3 may not be a big problem.

4 The biggest problem, though, of course, is costs
5 keep going up. So, on the positive side, I think the
6 combination of the MFP and maybe the most favored nation,
7 you know, one-off contracts, however we get there, I think
8 do represent a tackling of what had been one of the
9 historic third rails in America, thinking about insurance,
10 right? And that was we were willing to negotiate through
11 the government or alongside the government to bring down
12 drug prices, whether we do it through the IRA -- and yes,
13 it's a very systemic process -- or do it in a series of
14 one-offs. And so that's extremely positive, I think, when
15 we think about the health of the Part D program.

16 The other third rail, I pretty much have given up
17 on. The other third rail is that we're willing to say no
18 to a drug or a class of drugs based on lack of
19 quantitatively assessed clinical value, whether it's NICE
20 or ICER or whoever, quality-adjusted life years, whatever.
21 I just don't think we're anywhere in this country where we
22 in the next decade are going to be able to take that on.

1 So I think we shouldn't pretend.

2 I do think, though, a subtext to that is maybe at
3 the edges -- and Brian mentioned, should we revisit the
4 protected classes, because, you know, there's a little
5 tinkering with that. I think the answer should be, yeah,
6 absolutely, revisit it in a finite way periodically.

7 The biggest -- as I keep trying to get my head
8 around it, I think the biggest cost-saving opportunity is
9 really what Brian described, which is it's all about -- you
10 know, as Reinhardt said, "It's all about the prices,
11 stupid," it's all about the biologic drugs, right? I
12 mean, everything else is becoming a rounding error, and
13 generic market and plan sponsors play appropriate hardball
14 when there's several different brand-name products in small
15 molecules. So it's all about the biologics.

16 So I really think one of the best things we can
17 do is to continue to highlight that probably our single
18 biggest tool that's not yet been pulled out of the toolbox,
19 but could reasonably be pulled out of the toolbox, is to
20 accentuate a whole bunch of potential steps down a
21 competitive -- more competitive road in the biologic space,
22 net of biosimilars, et cetera, et cetera.

1 So thanks.

2 MS. KELLEY: Gina.

3 MS. UPCHURCH: Again, great work. I don't think
4 the American people, maybe they know how valuable the staff
5 of the MedPAC is, but you all just do a tremendous job, and
6 this chapter was a great example of that. It's such an
7 honor to be with these Commissioners, too, because as
8 Stacie was talking, I was like, amen, amen. She had a lot
9 of my comments, so I'm going to add a few things.

10 I don't think it's just the biologics. I mean,
11 not many people could afford a DOAC at \$600 a month. The
12 DOACs are the Eliquis, Pradaxa, and Xarelto of the world.
13 I mean, they're coming down, obviously, because of the
14 negotiated prices. And by the way, they're not just coming
15 down for Part D beneficiaries, but for a lot of people the
16 prices of those drugs are really dropping now, so it's
17 having wider influence. So I do think for big money, yes,
18 it is the biologics.

19 But I want us to follow the money also. I love
20 Uwe Reinhardt's comment, that the price is stupid. So I
21 want to know what money is earmarked to support Part D, the
22 inflation, you know. Eight percent of people pay IRMA,

1 Income-Related Medicare Adjustment for Part D. Is that
2 money going back to Part D? Six percent of people pay the
3 late enrollment penalty for Part D. I think many of those
4 people are struggling low-income people that may have been
5 in an FQHC and are trying to get in the game now, but 6
6 percent of those people pay a late enrollment penalty. Is
7 that going to back into the Part D drug benefit?

8 So I would love a chart of what's paying into the
9 drug benefit from all of the payers, not just what the
10 plans are paying, what the consumer is paying for the
11 enhanced drugs as well as the premiums that they pay for
12 enhanced or the basic benefit. So where is the money
13 coming from and where is it going. If we could get some
14 sort of graphic of that, because I do think it helps us to
15 understand it.

16 I'm a pharmacist. My background is geriatric
17 pharmacy practice. So my biggest concern with a lot of
18 this, in addition to the money and affordability, is
19 medication safety. We're finding people having to find
20 more and more sources of medication, whether it's Cost Plus
21 Drugs, you know, get patient assistance programs, copay
22 foundations, getting it at Costco for cheap over here,

1 multiple sources of medications.

2 Medication therapy management was supposed to be
3 the cornerstone of Part D, and thank you, Brian, for
4 pointing out it absolutely has not been. It was never
5 funded. It's an administrative cost of the Part D plans,
6 and it's never been funded. You all did a great job of
7 talking about the enhanced MTM pilot or whatever that was
8 done. But as a reminder, they were looking at savings to
9 Medicare A and B, not savings to D. Pharmacists know what
10 drugs costs.

11 So looking at savings to Part D I think should be
12 added to what value pharmacists bring, the health education
13 that pharmacists bring. Just as an example, the program
14 that I work with, you know, we talk about sleep hygiene, so
15 they don't need these expensive medicines for their sleep
16 hygiene. So I think there's a lot that pharmacists can do,
17 but we've not seen them as an investment and as a critical
18 source of health care. Now, we appreciate them when they
19 were giving vaccines during COVID, but we've really not
20 invested in MTM.

21 Just a couple of other quick points. With
22 Medicare Part D, if you're in a plan and you switch plans

1 in the middle of the year, that money follows you, so it
2 counts towards your cost sharing. We don't do that with
3 the medical out-of-pocket. So I'm just throwing it in now.
4 We have TrOOP follow a person. I'd love it if MOOP would
5 follow a person, certainly as we talk about networks,
6 moving forward.

7 I do think we're separating consumers from the
8 real cost of the drugs that they're taking, and I don't
9 think that's necessarily a good thing. I don't want them
10 to have to pay it all, but to understand what that is.
11 Costs are not transparent in the system. They just have
12 the cost sharing that they sometimes know, and that's
13 always not transparent either. But I do think we need
14 consumers to understand the actual costs of the medicines
15 that they're taking.

16 You mention at some point low-income subsidy, and
17 a lot of people obviously not being able to get in zero-
18 premium plans or very few of them being available. With
19 artificial intelligence -- Gokhan, I'm looking at you --
20 with artificial intelligence I don't know why we can't do
21 intelligent assignment, a sort of random assignment for
22 people with low incomes, to plans that actually cover their

1 drugs, not just because it's zero premium, but put them
2 into a plan that covers their drugs well at the overall
3 lowest costs. Sometimes they should pay a little bit of a
4 premium to get better prices overall, because their meds
5 are all covered. So can we use AI or something to do some
6 intelligent assignment to people into drug plans at the
7 lowest costs.

8 And the other reason we have a lot of people; you
9 mentioned that low-income subsidy enrollment has gone down.
10 I would argue, to some degree, our Department of Social
11 Services are slammed right now, and not doing a lot of
12 outreach about low-income subsidy for Part D.

13 Almost done.

14 I do think we need to keep an eye, and Stacie
15 mentioned some of this, on drug manufacturers. When
16 they're being squeezed in certain ways it's popping out in
17 other ways. And things that we're seeing in the community
18 now, some of the patient assistance programs are changing.
19 They're getting stricter and harder for people to access.
20 340b is getting squeezed in many ways from the drug
21 manufacturers. And we're seeing a move from patient
22 assistance to co-pay foundations, and that's often

1 supported by drug manufacturers, but keeps people in the
2 benefit where, again, we are paying through plans when they
3 hit the catastrophic level. So just watching that shift
4 and how that happens would be important.

5 And then, lastly, I can't help but say the health
6 insurance literacy requirements for Medicare Part D are off
7 the charts, and we put people through this every year. I
8 think a requirement for being on the MedPAC should be
9 getting a list of drugs and having you figure out the best
10 plan, and then I'll check it for you to make sure that's
11 right. But it's really off the charts. You all do a
12 tremendous job of explaining it, though, and thanks.

13 MS. KELLEY: Okay. Mike, I think we've reached
14 the end of the queue. Oh, Stacie, I think, maybe had a
15 follow-up.

16 DR. DUSETZINA: Yeah. It's probably more of an
17 on this point for one of the comments that Gina made that
18 just had me thinking a little bit about the issue of people
19 going outside of their Part D benefit to fill drugs. We
20 know this is happening a lot more, and obviously we have
21 more direct-to-patient sales of branded drugs and generic
22 drugs.

1 And, you know, I don't know that that's, again,
2 it might be like a callout box that's kind of other things
3 that are going on. But I think from a safety perspective
4 and one person knowing everything they're filling, it's
5 like those sales outside of your Part D benefit are
6 obviously a problem for understanding all the drugs a
7 person is taking. So I think that fragmentation of where
8 people fill their drugs and how.

9 I don't know if there is any good data on how
10 often Medicare beneficiaries are using these services, and
11 that might just be something we think about trying to
12 capture in some way moving forward.

13 The other thing that it just reminded me of is
14 some work that I've done previously looking at the costs in
15 Part D, the point-of-sale prices for specialty generics,
16 and that those incredibly high, and you could get them for
17 very cheap through some of these point-of-sale, like GoodRx
18 or Mark Cuban's Cost Plus Drugs. And I think that there
19 have been suggestions over time of Medicare having policies
20 a little closer to Medicaid, like using that as pricing for
21 setting the price for reimbursement amounts for generic
22 drugs. You know, it might be something we want to explore

1 in the future, especially as you think about if you see
2 more and more beneficiaries going outside of the benefit
3 because there are these weird payment effects for generic
4 drugs, like how do we make the system just automatically
5 more efficient and more consumer friendly so that
6 beneficiaries can use their Part D benefits instead of
7 going outside.

8 MS. KELLEY: Gina, did you have one more point?

9 MS. UPCHURCH: Yeah, sorry. Just looking at the
10 star ratings and what's rewarded in the Part D benefit,
11 it's been a heavy focus on adherence. And I can drink that
12 Kool-Aid too. It's really important to take your medicines
13 as prescribed. But when you're taking too many medicines
14 and they're causing more problem than harm, adherence is
15 not a good thing.

16 So just balancing adherence with medications with
17 adverse drug events I think is really important, and we're
18 not paying attention to adverse drug events in older
19 adults. And I think it needs more attention. We need to
20 simplify drug regimens to make it easier for older adults
21 to use their medicines safely. We don't put any attention
22 onto that. We don't reward people for helping people with

1 that. So I just want to point that out.

2 And it is true that DOACs are a lot less
3 expensive than more of these expensive drugs, but if you're
4 paying 25 percent of \$600, it's a lot. I mean, it's a lot
5 for some people, until you hit that cap of \$2,100. But
6 you're right. With prices going down, hopefully that will
7 get better.

8 DR. CHERNEW: Okay. You know, I was really
9 looking forward to the richness of our discussions on Part
10 D, and I wasn't disappointed. I want to start by thanking
11 Renuka, Betty, Shinobu, and Pamina for outstanding work.
12 It is really so, so, so, so, so complicated. If we did
13 have to take a test, I'd get kicked off MedPAC, which for
14 some people listening, that is why I'm leaving.

15 And I will say a few things that I will say are
16 broad themes, and I think part of the problem here is there
17 are so many things to investigate in so many different
18 ways. And some of them are narrow issues like the TrOOP
19 and extended plans, and some are big issues, like how do we
20 price drugs in this country. And just getting the right
21 altitude and the right hook is hard.

22 But I'm just going to go through a somewhat

1 poorly correlated lift. One is the interaction with MA
2 plans. And when we're paying MA plans in a particular way,
3 that it impacts on Part D. If Part D plans aren't
4 affordable, it has big impacts on how the balance works
5 between the fee-for-service side and the MA side. It's
6 challenging, and we really need to pay attention to that.

7 Consolidation in this market. I think the
8 comment was spot on. Remember, there's so much different
9 types of consolidation going on -- the number of companies,
10 the different things that they own or don't own. And I
11 think there can be a lot of efficiency. Consolidation is a
12 problem, but I wouldn't argue that there's no efficiency
13 between having connection between certain parts of this
14 market. So I think that's just an important issue to
15 understand when it's working, when it isn't, and when we
16 have market failures we need to address and when we don't.

17 The one that I think is biggest is essentially
18 this issue of price versus value and access and the amount
19 of innovation. I think we'd be remiss if we didn't
20 understand that a lot of this problem is because these
21 drugs are actually really good, and over the life course of
22 a drug we end up with very good, very expensive things, and

1 then we have really cheap medications. So, to Brian's
2 point about more biologics, quicker, or however we want to
3 do that, I think that's an important point.

4 But I do think we have to think through how we
5 balance that. It is a lot of policy well beyond what we're
6 doing, to focus on that topic. But I think we have to
7 acknowledge that is a core tradeoff.

8 Some things that I don't know as much about but I
9 think are important, that have come up, one is the market
10 for pharmacies and pharmacists, this whole issue of
11 independent pharmacies and how that plays out. That's
12 related to but not the same as consolidation. And, of
13 course, pharmacists themselves, the whole workforce
14 dimension that is worth exploring.

15 And then this issue about drug management and how
16 people are practicing, and is that a function of Part D
17 plans to do? Is that a function of how we think about --
18 it's just a very complicated set of interactions.

19 And then the last one -- and I saved the one that
20 actually I have to tell you is probably just a reflection
21 of the fact that I've read all of this material as you
22 have, which it just cries out for some version of

1 simplification. I'm not sure what it is. I'd like to
2 think that we could just bring technology to bear, as you
3 were saying at the very end, Gina. I don't disagree with
4 that. I think that would be helpful. But boy, it's so
5 complicated. There are so many phases of the drug benefit.
6 The drug benefits are changing. The drug prices might be
7 changing over time. Substitution is hard. There are all
8 these other programs that related to Medicare.

9 So there is a lot, a lot, a lot of things to do.
10 My general view, and the reason why I went through that
11 stuff is there will always be -- I shouldn't say always --
12 there is going to be, in my opinion, for the foreseeable
13 future, a Part D status chapter, which is packed full of
14 amazing information. But I think the right way to think
15 about some of those other topics is to take them in -- and
16 again, in the next year we'll have to decide -- in a
17 separate cycle, to try and have devoted attention to very
18 targeted things. Because it's very hard in what is an
19 immense, big sandwich, Part D status chapter to then really
20 delve into some of these issues, which really span a wide
21 range of topics.

22 So I'm going to jump back with just a thank-you

1 to the team. Oh, Cheryl has a question.

2 DR. DAMBERG: Yeah. I had a question here. You
3 know, you said something that just reminded me. So with
4 this consolidation piece, you know, as you say, it could
5 improve efficiencies. I don't think we know what the
6 effects are on quality. But I have to say, as a consumer
7 who gets prescription drugs from one of the big players, I
8 would say I've seen a decrement in quality.

9 And so my question is, and I don't know to what
10 extent we've done any surveys, interviews of beneficiaries
11 to really better understand their experience in this space,
12 to get some sense -- I think we all feel like we have some
13 sense of how this is playing out on the ground, but if
14 there were resources available, I would suggest doing some
15 additional work in that space.

16 DR. CHERNEW: And again, I agree, and I think
17 part of the issue ends up being an issue of scale. I think
18 there is an issue of price negotiation power. Now, of
19 course, with a lot of consolidation it's not clear how the
20 incentives work for that, so we could have a whole other
21 conversation. But at least there is some sense about
22 understanding how those markets work.

1 My bigger picture wasn't the pros or the cons.
2 That is a concerted --

3 DR. DAMBERG: Yeah, and I would say, layered on
4 top of that, is potential conflicts of interest, in terms
5 of steerage and what drugs get used.

6 DR. CHERNEW: Right, and so --

7 DR. DAMBERG: That's multilayered.

8 DR. CHERNEW: I 100 percent agree. So we may all
9 have different priorities. Again, we're going to talk in
10 April about priorities for the next cycle, in general, and
11 I think you should think through which of these many things
12 you would prioritize, because we're not going to do all of
13 them right away. But I think that's important. But I
14 think what we can agree on is, again, where I was going, is
15 to thank you guys for all of this. I think there is
16 widespread admiration for the work and appreciation of
17 trying to make a very, very complicated system a bit more
18 understandable. So anyway, thank you.

19 We're going to take another 5-minute break.
20 We'll come back at 4:45, and we are going to go on to
21 ambulatory surgery centers, ASC.

22 [Recess.]

1 DR. CHERNEW: Hello, everybody, and welcome back
2 to the last session of what has been a wonderful day, and
3 we're going to go through our ASC status report. And it's
4 obvious -- as care is moving between out of inpatient to
5 other ambulatory settings, it's important to track broadly
6 what's going on, and so I guess, Dan, you're starting.

7 DR. ZABINSKI: Yes, thanks Mike.

8 Okay. In this session, we'll provide a status
9 update on ambulatory surgical centers, or ASCs. And for
10 the broader audience, a PDF version of the slides is
11 available via the paperclip icon on the upper right of your
12 computer screens.

13 So the topics that we'll cover in this
14 presentation include a background on ASCs, the fee-for-
15 service Medicare beneficiaries' access to ASC services, the
16 growth in fee-for-service Medicare payments to ASCs, the
17 quality of care provided in ASCs, the state of the ASC cost
18 data, and then we close with a discussion.

19 We'll first present some background on ASCs. The
20 general purpose of ASCs is to provide outpatient surgical
21 procedures that don't require an overnight stay. For most
22 services covered under the ASC payment system, CMS bases

1 the ASC payment rate on the relative weights from the
2 outpatient prospective payment system, or OPPS, which is a
3 payment system for most services provided in hospital
4 outpatient departments, or HOPDs.

5 And the general process of setting the payment
6 rate for a service covered under the ASC system is to
7 multiply the OPPS relative weight for that service by a
8 conversion factor specific to the ASC system. This ASC
9 conversion factor, however, is much smaller than the OPPS
10 conversion factor. So the ASC payment rates are about 44
11 percent lower on average than the analogous OPPS payment
12 rates.

13 And for 2026, the ASC conversion factor received
14 an update of 2.6 percent, which is the same update that
15 hospitals received under the OPPS.

16 And some of the benefits of ASCs relative to
17 HOPDs include that, first, for patients, ASCs offer lower
18 cost sharing, easier scheduling, and less time in surgery,
19 and for physicians, they offer efficiency because they can
20 customize their surgical environments and hire specialized
21 staff.

22 The services provided in ASCs can also be

1 accessed in HOPDs and, in some instances, physician
2 offices. However, the cost of Medicare is always lower in
3 ASCs than in HOPDs because ASCs receive lower fee-for-
4 service payment rates. As a result, relative to HOPDs,
5 ASCs are less costly to the Medicare program.

6 And now we'll turn to Alex who will provide an
7 assessment of the status of ASCs in fee-for-service
8 Medicare.

9 DR. HARRIS: In 2024, there were about 6,400
10 Medicare-certified ASCs that served 3.4 million fee-for-
11 service beneficiaries. The number of surgical procedures
12 provided surpassed 6.4 million, totaling 7.5 billion in
13 fee-for-service Medicare payments.

14 Aligned with last year's report, the number of
15 ASCs, the share of beneficiaries served in ASCs, and the
16 volume of services provided in ASCs have all continued to
17 increase.

18 Regarding beneficiaries' access to ASC care for
19 2024, we found that the number of ASCs increased by about 2
20 percent, which was consistent with the annual rate of
21 growth from 2019 to 2023.

22 In addition, from 2023 to 2024, the share of fee-

1 for-service beneficiaries receiving ASC services increased
2 by 2.4 percent and the volume of ASC procedures per 1,000
3 fee-for-service beneficiaries rose by 3.4 percent. The
4 growth of both measures was higher in 2024 than the annual
5 rate of growth from 2019 to 2023.

6 Services that have historically contributed the
7 most to overall ASC volume continue to be the most common,
8 including cataract, gastroenterology, and pain management
9 services. For example, in both 2019 and 2024, one cataract
10 procedure accounted for about 18 percent of ASC volume. In
11 fact, 18 of the 20 most common ASC services in 2019 were
12 among the 20 most common in 2024. In 2024, 50 percent of
13 the ASC surgical volume was concentrated in seven
14 procedures.

15 Although not currently in the top 20 most common
16 services, the volume of total hip, knee, and shoulder
17 replacements is also rapidly increasing.

18 Next, we present ASC's growth in fee-for-service
19 Medicare payments. As seen in the figure, there has been a
20 steady increase in fee-for-service Medicare payments for
21 ASC services among beneficiaries using ASC services over
22 the last six years.

1 In 2024, among fee-for-service beneficiaries
2 receiving ASC services, payments per beneficiary rose by
3 13.1 percent, from \$1,954 to about \$2,200. This increase
4 is driven in part by the increased provision of relatively
5 complex services, such as hip, knee, and shoulder
6 replacements. The increased provision of complex services
7 is likely due, at least in part, to CMS's decision to move
8 some complex procedures off the inpatient-only list over
9 the last several years.

10 Given CMS's decision in the 2026 OPPS ASC final
11 rule to add several hundred services to the ASC-covered
12 procedures list starting in 2026, we expect payments and
13 volume to continue to increase.

14 Next, we present ASC market concentration.
15 Except for first-year Commissioners, this figure will look
16 fairly familiar. This chart shows that even though the
17 number of ASCs has been steadily increasing, the geographic
18 density of ASCs across states still remains uneven.

19 Among states, the number of ASCs per Part B
20 beneficiary, including both MA and fee-for-service, varies
21 from a low of about 1.4 ASCs per 100,000 benes in Vermont
22 to a high of about 36 ASCs per 100,000 beneficiaries in

1 Maryland.

2 One factor that does appear to affect the number
3 of ASCs in a state is whether the state has a certificate
4 of need or CON law and how restrictive those laws are.
5 However, even though Maryland has CON laws, it is an
6 outlier in terms of ASC concentration. The total cost-of-
7 care model for Maryland hospitals appears to be a driving
8 force behind the high concentration of ASCs in that state,
9 since services provided in ASCs only partially apply to
10 hospital global budgets.

11 Additional factors that may influence ASC density
12 are urbanicity and income level in a given geographic area.
13 There's also a difference in ASC concentration between
14 urban and rural areas, where urban areas are defined as
15 being in a metropolitan statistical area.

16 In 2024, 94 percent of ASCs were in urban
17 locations, and only 6 percent were in rural locations.
18 This is consistent with prior years. And for context,
19 about 20 percent of fee-for-service beneficiaries live in
20 rural areas.

21 We've heard from conversations with industry
22 stakeholders that one underlying reason for this geographic

1 discrepancy is that rural areas often lack the surgical
2 specialists and population density to support the ASC
3 business model.

4 On the next slide, we illustrate demographic
5 differences between patients treated in ASCs and those in
6 HOPDs. In 2024, we found that among the fee-for-service
7 Medicare beneficiaries receiving surgical procedures in
8 ASCs, 8 percent were dually eligible for Medicare and
9 Medicaid, while HOPDs had a higher percentage of about 14.

10 We also found that relative to HOPDs, ASCs had a
11 lower share of fee-for-service Medicare patients who were
12 under age -- excuse me -- under age 65, meaning they were
13 eligible for Medicare based on disability or who were 85
14 years and older.

15 Since 2012, the ASC payment system has had the
16 Ambulatory Surgical Center Quality Reporting Program, or
17 ASCQR. Specifically, the ASCQR program includes four risk-
18 adjusted outcome measures that assess the rate of hospital
19 visits within seven days after a surgical procedure in one
20 of the following categories: colonoscopy, orthopedic,
21 urology, or general surgery procedures. The data indicate
22 that there was a small statistically significant worsening

1 in the orthopedic and urology measure outcome rates from
2 2023 to 2024.

3 Another topic regarding ASCs that we've
4 frequently addressed over the last 15 years is MedPAC's
5 recommendation to the Congress that ASCs collect and submit
6 cost data. Some stakeholders have argued that submitting
7 cost data would be overly burdensome on ASCs because they
8 are small facilities. However, other facilities -- other
9 small facilities such as rural health clinics, home health
10 agencies, and hospices submit cost data.

11 Submission of cost data is important. Without
12 cost data, CMS cannot create payment rates that accurately
13 reflect ASCs' costs and cannot create an ASC market basket
14 that could be used to update ASC payment rates.

15 So in sum, we have a few key takeaways of our ASC
16 status update for 2024.

17 First, the number of ASCs is growing with 140 net
18 openings in the last year, a roughly 2 percent increase.
19 The volume of ASC services and fee-for-service Medicare
20 payments to ASCs are increasing, though payments are
21 increasing faster than volume. There's considerable
22 variation in ASC market concentration. So accessing

1 services at ASCs in some areas may be challenging.

2 Beneficiary case mix differs between ASCs and
3 HOPDs. Relative to HOPDs, fee-for-service Medicare
4 beneficiaries treated in ASCs are less likely to be dually
5 enrolled, be disabled, or be age 85 and older.

6 And finally, national ASCQR quality measure
7 performance has remained fairly stable over the last three
8 years, though two measures have worsened slightly in the
9 last year.

10 That concludes our ASC status update
11 presentation. For today's discussion, we will address the
12 Commissioners' questions about the material, would like to
13 hear any suggestions for future work.

14 We do plan to publish this material in the ASC
15 status update chapter in the March 2026 report to the
16 Congress.

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

18 DR. CHERNEW: Great. So, Alex, thank you. Dan,
19 thank you.

20 We're about to start Round 1, but I do want to
21 say -- I want to ask actually a Round 1 question myself
22 first.

1 This is largely -- the presentation largely
2 focuses on ASCs and HOPDs. How many or are there any
3 procedures that are often done in a physician office? And
4 do we have to think through the type of substitution, not
5 just between HOPD and ASC, but between office and ASC?

6 DR. ZABINSKI: Yesterday we took a quick look at
7 that, and there is -- you know, it does happen. It is a
8 concern.

9 In general, I think we'll find like about maybe
10 150 HCPCS codes where it happens, but being that this is
11 the ASC system and things are really concentrated in a
12 small number of HCPCS codes, really in terms of having
13 volume that you might want to pay attention to, there's
14 probably a handful of HCPCS codes. So it's an issue.

15 For example, probably the biggest HCPCS code is,
16 as usual, cataract removal with the IOL insert, and yeah,
17 it does look like there has been some shifting from offices
18 to ASCs for that. But it is also true that the volume in
19 the ASCs has always been much higher than the offices as it
20 is. That's all we know.

21 DR. CHERNEW: Okay. I'm not going to waylay from
22 this. Maybe we'll come back to it at the end if we get

1 there. I guess I get to control when we end.

2 But I think Tamara is the first one in round --
3 like the official Round 1 queue. So, Tamara?

4 DR. KONETZKA: Thanks for a really interesting
5 chapter.

6 I'm not a huge fan of certificate of need. I
7 think it's mostly anti-competitive. But my understanding
8 of the motivation usually for certificate of need is that
9 states want to control total capacity, right, so that they
10 can control overall spending. It doesn't make any sense to
11 me in this sense in that it's really a substitution away
12 from more expensive settings or at least what we can tell.

13 So I guess my question is, do you know why these
14 states have certificate of need for ambulatory surgical
15 centers, and is there evidence that it somehow increases
16 total volume of these procedures, or is it just a
17 potentially lower cost setting for the state?

18 DR. ZABINSKI: That's a good question: Why? I
19 think I know a little bit about -- Vermont is kind of the -
20 - you know, they have probably the strictest COM law
21 regarding ASCs. And I think there's just a lot of concern
22 about -- they talk about patient access and that sort of

1 thing.

2 I'm not sure the extent to which that is a real
3 viable argument, but I think that's what they usually say
4 about it. And, you know, I know like -- okay. Vermont,
5 they have two ASCs in the whole state, and so obviously,
6 it's having an effect to which Medicare beneficiaries in
7 Vermont can get ASC services. Whether that has an effect
8 in general on outpatient surgical access, I don't know.
9 It's a good question.

10 DR. RAMBUR: I can comment on that if you like.
11 I was actually on the Green Mountain Care Board that
12 oversees certificate of need, hospital budgets, insurance
13 rate setting, and very early in my career, like 20 years
14 before that, when I was in North Dakota, someone who I
15 thought was very wise said certificate of need does not
16 work and not having certificate of need does not work.

17 So I think when we look at the two polls that we
18 have here, we have an all-payer rate setting model in
19 Maryland, and so then the cost just squishes out --
20 technical term, squishes out to the ASCs.

21 So in Vermont for many years, there was a very
22 conscious attention, and it is very strong regulatory, say

1 five people oversee that decision. And it was really felt
2 that there just wasn't enough people to have things crop up
3 all over. There's only 600,000 people. I'm not saying
4 that's right or wrong. I'm just telling you that that's
5 the thought, and then the concern was that there'd be
6 cherry-picking.

7 So at the time that I left, there was five
8 people. I didn't have to do that vote, and I was glad it
9 ended up being three to two. And there were really strong
10 arguments on each side, but they've had very strict
11 certificate of need in a state that was trying to do an
12 all-payer model. So that's what I know about Maryland and
13 Vermont.

14 MS. KELLEY: Gina, Round 1?

15 MS. UPCHURCH: Thank you so much. Yeah, thank
16 you so much for this chapter and information.

17 I had a question, but I think the things that
18 I've heard about certificate of need -- North Carolina has
19 it -- is it is the cherry-picking. Potential hospitals
20 think that they're cherry-picking.

21 It has something to do with provider
22 reimbursement too. I think a lot of providers go and start

1 ASCs because it definitely is incentive for them to make
2 more money. I don't know if it's because you're avoiding -
3 - I don't know. I think it has something to do with
4 facility fees, but I'm not -- I'm not -- you're avoiding
5 facility fees, but you can charge more. I'm not sure, but
6 a lot of providers go out and do that because it's seen as
7 a big money maker in many ways for them, so something about
8 cherry-picking and facility fees and providers getting paid
9 more. I don't remember.

10 My question is, do they have to provide charity
11 care or hardship? I'm assuming not, but do ambulatory
12 surgical centers have to provide any sort of support?

13 DR. ZABINSKI: Not that I'm aware of.

14 MS. UPCHURCH: Yeah. Didn't think so, and that
15 just gets at the cherry-picking, right? The hospitals are
16 left with having to deal with stuff that -- yeah, so that's
17 -- thanks.

18 MS. KELLEY: Robert?

19 DR. CHERRY: Yes, thank you.

20 My question -- and by the way, this is a great
21 report and great summary.

22 I guess I'm trying to understand with the ASC

1 unplanned hospital visits, Nos. 17 and 18, they refer to
2 orthopedics and urology. When you look at it, the
3 difference is when you look at really the four-year period,
4 going to the primary reading materials, seem relatively
5 small. So I wonder if you can unpack exactly how we're
6 coming to the conclusion that the results were slightly
7 worse, and how are we risk adjusting? Are we using CMI, or
8 what methodology are we using?

9 DR. HARRIS: Good question. So these are CMS
10 measures. We don't internally calculate these. We
11 calculate the median values based on kind of ASC-level
12 results. So we are not in charge of the methodology for
13 these, but I will say based on my prior professional
14 knowledge, working on these measures, at least some of
15 them, they do have very low outcome rates, which I think
16 can contribute to not seeing like major differences year to
17 year.

18 This year, the two that we flagged, that we did
19 see statistically significant changes. As you can see,
20 just from an absolute sense, I mean, they're really small.
21 These are small differences, was more of a flag than a kind
22 of a red flag about, oh, gosh, what's going on here? But

1 it's something that we want to keep track of kind of over
2 time, since I think it is the first time over the six-year
3 period that we report in the chapter that we did see an
4 increase.

5 So I can't speak to the entire methodology of how
6 these are created and what might actually be going on here.
7 Certainly, something I think we're interested in looking
8 into a little bit further, but yeah.

9 I will note, even though they're statistically
10 significant, the changes are perhaps -- I mean, I'm not a
11 clinician, but you could maybe argue that clinically not
12 that meaningful. I can't really speak to them.

13 DR. CHERRY: Maybe we could revisit it because
14 we're calling out two specialties and it just -- we want to
15 make sure that we get it right, because when I look at the
16 four-year period, for ortho, it's 2.2, 2.2, 2.2, and then
17 2.3. And then we kind of call it out in that last year.
18 And then for urology, there's actually an overall trend
19 towards improvement, 5.1, 5.1, 5.1, but then the 5.2, we
20 call it. So it doesn't seem really kind of intuitive here.
21 So just wondering if we can kind of revisit the asterisks.

22 Thanks.

1 MR. MASI: Yeah, we can take a look at that,
2 Robert.

3 MS. KELLEY: Okay. That's all I have for Round
4 1. Should we go to Round 2?

5 DR. CHERNEW: Absolutely.

6 MS. KELLEY: Brian, you're first.

7 DR. MILLER: So favorite chapter, also love that
8 a Northwestern alum is working on. Go Cats.

9 So the Mercatus Center has a 20-year history of
10 research on CON. We probably should look at that and
11 reference that. They do a lot of -- it was, I believe,
12 Matt Mitchell who was there for 15 or 20 years, and so all
13 of his stuff should still be on the website. There's also,
14 if you want to entertain yourself, a fun YouTube video
15 about the "Wrath of CONs," about restraining competition
16 and raising costs.

17 I appreciate the chart showing the push towards
18 ASCs from HOPDs and that there's still a difference. That
19 difference may also be due to the fact that we still have
20 HOPDs as a separate billing category with untold thousands
21 of them owned by health systems, and they have a financial
22 incentive. And this is not to disparage them, but they

1 have a financial incentive to direct people towards a high
2 cost, already owned site of care, as opposed to building a
3 new ASC and pushing procedures out into a lower-cost care
4 site, because if you can go to an ASC and it's 50 percent
5 or you can do it in your existing HOPD, you do not have a
6 financial or economic incentive to move that Medicare
7 beneficiary to the lower site for cost of care. So we
8 should probably mention that that lack of incentive exists,
9 and it's not necessarily the health system's fault. It's
10 the rules and incentives that we have created for them, as
11 our Chair would say.

12 I think one of the things that is really
13 interesting is that if you look at private practice markets
14 from a clinical operations perspective, a lot of private
15 practices, the clinicians who do procedures and surgeries
16 have procedures at the ASC and the HOPD, and often when the
17 beneficiary goes and gets that procedure, that procedure is
18 a discussion between the patient and the physician about
19 whether they think that that is appropriate to go to an ASC
20 or an HOPD.

21 That is, I think, an interesting question that if
22 we had the data would be fun to look at and useful for us,

1 for as we think about what additional procedures could move
2 from HOPDs to ASCs.

3 As our Chair mentioned, we should also be
4 thinking about ASCs to clinics, and so thinking about the
5 HOPD-ASC clinic sort of transition, that's a product of
6 clinical innovation. So almost 20 years ago, when I
7 started medical school, it was considered nuts to do a hip
8 replacement as an outpatient, and they literally said it
9 was unsafe and that you were insane as a patient or an
10 orthopedic surgeon if you thought you were doing that.

11 Now, if you get your hip replacement as an inpatient and
12 you otherwise have a handful of comorbidities, people look
13 at you sort of confused and think you're a Nervous Nellie.

14 So I think that we need to recognize that there's
15 a clinical innovation from technical, like surgical and
16 procedural technique and then also technology allows us to
17 move more patients to lower cost, lower acuity settings.

18 I would suggest that ophthalmology is the best
19 example of this. So cataract surgery many years ago,
20 probably from when I was a small child, was an inpatient
21 surgical procedure, and you could not imagine doing it in
22 an ASC. And now it is all in ASCs, and the

1 ophthalmologists are thinking about moving it into the
2 clinic as a clinic procedure.

3 We might benefit from a conversation with the
4 American Society of Cataract and Refractive Surgery to sort
5 of understand that transition of clinical innovation
6 driving care to lower cost sites, and so I think that
7 that's something that we should be thinking about.

8 And I personally don't really have an attachment
9 to who owns the ASC or the clinic or the HOPD as long as
10 the patient gets the right procedure in the right clinical
11 setting at the right time, and that we do that in a way
12 that is safe and effective and creates as low cost for the
13 beneficiary as possible, because yes, we're thinking about
14 cost for the Medicare program, but the beneficiary for
15 outpatient does eat some of those costs. So when we're
16 reducing costs for the program, we're also reducing costs
17 for the beneficiary.

18 I did want to say something again on cost
19 reporting. I know everyone's getting tired of hearing me
20 say this, and that's okay. I going to say it again. I
21 don't think we should require cost reporting is a burden on
22 small businesses. If we want a regulatory environment that

1 facilitates competition, we do not need cost reporting for
2 what is equivalent to a McDonald's franchise. We do not
3 have cost reporting in a lot of other markets that are paid
4 for by insurance. With third-party payments such as
5 dental, my dentist does not have cost reporting. My
6 optician --and I have vision insurance -- does also not
7 have cost reporting. And auto insurance for when I get
8 into fender benders, there is also not cost reporting for
9 their entire line of business. So there are lots of other
10 markets that are insured that have third-party payment and
11 even have majority third-party payment that do not have
12 cost reporting to either the company or the government.

13 And so I think that there are other business
14 operational ways to do this without imposing that
15 regulatory burden.

16 Thank you.

17 MS. KELLEY: Betty.

18 DR. RAMBUR: Thank you so much. This is really a
19 terrific report. And I just want to sort of amplify or
20 underscore something that was said very well in here, but
21 it really, really troubles me.

22 The ASCs have to submit their quality

1 measurements, as you know, or they'll have their payment
2 reduced by 2 percent. But their performance on those
3 measures does not affect their payment. I think that's
4 very troubling, and as a patient advocate, that's very
5 troubling to me. And contrary to Dr. Miller, I respect his
6 opinion, I do think that the lack of cost reporting is this
7 issue of transparency. People really don't know, in a
8 sense, what they're getting quality-wise, right. You don't
9 really know unless you had something really bad happen and
10 you're hospitalized. And we can't really tell what it
11 costs. And in that way, I see it's very different than
12 dental or vision, where you can have some idea of what
13 you're getting. You can have some idea.

14 So I just want to be on the public record. I
15 know that we have an existing recommendation on this, but I
16 think it's absolutely essential, as these grow, everything
17 else is being assessed for outcomes, and we're really
18 trying to move to a more transparent system. So I just
19 wanted to amplify what is in here, and again support the
20 cost reporting. Thank you.

21 MS. KELLEY: Cheryl.

22 DR. DAMBERG: Thank you for this work. I also

1 support the reporting of cost data, so I'm going to amplify
2 Betty's comment. You know, as we see the number of
3 procedures, especially with the elimination of the IPO
4 list, more services being delivered in this space, I think
5 we need to have a better understanding of what the cost of
6 delivering that care is in that environment.

7 One last comment. There is a vertical
8 integration aspect to this space, both physicians who were
9 previously in independent practice who then get vertically
10 integrated with health systems and when they do that, they
11 have a lower propensity to send people to ASCs. They send
12 them to the HOPDs. And then there are several studies in
13 that space. I can point them to you. That then conversely
14 -- so this is all about the incentives -- health plans have
15 vertically integrated with ASCs. So from their
16 perspective, the incentive is to direct people to the ASCs.
17 So I think that's an aspect that I would welcome you
18 pulling out a little bit more in this chapter.

19 MS. KELLEY: Paul.

20 DR. CASALE: Thank you for this chapter. I think
21 it's terrific. Just comments. I think, as you pointed
22 out, the ASC experience, you know, the physicians generally

1 are part owners in the ASC, so they are aligned to be
2 efficient. They often recruit the best staff that they
3 know, who may have been in the hospital, to work in their
4 ASC, and then they train them on efficiency. And with
5 that, the patients get a better experience. So I think
6 that is reflected in what you pointed out.

7 To the point Brian made about hips and knees, as
8 you said, in 2020 there were 11,000, and then in 2024,
9 50,000. And part of that is the elimination of the IPO
10 list, and part of it is the innovation and the improvement
11 in the actual procedure that allows that to be done.

12 You also highlight the growth in single specialty
13 ASCs, and you mention cardiology as one of them, that has
14 grown 6.3 percent. We should keep our eye on those,
15 because I think with several of the cardiology procedures
16 now coming off the IPO list, we're going to see even more
17 growth in that. You know, the most recent one coming off
18 are ablations for EP procedures. Again, there has been
19 innovation. It's become a much safer procedure. Years
20 ago, we would never think of doing that as an outpatient,
21 and now it can be done.

22 And just to reflect my age, to Brian's point

1 about cataracts, when I was in medical school we admitted
2 patients for cataracts the day before. They got their
3 preop, they had their procedure, and then they stayed in
4 three to four days afterwards before they went home. So,
5 Brian, I experienced all of that, and it's remarkable how
6 that's changed.

7 I'm talking about cardiology, because I think I
8 know that better. For the independent cardiologists, a lot
9 are now partnering with private equity to get the capital
10 to then build the ASC, to then move procedures to the ASC.
11 Again, it's part of the sustainability to being an
12 independent practice, because, Gina, they do get a facility
13 fee and not just a procedure fee. So again, just something
14 to keep an eye on.

15 And I think to the point others have made about
16 cherry-picking, you reflected that in the dual eligible,
17 disabled, greater than 85. They tend to be higher risk
18 patients, and the physicians are likely going to say, "I'm
19 going to do that in a hospital," where they have full
20 service. And so, again, keeping your eye on that I think
21 is really helpful.

22 And then the last is around cost measures. You

1 mentioned the Pennsylvania Health Care Cost Containment
2 Council. I was on their board for like 20 years, so I know
3 them well. And I remember the debate about trying to get
4 the data from ASC, which they eventually got. And I think
5 I am in favor of getting that. I think it's helpful. I
6 think they can provide it. They sometimes, you know,
7 initially resist, for the reasons that you highlighted.
8 But I think it can be done. I think in Pennsylvania it
9 certainly can be done, and I think it's helpful.

10 And the last thing are the quality measures. You
11 know, hospital visits have the procedure. Important to
12 know, but insufficient in terms of quality measures. And I
13 think as this ASC market grows, we really do need to have
14 more robust quality measures. Thanks.

15 MS. KELLEY: Greg.

16 MR. POULSEN: Thanks. Paul just said a number of
17 the things that I wanted to say, and I think -- well, let
18 me just reiterate a few of the points that I think are a
19 big deal.

20 In the chapter it said that most ASCs are partly
21 or completely physician owned. A couple of studies that
22 I've seen suggest that it's 95 percent. I mean, it's a

1 huge percentage. And so that ends up being, I think,
2 really meaningful.

3 I agree with a lot of the things that Brian said,
4 but one of them I really don't agree with, and that is I
5 don't think that there are many hospitals that are sending
6 people to hospital outpatient departments that
7 appropriately belong in a freestanding surgery center, for
8 a couple of reasons.

9 One, I don't know a large health system that
10 doesn't have a bunch of freestanding surgery centers. They
11 all do. And the majority of them make more money on the
12 freestanding surgery centers than they do on the hospital
13 outpatient departments because they're much less expensive
14 to run, for the reasons that Paul talked about. You can
15 move people through it. It's a more efficient process. It
16 makes a lot of sense.

17 The only patients that get intentionally moved
18 into hospital outpatient departments are done for one of
19 two reasons -- financial, they can't get it covered in the
20 ASC because some of the ASCs don't cover all payers; and
21 the other reason is clinical. Not that you couldn't do the
22 procedure safely in the outpatient surgery center, but if

1 something goes sideways you want to have the backup of the
2 hospital right there. I'm glad I'm seeing some of the
3 clinicians nodding, because I really do think those are the
4 only circumstances that I've seen where people are directed
5 to a hospital outpatient department that could potentially
6 have been "appropriately" -- I'm using air quotes --
7 "appropriately" cared for in an ASC.

8 Let's see. There was one other thing I wanted to
9 point out. Oh yeah. I think one of the key issues too is
10 that with physicians, even for those ambulatory surgery
11 centers that are owned by larger organizations, they almost
12 always have some component of physician ownership there
13 too. And so directing people away from that is going to
14 incur the wrath of the affiliated physicians, so they don't
15 do that for that reason either.

16 There are a whole number of reasons why the ASCs
17 are preferred in almost every circumstance, and I would
18 argue that we need to be very, very careful that we don't
19 make it even less attractive than it is to do things in
20 hospital outpatient departments, because that really could
21 put folks that don't have an effective payment mechanism at
22 risk. It would put people in smaller communities where

1 they're doing surgeries but they're certainly not doing it
2 in a lucrative fashion, and if those were to be squeezed
3 into -- this is one of the areas where I think, almost de
4 facto, same payment rate between the two is going to create
5 a very unattractive, unintended consequence.

6 MS. KELLEY: Brian, did you have something on
7 this point?

8 DR. MILLER: Yeah, a quick thing. Thinking about
9 clinic versus ASC plus HOPD, my colleagues who practice
10 around the country have seen people referred by their
11 corporate-owned health system for the wrong reason. And I
12 have heard a lot about that from my surgical and procedural
13 friends, and I respect your opinion that your health system
14 and the health systems that you know are good operators.
15 There is a range of operators, I think.

16 And I think part of this gets to all of the
17 challenges that we have around site neutral payment. And I
18 think that the answer is probably, if a procedure is, say,
19 95 percent ASC appropriate, you want us to get those 95
20 percent of patients into the ASC, and you want those 5
21 percent in the HOPD. So I think part of that discussion
22 about site neutral, whether it's ASC versus HOPD, HOPD

1 versus clinic, clinic versus ASC, is sort of parsing out
2 those populations amongst procedures, and the also adding
3 some sort of risk measurement, knowing that risk adjustment
4 isn't perfect, et cetera, so that the patients who do
5 definitely 100 percent belong in an HOPD, or likely belong
6 in an HOPD, are appropriately clinically referred them.
7 And I think the current barrier we have to that is because
8 we are all -- not us, personally, but the system is
9 anchored on payment levels as the differentiator as opposed
10 to the patient and their clinical procedure and clinical
11 risk. And that might be a broader stream of work for us to
12 think about. I mean, it would be several years, as a
13 potential solution to a lot of the site of service payment
14 differentials.

15 DR. CHERNEW: Thank you, Brian. I want to jump
16 in because I want to ask a question, but I want to point
17 out that the complexity that you just mentioned is why it
18 is so hard to think about HOPD as sort of standalone,
19 because you have to think about how to integrate it with
20 ASC and with potentially offices, and a bunch of other
21 things.

22 The question I have for you all is I want to make

1 a distinction between -- first of all, let me say I've
2 never practiced medicine. I have, unfortunately, been in
3 an HOPD. But I want to ask if it's important to think
4 about the distinction between the structure of the building
5 and its sort of production efficiencies, the way Greg
6 described them. They can get you in. They can get you
7 out. Where I went it was great. In fact, where I went had
8 every feature of an ASC except for the fact that it was an
9 HOPD, because it happened to be very, very close to where
10 the hospital was.

11 So there's a distinction in my mind, that I'm
12 asking if it's important, between the sort of production
13 efficiencies of an ASC and then the labeling of which fee
14 schedules are billing under. Because you could take
15 something that, if it's close enough to your hospital, you
16 can say, oh no, this is an HOPD, even though its
17 effectively functioning just like the ASC, there might be
18 some other place that you can't classify.

19 So right now what we're doing in this is we're
20 actually talking about the facilities that are billing
21 under the fee schedule as an ASC. And some of the HOPDs
22 may be functioning similarly. And I don't know if that's

1 an important distinction, but it seemed to be in my
2 appendicitis case.

3 Okay. That was a rhetorical question. You can
4 reach us at meetingcomments@medpac.gov.

5 [Discussion off microphone.]

6 DR. CHERNEW: I was not ending the session
7 because I caused dramatic silence.

8 DR. HARRIS: Mike, I do have a piece of an answer
9 to that.

10 DR. CHERNEW: Okay. Thank you, Alex.

11 DR. HARRIS: You have to add the layer of
12 facilities that are single specialty and the efficiencies
13 that come along with that. I'm thinking of like
14 ophthalmology versus general surgery ASC, which has
15 potentially multiple kinds of procedures that may not share
16 the same types of efficiencies that you're alluding to.

17 So I don't have a clear answer for you, but I
18 think to make it more complicated I think that's an
19 important factor to consider when you're thinking ASC
20 versus an HOPD.

21 DR. CHERNEW: Yeah. My sense was some of it is a
22 regulatory, like you're choosing a fee schedule versus a

1 building, and there are some regulatory things.

2 I know that Lynn is actually next in the queue,
3 and so I was joking. There are actually a few other people
4 in the queue. But Lynn, take it away. And by the way, I
5 time all of you. I don't time me.

6 MS. BARR: Anyway. All right. I agree with a
7 lot of what's been said. There are a bunch of issues that
8 have been mentioned and I want to go through them. One of
9 them is about rural and small community hospitals. You
10 know, there's only 6 percent of ASCs in those areas,
11 because they can't support. And, I mean, they have just
12 endless open capacity. Many of them are critical access
13 and they're cost-based reimbursed. So if we send them to
14 an ASC we pay more as Medicare because we're going to pay
15 their costs anyway, all the overhead. So volume in those
16 communities might be a good thing as opposed to trying to
17 set up an ASC.

18 I have found that most of the ASCs do have
19 ownership by physicians. So we talk about, well, the
20 hospital has an incentive, and we talked about the health
21 plan has an incentive. Well, the physicians have an
22 incentive to send to the patients to the ASC they own. So,

1 I mean, we're all capitalists. Let's not make one actor
2 bad and one actor good. We're all capitalists, and that's
3 how it works.

4 On certificate of need, I think it's a very
5 interesting thing in the Rural Health Transformation
6 Program, that they're going to pay states millions of
7 dollars to suspend their CON law. And so they're actually
8 going to give them, I think it's up to \$20 million, right
9 off the bat, and if they don't get their CON laws out in
10 two years, they claw it back. So it will be very
11 interesting to see where the CON laws are two years from
12 now. We'll all be watching that.

13 Yes, I agree that as technology changes, you
14 know, more and more can be done. It's definitely more
15 profitable to do it in an ASC if you can. So I also agree
16 with that comment. And I'm definitely in support of cost
17 reporting for these facilities and some accountability for
18 their quality. I think that's important. But I do think
19 that they're wonderful, and I'm glad they're there. And
20 for what's appropriate, it's great, and it reduces the cost
21 of care, and it's safer in many cases, and a great
22 experience. Thank you.

1 MS. KELLEY: Robert.

2 DR. CHERRY: Yes. Thank you. Actually, my R2
3 comments were directly related to Mike's question and also
4 kind of a piling-on of Greg and Brian's comments, as well.
5 And although not intended, when you look at the chapter you
6 can't help but think about and talk about site neutrality.

7 And as many of you know, I was a hesitant voter
8 into the site neutrality model. And the disclaimer here is
9 that I'm okay with it if there are two provisions
10 associated with it. One, it has to be safe, and two, it
11 has to be appropriate. And what do I mean by appropriate?
12 It's not just the clinical indications to do the procedure
13 but appropriateness criteria to make sure that the setting
14 and the team and the environment is appropriate to what
15 needs to be done, relative to the patient's risk model.

16 And so what's in this report here is that you see
17 the difference between ASC patients and HOPD patients has
18 to do with age. So what happens when patients are older?
19 They tend to have comorbidities, right. And the more
20 comorbidities they have, they tend to be more costly, and
21 they require more resources to keep them safe. And that's
22 the problem with site neutrality is that you can't treat

1 all these patients the same, because if there's 5 percent
2 of patients that require an HOPD because of the proximity
3 to advanced resources attached to that hospital building,
4 it's one of the reasons why you have a small number that
5 are older. And I would say that they're probably sicker
6 than what they were several years ago, because more
7 patients are migrating from hospital environments into
8 ASCs, leaving behind a higher acuity patient population in
9 the HOPD.

10 So I think another way of saying this, if we
11 weren't Commissioners and we were an IRB thinking about a
12 research protocol, and we said we just want to randomize
13 patients to ASCs and an HOPD and just see what happens, I
14 think as IRB members we would have a problem with that
15 protocol, to say that we would just take the 85-year-old
16 and just put them in to the ASC, regardless of their
17 advanced age, regardless of their comorbidities, to do this
18 study.

19 And so if it's problematic in a research
20 environment, it should be problematic within the clinical
21 environment, because the two are making comparable
22 decisions around the safety around the patient.

1 So this the direct answer to your question, Mike,
2 is that, yeah, I think there is a difference between
3 clinicians that make a very purposeful decision to put a
4 patient in an HOPD versus an ASC, for the reasons that I
5 mentioned. So thank you.

6 MR. MASI: Thanks very much for that, Robert.
7 And just for the public at home, MedPAC is not going to be
8 randomizing patients anywhere.

9 [Laughter.]

10 MR. MASI: But appreciate the comments very much.
11 That's well taken.

12 DR. CHERNEW: And we do have those provisions in
13 the recommendations of site neutral.

14 MS. KELLEY: Tom.

15 DR. DILLER: Yeah. Very good section on this.
16 What fascinates me is the differences in incentives and
17 differences probably in geography and market. So Greg, as
18 I was listening to your comment I had just punched in that
19 I wanted to do a Round 2 comment prior to that, and I was
20 going to say the exact opposite of what you said, which is
21 in my experience. And that is that hospitals have fixed
22 costs in their hospital outpatient setting, and in at least

1 some settings what they're doing is trying to make those as
2 efficient as they possibly can. They don't want to enter
3 into ASC because why should I get paid 50 percent less to
4 move that same patient to the ASC? So they do things to
5 try to hang onto them, including telling their employed
6 physicians you can't go to an ASC, which we know in some of
7 the literature that will occur.

8 So they get involved in ASCs when one of two
9 things happens. One is that the payer is now requiring the
10 patient to go to an ASC. Might as well get paid at least
11 some of that. Or if they're faced with loss of business,
12 because the market forces are like, I don't know, we've got
13 to go in the other direction.

14 Now on the physician side, 95 percent of the ASCs
15 are owned by physicians. Incredible incentives for them to
16 go to take their patients to their own ASC, because they
17 get a facility fee associated with their surgical fee. And
18 so exploring that is significant, and I know of at least
19 one market where -- well, I will say it's orthopedic
20 surgeons that own ASCs, and they do Medicaid at the
21 hospital and they do everything else in their ASC. And
22 it's just the way it is.

1 So I guess what I'm encouraging is us to explore
2 that more as we move forward, with what are these different
3 incentives doing and how does CON play into it, and all of
4 that. Because I think we're both right. I think there's
5 just geographic variations and different ways that
6 different organizations are focusing on this.

7 MS. KELLEY: Mike, that's all I have for Round 2.

8 DR. CHERNEW: And that was all I had, so we're on
9 the same page.

10 So that was great. I will make a few summary
11 comments and then I will thank Alex and Dan, and just now,
12 Lynn, I'm actually saying for real to everybody, if you
13 want to comment on this or other things, reach us at
14 meetingcomments@medpac.gov, or reach out in some other way.

15 This has been a really interesting and important
16 discussion, and I think it does dovetail with broader
17 issues that deserve deeper attention, like site neutral and
18 whole range of things about how to do that.

19 I'll say two things that really didn't come up a
20 lot in the discussion that I think are important. The
21 first one is we don't have a sense about how much of the
22 entry of ASCs increases volume particularly. So it's not

1 just where you get the procedures. Do you get a procedure
2 at all, and how that plays out in making sure that the
3 people, to Robert's point, and I think the issue here is
4 measurement, not in concept, is you want to make sure the
5 procedure is appropriate for somebody in the first place,
6 not only that the site is appropriate. And I think there
7 is some concern about that, and I think it varies. And we
8 mentioned some of the incentive effects related to that.
9 But I want to point out it's not just directing people
10 where to go. It's getting people actual procedures. And I
11 think it matters. It's just very hard to measure.

12 The second thing, and I think this will be much
13 in the spirit of a lot of what Tom does, is in some ways
14 the right way to think about this is to have accountability
15 for patients at a higher level in some sort of alternative
16 payment model, and let the delivery system decide what the
17 appropriate place is, where you're not trying to manage
18 this, because it is very, very, very, very hard to get the
19 relative prices right in this context.

20 So I could see a situation in which, if you are
21 bearing population lists for some other risk or some other
22 type of model, where you could then say, all right, we get

1 paid for this population of people. Some of them we'll put
2 here. Some of them we'll put there. We'll have incentives
3 to do that efficiently.

4 I like the idea of having the incentives there,
5 because I don't think it's easy -- it's easy to say, well,
6 let's just get the prices right and we'll solve the problem
7 with site neutral, and we'll just do it appropriately here
8 or there. That's a really, really, really hard to thing to
9 do, because there's so much contextual difference in
10 patients. So I think it's much easier to have a higher
11 level payment model and give the delivery system some
12 flexibility, and then try and monitor it make sure they're
13 doing it right, or at least not doing it horribly.

14 But again, I'm not being timed, so that works
15 well.

16 DR. RAMBUR: For you.

17 DR. CHERNEW: Yeah. Thanks, Betty. Anyway, this
18 was really a wonderful session, and it was really a
19 wonderful day. It seems like a week ago we were going
20 through all of the votes.

21 I want to thank all of you for engaging with all
22 of the work that we've done. Again, I want to thank the

1 staff here, Alex and Dan, and all of the staff that
2 presented. It is really an amazing volume of work across
3 the board today, and I happen to know it's coming tomorrow,
4 so thank you all for tomorrow in advance.

5 Again, for those of you at home, tomorrow we're
6 going to be talking about Medicare Advantage. That's a big
7 sandwich -- now I'm talking like Paul -- and then D-SNPs,
8 which is also sort of a Medicare Advantage topic. So we
9 really hope those of you at home can join us tomorrow at 9.
10 Other than that, let me say thank you and we'll see you
11 again tomorrow.

12 Paul, did you want to add anything?

13 MR. MASI: We'll see you tomorrow.

14 [Whereupon, at 5:40 p.m., the meeting was
15 recessed, to reconvene at 9:00 a.m., on Friday, January 16,
16 2026.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 16, 2026
9:00 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
BETTY RAMBUR, PhD, RN, FAAN, Vice Chair
LYNN BARR, MPH
PAUL CASALE, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
THOMAS DILLER, MD, MMM
STACIE B. DUSETZINA, PhD
KENNY KAN, FSA, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
JOSHUA LIAO, MD, MSc
GOKHAN METAN, MSc, PhD, NACD.DC
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
WAYNE J. RILEY, MD, MPH, MBA
SCOTT SARRAN, MD, MBA
GINA UPCHURCH, RPh, MPH

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

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P R O C E E D I N G S

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[9:00 a.m.]

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DR. CHERNEW: Hello, everybody, and we're about to get going. Oh, we're going. We've gotten going. Hello and welcome, everybody, to our Friday morning MedPAC meeting.

The chapter we're going to start with is the Medicare Advantage Status Report. It's the chapter that people stop me on the street and ask about. So for all of you who I've seen on the street, now we're going to hear the real numbers.

So I think Andy is starting. Andy, take us away.

DR. JOHNSON: Good morning.

This presentation updates our findings on the status of the Medicare Advantage program. The audience can download a PDF version of these slides in the materials section of the control panel on the top right corner of your screen.

I want to acknowledge Stuart Hammond's contribution to this report. He's not able to be here today. So I will present his work, which is covered in the first two sections of today's presentation. Katelyn

1 Smalley also contributed information about quality in MA,
2 which is included in your meeting materials.

3 First, I will present an analysis of the latest
4 data on MA enrollment, plan availability, and the structure
5 of the MA market. Then I will review MA rebates and the
6 supplemental benefits that rebates finance. Next, Luis
7 will introduce MA plan payment policy, and we will provide
8 an update on the trends in MA payments, risk-coding
9 intensity, favorable selection, and our comparison of MA
10 and fee-for-service spending. Finally, Grace will provide
11 an update on MA plan costs and revenues for enrollees with
12 end-stage renal disease.

13 As you all know, the Commission is required by
14 law to make payment update recommendations for providers
15 paid under Medicare's traditional fee-for-service payment
16 systems. The Commission also is required to report on the
17 status of the MA program, including a review of MA payment
18 policies, risk adjustment methods, the impact of risk
19 selection, mechanisms for promoting quality, access to
20 care, and other issues.

21 The MA program gives Medicare beneficiaries the
22 option of receiving benefits from private plans, rather

1 than from the fee-for-service Medicare program. The
2 Commission strongly supports the inclusion of private plans
3 in the Medicare program. Beneficiaries should be able to
4 choose among Medicare coverage options.

5 For beneficiaries, the primary trade-off between
6 MA and fee-for-service is access to the supplemental
7 benefits that MA plans provide versus a broader choice of
8 providers and fewer constraints on utilization in fee-for-
9 service. MA plans' supplemental benefits often offer
10 better protection against the high out-of-pocket spending.

11 Over the past several years, the Commission has
12 recommended important reforms to improve Medicare's
13 policies for paying and overseeing MA plans.

14 First, we'll discuss trends in MA enrollment,
15 plan availability, and the structure of the MA market.

16 Medicare beneficiaries enrolled in both Part A
17 and Part B have the choice of enrolling in an MA plan or in
18 fee-for-service Medicare. Since 2023, the majority of
19 eligible beneficiaries have been enrolled in MA. Fifty-
20 five percent of eligible Medicare beneficiaries were
21 enrolled in MA in 2025, a substantial and growing
22 difference from 26 percent in 2010. Also in 2025, MA

1 enrollment grew 4 percent to 34.9 million enrollees.

2 MA enrollment is concentrated in a small number
3 of large for-profit insurers that compete in most markets
4 across the country. High enrollment concentration,
5 particularly at the local level, can be a cause for concern
6 if it dampens the competitive pressures that might
7 otherwise drive insurers to maintain or improve quality,
8 make care delivery more efficient, lower premiums, or
9 provide supplemental benefits.

10 This figure shows the concentration of MA
11 enrollment at the national and local level. The data are
12 for conventional MA plans; that is, non-employer, non-
13 special needs plans.

14 On the left, we show the share of MA enrollees in
15 the three largest insurers nationally. In 2025,
16 UnitedHealth, Humana, and CVS Health enrolled 54 percent of
17 all MA enrollees. The green segment at the bottom of the
18 column shows that the remaining 46 percent of enrollment is
19 shared among all other insurers.

20 On the right, we show local enrollment. The top
21 three segments of the column show that the average
22 enrollment shares in the three largest insurers in a

1 county, regardless of whether the insurer is one of the
2 three largest nationally. The three largest insurers in a
3 county typically enroll over 80 percent of MA enrollees in
4 the county.

5 Medicare beneficiaries have a large number of
6 plans to choose from, and MA plans are available to almost
7 all beneficiaries. In 2026, the average Medicare
8 beneficiary can choose from 39 plans sponsored by eight MA
9 organizations, similar to the numbers available in 2025.
10 For 2026, nearly 100 percent of Medicare beneficiaries have
11 at least one plan available in their county. Ninety-eight
12 percent have a zero-premium option that includes Part D
13 drug coverage. Special needs plans for beneficiaries who
14 are dually eligible for Medicare and Medicaid, or D-SNPs,
15 are also widely available. Ninety-eight percent of
16 beneficiaries live in a county with at least one D-SNP.

17 Now I'll turn to discussing MA rebates and the
18 supplemental benefits they fund.

19 MA plans that bid below their benchmark are paid
20 a rebate, which is based on the difference between the bid
21 and the benchmark. Nearly all plans expect to be able to
22 offer basic Medicare benefits for less than the benchmark

1 amount and will receive a rebate. Rebates must be used to
2 provide supplemental benefits to plan enrollees.

3 The light gray line in this figure shows that the
4 average monthly rebates are expected to reach an all-time
5 high of \$222 per member per month in 2026. Rebates for
6 special needs plans, shown in orange, are expected to be
7 higher than the average at \$275 per member per month. For
8 conventional plans, shown in blue, the expected average is
9 \$199 per member per month. Although, altogether, rebates
10 are expected to account for 15 percent of total plan
11 payments in 2026.

12 MA plan bids include a projection of how plans
13 anticipate using these rebates. This slide shows how
14 conventional plans and special needs plans anticipate using
15 their rebates in 2026

16 In the blue portion of the upper bar,
17 conventional plans project using the largest share of their
18 rebate dollars to reduce cost sharing for Part A and Part B
19 services.

20 Because SNP enrollees are dually eligible for
21 Medicare and Medicaid and have many of their out-of-pocket
22 expenses covered by other programs, SNPs have less reason

1 to use rebates to cover these costs. Instead, SNPs
2 anticipate using most of their rebate dollars to provide
3 non-Medicare services, such as gym memberships and
4 discounts on dental services, which is shown in the orange
5 segment of the lower bar.

6 Relatively little is known about MA enrollees'
7 use of supplemental benefits. However, CMS recently
8 initiated a set of new data collection programs to gather
9 more information about enrollees' use of supplemental
10 benefits and plan spending on them.

11 One such effort requires that MA organizations
12 report greater detail in the medical loss ratio data they
13 submit to CMS. Under the new rules, MAOs must report how
14 much they spend on the non-Medicare services they offer
15 each year.

16 The spending reported here is funded primarily
17 through rebates that plans receive from Medicare. A small
18 share is funded by enrollee premiums.

19 Altogether, MA insurers report spending nearly
20 \$24 billion on non-Medicare services in 2023. Looking
21 across services, the largest amount was for dental
22 services, which accounted for more than \$6 billion, or

1 roughly 28 percent of reported spending. The second
2 highest amount was for services that are not primarily
3 health-related, which can include things like food and
4 produce, pest control services, or housing support. Plans
5 report spending nearly \$6 billion on these benefits in
6 2023.

7 These data are the first time we have information
8 about plan spending for supplemental benefits. Additional
9 details are available in your mailing materials.

10 Now I'll hand it over to Luis.

11 MR. SERNA: Thanks, Andy.

12 Now we'll turn to our update on Medicare's
13 payments to MA plans.

14 Payments to MA plans are the product of a plan's
15 base rate and the average risk score for plan enrollees.
16 The base rate is determined by comparing a plan's bid and
17 benchmark. Plans submit bids each year for the amount they
18 think it will cost them to provide Part A and B benefits.
19 Benchmarks are the maximum amount Medicare will spend in a
20 county. Counties are divided into quartiles, and
21 benchmarks are calculated as the fee-for-service spending
22 in the county, multiplied by the quartile percentage, which

1 ranges from 115 to 95 percent.

2 A plan's benchmark can be increased by a quality
3 bonus of 5 percentage points or, in some counties, 10
4 percentage points for plans achieving a rating of four or
5 more stars. Nearly all plans bid below their benchmark,
6 and so plans are paid a base rate equal to their bid plus a
7 rebate, which is calculated as a percentage of the
8 difference between the bid and the benchmark.

9 Demographic characteristics and diagnoses are
10 used to calculate a risk score for each beneficiary. Risk
11 scores are an index of predicted spending relative to
12 national average spending, which is assigned a risk score
13 of 1.0.

14 Risk scores increase MA plans' base payment rates
15 for enrollees expected to have higher-than-average spending
16 and decrease rates for enrollees expected to have lower
17 spending.

18 Also, risk scores are used to standardize the
19 fee-for-service spending estimates that are the basis for
20 benchmarks so that the spending estimate for each county
21 reflects spending for a beneficiary of average risk.

22 The risk adjustment model is developed using fee-

1 for-service beneficiary data. So risk scores reflect fee-
2 for-service diagnostic coding patterns and spending that
3 would occur in fee-for-service Medicare.

4 Two phenomena distort spending predictions when
5 MA tendencies differ from fee-for-service. First, coding
6 intensity results from MA diagnostic coding patterns that
7 differ from fee-for-service. Second, favorable selection
8 results from MA enrollees having spending tendencies that
9 differ from the average fee-for-service beneficiary,
10 independent of the effects of coding intensity.

11 Each year, the Commission compares spending on MA
12 to what Medicare would have spent if MA enrollees were
13 instead enrolled in fee-for-service. This comparison
14 accounts for differences in health status, including the
15 effects of favorable selection and differences in
16 diagnostic coding, geographic distribution, and Medicare
17 service coverage between the two programs.

18 We compare MA and fee-for-service spending in
19 three steps. First is a base comparison incorporating the
20 effects of MA payment policies other than risk adjustment.
21 Then we add the effects of differences in MA and fee-for-
22 service coding intensity and of a favorable selection of

1 Medicare beneficiaries into MA.

2 Andy and I will describe the effects of each of
3 these over the next several slides.

4 In response to Commissioner interests, we now
5 estimate what fee-for-service spending would have been for
6 MA enrollees with ESRD. Because there is a different
7 system for establishing payment rates for enrollees with
8 ESRD and different ESRD risk models, we conducted separate
9 comparisons of MA to fee-for-service spending for each of
10 the three ESRD populations: those on dialysis, receiving a
11 transplant, or with a functioning graft.

12 For 2026, we estimate that payments to MA plans
13 for enrollees with ESRD are projected to be 12 percent
14 above what fee-for-service Medicare would have paid. This
15 estimate is made up of three components: +3 percentage
16 points for payments before the effects of coding and
17 selection, +9 percentage points for the effects of coding
18 intensity, and effective selection is zero, indicating no
19 favorable selection or adverse selection for MA enrollees
20 with ESRD.

21 We incorporated these estimates into our overall
22 comparisons of MA payments relative to fee-for-service

1 spending, which has a relatively small effect because the
2 ESRD population accounts for an estimated 6 percent of MA
3 payments in 2026.

4 Now we turn to our overall estimate of MA bids
5 and benchmarks and payments relative to what fee-for-
6 service spending would have been for MA enrollees. We
7 include coding and favorable selection into our analysis so
8 that the MA and fee-for-service populations are comparable.
9 With these adjustments, we project that benchmarks in 2026
10 are 124 percent of fee-for-service spending.

11 Plan bids include a plan's projected medical
12 expenses, administrative expenses, and profit. In 2026,
13 plan bids are an estimated 95 percent of fee-for-service
14 spending.

15 Overall, we estimate that coding and selection
16 cause MA payments, including those for ESRD enrollees, to
17 be 14 percent above fee-for-service spending in 2026. The
18 payments above fee-for-service spending will be used to
19 finance supplemental benefits for MA enrollees.

20 We estimated MA payments relative to what fee-
21 for-service spending would have been for MA enrollees over
22 a longer period from 2015 through 2026. Here, we show MA

1 payments as a percentage above or below fee-for-service
2 spending.

3 Prior to the effect of selection and coding, the
4 dark blue bars show that MA payments were generally similar
5 to fee-for-service spending since 2017, when ACA benchmarks
6 were fully phased in.

7 During the pandemic in 2020 and 2021, there was
8 some divergence due to prospective payments being less
9 accurate.

10 The gray bars show the estimated effect of
11 favorable selection, which contributed to MA payments being
12 at least 9 percent above fee-for-service spending since
13 2015.

14 The orange bars show the estimated effect of
15 coding, which increased from 2017 to 2022. With the start
16 of the phase-in of the V28 risk model in 2024, the effect
17 of coding began to decrease.

18 The sum of all three effects is shown at the top
19 of the stacked bars.

20 We estimate MA payments were at least 13 percent
21 more than fee-for-service spending for comparable
22 beneficiaries in each year.

1 We estimate that MA payments were 21 percent
2 above fee-for-service spending in 2023, but are projected
3 to decline in subsequent years, reaching 14 percent above
4 fee-for-service spending in 2026, when V28 will be fully
5 phased in.

6 Given the increasing share of Medicare
7 beneficiaries enrolled in an MA plan, these differences
8 translate to a substantial amount of MA payments above fee-
9 for-service spending in dollar terms.

10 Here, the percentages above or below fee-for-
11 service spending are converted to dollars. We estimate
12 that MA plans will be paid \$76 billion above fee-for-
13 service spending in 2026. These payments in excess of
14 Medicare fee-for-service spending are driven by favorable
15 selection and coding intensity, which we estimate accounted
16 for the largest share of payments above fee-for-service
17 spending.

18 Now we discuss changes to our overall
19 projections.

20 This year, we project MA to fee-for-service
21 spending for 2026 to be 14 percent, which is lower than
22 last year's projection for 2025 of 20 percent. Updates to

1 our estimate of coding intensity account for the
2 difference.

3 First, incorporating new risk score data reduced
4 our projection factors and lowered our estimate for 2025
5 from 20 percent last year to 17 percent this year.

6 Also, this year we project from 2025 to 2026,
7 which further lowers the overall estimate to 14 percent due
8 to the final phase-in of the V28 risk model. The V28 model
9 was used for two-thirds of payments to MA plans in 2025 and
10 100 percent of payments in 2026.

11 Other updates for newer data and methodological
12 improvements had very small effects on recent estimates.

13 The Commission supported V28 in order to mitigate
14 higher payments from coding intensity. From 2024 to 2026,
15 V28 resulted in decreased MA payments relative to fee-for-
16 service due to lower coding intensity, supplemental
17 benefits that remained stable, and plan availability that
18 remained high and stable.

19 Bid data suggests plans adapted to lower payment
20 rates by lowering projected costs and bids. In 2026, we
21 estimate MA plan bids are 5 percent below fee-for-service
22 spending. MA plans' projected medical expenses are 18

1 percent below fee-for-service spending.

2 Now we discuss the three components that comprise
3 our MA to fee-for-service spending comparison.

4 First, the base comparison of MA and fee-for-
5 service spending captures aspects of MA payment policy
6 other than risk adjustment, such as changes in the accuracy
7 of fee-for-service spending projections. These fee-for-
8 service projections include the Part A only population,
9 which are used for the calculation of payment benchmarks.

10 The base comparison also accounts for MA
11 eligibility, which excludes the Part A-only population.
12 The base comparison further accounts for the distribution
13 of MA enrollment across the county benchmark quartiles,
14 changes in the share of enrollment in plans receiving a
15 quality bonus, and the bidding levels of plans that are
16 below payment benchmarks.

17 This base comparison uses MA payments and local
18 area fee-for-service spending data that has been adjusted
19 to have the same risk score profile as MA enrollees.

20 For years when historical data are available, we
21 use actual payment data, including non-claims fee-for-
22 service spending, as well as risk scores and enrollment

1 data for MA and fee-for-service beneficiaries who have both
2 Part A and B coverage.

3 For years when these data are not available, we
4 use spending estimates from MA bid data and CMS's
5 projections of local area risk standardized fee-for-service
6 spending. These two methods produce very similar estimates
7 of MA and fee-for-service spending within 1 percentage
8 point of one another for all years we analyzed, except for
9 two years that were affected by the pandemic.

10 For most of the past several years, this base
11 comparison has found that MA payments are similar to fee-
12 for-service spending, before accounting for the effects of
13 coding intensity and favorable selection.

14 Now I turn it back to Andy.

15 DR. JOHNSON: The second component of our MA to
16 fee-for-service spending comparison is coding intensity.
17 MA plans have a financial incentive to document more
18 diagnoses than providers in fee-for-service Medicare,
19 leading to larger MA risk scores and greater Medicare
20 spending when a beneficiary enrolls in MA.

21 MedPAC uses the demographic estimate of coding
22 intensity method, modified to account for differences in

1 Medicaid eligibility and institutional status. More
2 details on this method are included in the technical
3 appendix.

4 We have data available to estimate coding
5 intensity through 2024, and we project coding intensity
6 estimates for 2025 and 2026. We base these projections on
7 an annual coding intensity trend, and an estimate of the
8 effect of the V28 risk model, which was phased in by one-
9 third each year between 2024 and 2026. We estimate that
10 coding intensity in 2024 was 8.8 percentage points lower
11 under the V28 model than under the prior V24 model.
12 Payments in 2024 reflect a blend of the two models.

13 For 2026, with V28 sole risk model used for
14 payments, MA risk scores are projected to be about 10
15 percent higher than they would be if MA enrollees were
16 instead enrolled in fee-for-service Medicare. This
17 estimate is before accounting for the coding adjustment.

18 In this figure, the numbers at the top of each
19 bar shows coding intensity estimates for each year. The
20 estimated effect of the V28 phase-in is reflected in the
21 estimate for 2024 and the projections for 2025 and 2026.
22 In addition, we estimate an annual coding intensity trend

1 of +0.7 percentage points based on the V24 risk model trend
2 from 2023 to 2024. We apply that trend to the projections
3 for 2025 and 2026.

4 The Secretary is mandated by law to reduce MA
5 risk scores to account for coding differences, but this
6 adjustment, shown in dark blue, does not account for the
7 full impact. After accounting for the coding adjustment,
8 remaining coding differences, shown in orange, generate
9 higher payments to MA plans. For 2026, net of the coding
10 adjustment, we project MA risk scores to be about 4 percent
11 higher and payments to be about \$22 billion more due to MA
12 coding intensity.

13 Each year, we update our coding intensity
14 projections with newly available data. Last year, we
15 projected coding intensity for 2025 to be 16.4 percent,
16 shown by the column on the left. This year, with 2024
17 data, we estimate a larger impact of the V28 model than we
18 had previously estimated and a slower V24 coding trend.
19 Each of those factors contributed a 1.8 percentage point
20 decrease to our 2025 projection of coding intensity.

21 In addition, this year we made a technical
22 revision to our method which further decreased the

1 projection by 0.3 percentage points. We now project that
2 coding intensity in 2025 to be 12.5 percent.

3 To project coding intensity from 2025 to 2026,
4 first we apply one-third of the overall V28 effect, or -2.9
5 percentage points, and we add 0.7 percentage points for one
6 additional year of coding intensity trend. We project that
7 coding intensity for 2026 will be about 10.3 percentage
8 points.

9 We remain concerned about the uniform coding
10 adjustment, given the variation in coding intensity across
11 MA organizations. Each bar in this figure shows one MA
12 organization's coding intensity relative to fee-for-service
13 for 2024. Among the 10 largest MA organizations, shown
14 here by the dark blue bars, there is a 28 percentage point
15 range in coding intensity.

16 The coding adjustment reduces MA risk scores by
17 5.9 percent, generating payment differences by penalizing
18 MA organizations left of the vertical line, and by failing
19 to prevent the higher payments to organizations right of
20 the vertical line.

21 Higher-coding intensity organizations have a
22 competitive advantage. They receive larger payments than

1 other organizations for enrolling the same beneficiaries.
2 Because of these higher payments, they can offer more
3 supplemental benefits and attract new enrollees, simply
4 because of their coding efforts.

5 Note that the penalized organizations tend to be
6 smaller, representing 16 percent of all MA enrollees, while
7 the higher paid organizations tend to be larger, enrolling
8 84 percent of all MA enrollees.

9 This slide shows coding intensity for each MA
10 organization under the V24 model in orange, and under the
11 V28 model in dark blue. Parent organizations are ranked by
12 their V24 coding intensity.

13 We find that the V28 model generally reduced
14 coding intensity by larger amounts for organizations with
15 higher V24 coding intensity, those organizations toward the
16 right side of the figure. V28 had smaller effect or no
17 effects for organizations with lower V24 coding intensity,
18 on the left side of the figure.

19 For example, we find that organizations that had
20 negative V24 coding intensity had coding intensity that was
21 only 2 percentage points lower under V28. In contrast,
22 organizations with 25 percent or higher V24 coding

1 intensity had a V28 effect that was 23 percentage points
2 lower, on average.

3 We conclude that the V28 risk model reduces
4 overall coding intensity and improves the fairness of the
5 risk adjustment system by reducing the variation in coding
6 intensity across MA organizations.

7 Your mailing materials summarize several studies
8 analyzing MA coding intensity. This year, six new studies
9 addressing coding intensity were published. As with the
10 prior studies, all of the new studies corroborate our
11 coding intensity estimates and our analysis of differential
12 MA and fee-for-service coding rates for certain conditions.

13 The first three studies calculated overall
14 estimates of MA coding intensity, each using a different
15 method. The second study also estimated the effect of the
16 V28 risk model to be similar to our estimated effect.
17 Three studies produced parent organization-level estimates
18 of coding intensity.

19 Finally, a review of medical records and lab data
20 estimated the prevalence of four common conditions in MA
21 relative to their prevalence in fee-for-service. We
22 compared the medical record-based prevalence of these

1 conditions to their prevalence based on HCC data. We found
2 that the relative prevalence of each condition was higher
3 in MA when using HCC data, compared to the medical record-
4 based prevalence. Thus, evidence from this study suggests
5 that some of the conditions used for risk adjustment are
6 not supported by medical record data.

7 Now, I'll turn it back to Luis to discuss
8 favorable selection.

9 MR. SERNA: Prior to the effects of coding
10 intensity that Andy mentioned, risk scores for MA enrollees
11 can overpredict their spending relative to what would have
12 occurred in fee-for-service.

13 Every beneficiary has a risk score that predicts
14 what their spending will be in the next year based on
15 demographics and diagnoses. Risk models, which are
16 calibrated using the fee-for-service population, are
17 imperfect. There is a distribution of actual spending for
18 individuals with each risk score. Some beneficiaries have
19 lower than expected spending while others have higher than
20 expected spending. Favorable selection can occur if
21 beneficiaries with lower-than-expected spending on average
22 choose MA over fee-for-service.

1 The effects of favorable selection are absent any
2 intervention from plans. Favorable selection occurs if
3 risk-standardized MA spending would have been lower than
4 the local fee-for-service average. This means that risk
5 scores would overpredict MA spending and lead to higher
6 payments.

7 MA plans may influence favorable selection
8 through features that are not prevalent in fee-for-service-
9 -such as preferred networks and prior authorization. In
10 contrast to comprehensive Medigap coverage, MA plans also
11 have an incentive to require at least some cost sharing for
12 many services to avoid unnecessary care.

13 Beneficiaries may respond to these plan tools by
14 self-selecting into or out of MA. Perceptions of limited
15 networks and prior authorization may influence their choice
16 of coverage. In addition, beneficiaries who expect to seek
17 more care may prefer fee-for-service in combination with
18 comprehensive Medigap coverage. On the other hand, those
19 who seek less care and extra benefits may prefer MA.

20 To the extent selection occurs, it allows plans
21 to bid lower than fee-for-service spending before producing
22 any efficiencies in care delivery. This creates both

1 higher payments for MA plans and introduces bias in the
2 comparison of risk-standardized spending between MA and
3 fee-for-service enrollees.

4 We emphasize that selection is separate from
5 coding, and the two effects are additive.

6 In March 2025, MedPAC estimated that favorable
7 selection led to substantially higher payments than fee-
8 for-service annually. MedPAC has examined the effects of
9 favorable selection in multiple years, and we continue to
10 refine our estimates.

11 We updated our method this cycle to better
12 account for dual-eligibility status. This change improves
13 our modeling of changes in selection during MA enrollment
14 and improves how we model beneficiaries that entered MA
15 upon Medicare eligibility.

16 In addition, we include technical corrections
17 that improve the comparability of our MA study population
18 and fee-for-service comparison groups. We also include an
19 estimate for beneficiaries with ESRD. More information can
20 be found in your mailing materials.

21 Now, we show our estimated selection effect
22 annually from 2015 to 2023, which accounts for both

1 enrollment attrition and mean reversion over time.

2 Overall, we estimate that the effect of selection
3 was consistently above 9 percent during the period. Since
4 2019, the effect of favorable selection has been at least
5 10 percent. Given the consistency of our most recent
6 estimate, we would expect favorable selection to persist in
7 future years.

8 Our estimates of favorable selection are
9 consistent with a substantial body of research that
10 suggests risk scores, on average, overpredict spending for
11 the MA population. Our approach relies on switchers from
12 fee-for-service to MA and generalizes to other MA enrollees
13 by adjusting for enrollees' year of entry into MA, dual
14 eligibility status, and mortality status.

15 Other research provides support for prevalent
16 favorable selection for both switchers into MA and
17 beneficiaries who directly enroll into MA upon Medicare
18 eligibility. Researchers that have examined switchers from
19 fee-for-service to MA found 13 to 14 percent lower risk-
20 standardized spending before MA enrollment. Researchers
21 that have examined spending prior to Medicare eligibility
22 have also found substantial favorable selection by

1 calculating pre-Medicare spending and risk scores for MA
2 and fee-for-service enrollees.

3 One paper examined MA and fee-for-service
4 enrollees who had commercial insurance at age 64. This
5 paper indicated that MA enrollees had 13 percent lower
6 risk-standardized spending than fee-for-service enrollees
7 prior to Medicare enrollment.

8 One peer-reviewed study examined MA and fee-for-
9 service enrollees before dual-eligibility in Medicare.
10 This study indicated that MA duals had 23 percent lower
11 risk-standardized spending than fee-for-service duals prior
12 to Medicare enrollment.

13 Taken together, the research on favorable
14 selection has examined samples from every segment of the MA
15 population and found substantial favorable selection that
16 is consistent with our findings.

17 Now, Grace will discuss MA plan costs and
18 revenues for enrollees with ESRD.

19 DR. OH: Thanks Luis.

20 Individuals with ESRD have been entitled to
21 Medicare Part A and Part B benefits since 1972, but they
22 were mostly prohibited from joining MA plans until 2021.

1 In 2021, the 21st Century Cures Act allowed all
2 beneficiaries with ESRD to sign up for MA plans.

3 MA enrollment grew significantly among
4 beneficiaries with ESRD, from 27 percent in December 2020
5 to 55 percent by December 2024.

6 In the 2021 report to the Congress, the
7 Commission assessed plan prices for dialysis, MA enrollment
8 trends by coinsurance amounts, and MA plan costs and
9 revenues for individuals with ESRD in 2018.

10 For this year's report, we updated each of these
11 analyses with additional years of data to assess whether
12 and how these measures changed following the 2021 statutory
13 change and the subsequent growth in MA enrollment among
14 individuals with ESRD. Details on one specification change
15 to our analysis of MA plan prices for dialysis is included
16 in your reading materials.

17 First is our updated analysis of MA plan prices
18 for dialysis services in 2018 through 2022. We find that
19 most MA contracts paid more per dialysis treatment than
20 fee-for-service Medicare rates, after accounting for
21 differences in age and wage index.

22 The dots on the graph represent the national

1 average MA plan prices for dialysis, relative to fee-for-
2 service Medicare rates. These prices increased from 26
3 percent higher than fee-for-service rates in 2018 to 28
4 percent higher than fee-for-service rates in 2020. MA
5 prices then dropped, on average, to 22 percent higher than
6 fee-for-service rates in 2022.

7 The bars on the graph represent the distribution
8 of contract-level prices for dialysis services, weighted by
9 treatment volume. In 2018, MA plan prices for dialysis
10 ranged from between 1 percent below fee-for-service rates
11 at the 10th percentile, to 56 percent above fee-for-service
12 rates at the 90th percentile. In 2022, the range was
13 narrower, between 2 percent to 39 percent above fee-for-
14 service rates.

15 One reason that MA plans pay more for dialysis
16 than fee-for-service Medicare could be the high level of
17 consolidation in outpatient dialysis facilities. In 2024,
18 two large dialysis organizations operated three-quarters of
19 dialysis facilities.

20 On the other hand, increasing MA enrollment by
21 beneficiaries with ESRD, combined with the removal of
22 network adequacy requirements for outpatient dialysis

1 facilities in 2021, may have increased the negotiating
2 leverage for many MA plans, and contributed to the drop in
3 MA prices for dialysis in 2021 and 2022.

4 Next, we updated our analysis of MA enrollment
5 trends by coinsurance amounts, with additional years of
6 data from 2019 to 2022. We find that the share of MA
7 enrollees with ESRD in plans with 20 percent, or the
8 maximum allowed coinsurance for dialysis generally
9 increased over time.

10 Among enrollees in conventional MA plans, the
11 share rose from 79 to 90 percent between 2018 and 2022 as
12 shown in the dark blue bars. Among D-SNPs, the enrollment
13 share rose from 80 to 93 percent. Among C-SNPs, however,
14 the enrollment share remained relatively stable, at 75
15 percent in 2018 and 76 percent in 2022.

16 The share of enrollees with ESRD with no cost
17 sharing for dialysis, as shown in the gray bars, decreased
18 during this time from 19 percent to 8 percent among
19 enrollees in conventional MA plans and from 11 percent to 1
20 percent among enrollees in D-SNPs. Because the maximum
21 out-of-pocket limit in MA constrains total out of pocket
22 spending for enrollees, it is likely that most MA enrollees

1 on dialysis for the full year will pay cost-sharing for
2 dialysis for only a part of the year until they reach this
3 limit.

4 Lastly, we examined MA plan costs and revenues
5 for individuals with ESRD between 2018 and 2023. We use
6 the bid pricing tool, or the BPT, which includes plan-
7 reported costs for Medicare-covered services and Part A and
8 B mandatory supplemental benefits for their members with
9 ESRD. Expenses for optional supplemental benefits are not
10 included. Because administrative expenses are not
11 identified separately for enrollees with ESRD in the BPT,
12 they are also not included in our estimate of average
13 medical costs for enrollees with ESRD.

14 Plan revenues, as reported on the BPT, include
15 revenue from CMS and premiums.

16 Between 2018 and 2023, MA plan revenues for
17 enrollees with ESRD grew faster, on average, than plans'
18 reported medical costs. MA plans' medical costs for
19 enrollees with ESRD was, on average, \$6,752 per member per
20 month in 2018, and roughly equal to plan revenues from CMS
21 and premiums, at \$6,769 per member per month on average.

22 By 2023, average medical costs rose 8.0 percent,

1 to \$7,291 per member per month, while plan revenues climbed
2 22.4 percent, to \$8,287 per member per month. More than 90
3 percent of contracts in 2023 had higher ESRD revenues than
4 medical costs.

5 Average per member per month plan revenues may be
6 rising faster than plan medical expenses for several
7 reasons. Lower negotiated payment rates for dialysis, over
8 time, may have contributed to reductions in costs. It is
9 also possible that MA plans reduced their costs by becoming
10 more efficient in caring for enrollees on dialysis, for
11 example by providing tailored care coordination and case
12 management to reduce ESRD complications and
13 hospitalizations.

14 Concentrated MA enrollment growth in states with
15 above average ESRD payment rates, as well as growth in
16 spending among beneficiaries with ESRD who remain in fee-
17 for-service may have contributed to the faster growth in
18 average plan revenues relative to medical expenses.

19 This concludes our presentation, and we would be
20 happy to answer your questions on the topics presented
21 today.

22 The Commission plans to publish this material in

1 the March 2026 MA status chapter, along with a technical
2 appendix covering our methods for estimating spending on MA
3 relative to fee-for-service, specifically, the methods for
4 making the base comparison and for assessing the effects of
5 MA coding intensity and favorable selection.

6 We will now turn it back to Mike.

7 DR. CHERNEW: Grace, Luis, and Andy, thank you.

8 There's just a ton there, and I'm really looking
9 forward to the discussion we're about to have, but I am
10 going to make a quick sort of general level-setting
11 comment, at least from my point of view, and we'll see if
12 other people agree or disagree.

13 But in any case, I think it's important to note
14 that the Medicare Advantage sector differs from the
15 provider sectors that we were talking about yesterday for a
16 few really important reasons. The provider sectors are
17 providing access to care, and we spend a lot of time
18 worrying about that care and the quality of it and the
19 support for those sectors. But there's sort of an inherent
20 value in some ways in all of those sectors.

21 I think the Medicare Advantage sector should be
22 much more thought of as a tool to provide care

1 efficiencies, which I think they can do. I think the
2 evidence suggests they can do. I'm generally very positive
3 on the ability of plans to do that, although I certainly
4 think there's heterogeneity, and then, at least in some
5 people's mind, a tool to get people access to added
6 benefits, which I think is a different issue, but it's not
7 the same as access to care, which we spend a lot of time
8 thinking about.

9 So I think the core issue when we think about
10 this MA chapter is thinking about the level and the
11 distribution of the added benefits, many of which, as you
12 pointed out, we don't know their exact value of, and we
13 have to think through that.

14 But we don't -- and again, this is the part I'll
15 see what you all say. We don't have the same inherent
16 interest in making sure that the MA sector inherently is
17 vibrant. We have an interest in allowing it to do what we
18 want it to do. Different people may view that differently.

19 So I think as we think through this, this is not
20 about, oh, we want the MA sector to inherently -- if
21 there's places where fee-for-service is more efficient, I
22 think then we really have to decide what role does MA have

1 there and how do we think about the benefits that may or
2 may not exist in those places, which happens in policy.

3 But I just want to lay out, this is not sort of
4 parallel to the hospital sector, the professional sector,
5 or all the post-acute sectors. MA plays a fundamentally
6 different role in our system, which I think collectively,
7 the Commission has been very supportive of having those
8 plans and supporting some of the benefits, and I think
9 we're just worried about the balance. At least I'm just
10 worried about the balance of those benefits and what we're
11 getting, acknowledging the potential plans to do that.

12 So I rarely give such a speech. I appreciate
13 your patience in listening to my speech. We are going to
14 jump into Round 1 questions, and I think the first person
15 in Round 1 was maybe Robert.

16 MS. KELLEY: Yes, Robert.

17 DR. CHERRY: All right. Well, thank you. This
18 is an excellent report, and I was glad to hear that we're
19 going to update the methodology to include dual eligibles.

20 I had an additional question regarding the dual
21 eligibles. Based on the information that we currently
22 know, it would be interesting to kind of break out some of

1 the data by dual eligibles versus everyone else, and by
2 that, I mean there's a really interesting slide on the
3 spend based on benefit category, where dental, the spend is
4 28 percent. It would be nice to know what the differences
5 are between the MA population and dual eligibles, just to
6 see if there's material differences.

7 The same is true for rebates as well. Are there
8 material differences between the general population of MAs
9 and dual eligibles, particularly since many of these
10 patients have disabilities?

11 Otherwise, excellent report. Thank you.

12 MS. KELLEY: Gokhan.

13 DR. METAN: Great. Thank you very much, first of
14 all, for this chapter. Truly enjoyed it.

15 I have a quick question about the data. So when
16 I look at the favorable selection, one interesting
17 observation I have is, despite the fact that Medicaid
18 advantage nearly doubled between 2015 and 2025, favorable
19 selection impact stayed at 10 percent. So when the
20 population doubles and if the favorable selection still
21 remains the same, it is telling me that it's maybe not the
22 members that are selected into the MA program. It's maybe

1 by design the program is, you know, working that way.

2 So is there a kind of additional kind of insight
3 that you can provide so I can get my head around this, like
4 that persistent 10 percent despite the fact that the
5 population has doubled that I'm missing in the report?

6 MR. SERNA: So when we calculate or estimate the
7 favorable selection, it's on the remaining population fee-
8 for-service rather than thinking it as favorable selection
9 on the entire Medicare population. It's based on the
10 population that is in fee-for-service. So whatever local
11 fee-for-service average is computed, it's going to be based
12 on that average.

13 We have looked at whether favorable selection
14 differs by MA penetration, and we have included some of
15 those sensitivity analyses in the appendix, but it didn't
16 seem to really affect the estimate of favorable selection.

17 DR. CHERNEW: Gokhan, I mean, this is an
18 important point. So I'm going to try and say it, and then
19 I'm going to let Luis and Andy get this right.

20 Payment is based on what's in fee-for-service.
21 So when people shift from, say, fee-for-service to MA,
22 because payments calculated on a fee-for-service, that goes

1 up. So you can maintain the same level of selection
2 because you're moving both pieces of that thing as opposed
3 to you have a big pool and you're looking at what's
4 happening in that big overall pool.

5 That's in some ways how the math can work and a
6 little bit, I think, what Luis was saying. He'll correct
7 me. But it's not we have one pool and we're just pulling
8 from a constant pool. We're comparing to payment, and
9 payment rises when people move.

10 So the extent to which the remaining -- it could
11 go either way mathematically. The analysis shows you which
12 way we think it goes, but as you raise the payment and then
13 change all the calibration, there's more room for
14 selection, even if other people are joining, because not
15 only are the people who are joining matter, but the
16 comparison group is changing.

17 DR. METAN: Yeah. So that is telling me that
18 like maybe the favorable selection is not happening because
19 these individuals are intrinsically -- they don't want to
20 leverage health care system more, but maybe the MA plans is
21 kind of like bringing some sort of efficiency to when these
22 individuals switch to MA plans, they don't maybe utilize as

1 much.

2 So maybe it's -- to your point, actually, you
3 mentioned that one of the roles of the MA is care
4 efficiency and could this favorable selection --

5 DR. CHERNEW: The analysis is based on people
6 before they join MA. So there's some complicated issues
7 about managing regression to the mean and matching, a ton
8 of stuff they do, but the 10 percent number you talk about,
9 there's no MA care efficiency in that at all, because it's
10 people that were before they joined MA.

11 DR. METAN: So how do we explain, then, even
12 though the population doubled in 10 years?

13 DR. CHERNEW: Because you're taking the
14 denominator part and the numerator part, and you're
15 changing. And so you can get doubling of the population,
16 just depends on the distribution of people. You're
17 comparing one group to a change in another group. So when
18 it doubles, the other thing that's happening is you're
19 shrinking the comparison group.

20 So we should go on because now I've seemed to
21 obfuscate a clarifying question, but I will say in separate
22 discussion, we can talk about how the math makes that work.

1 DR. METAN: But the part that I cannot get my
2 head around is, despite the fact that we have almost
3 doubled the population, favorable selection remains at 10
4 percent. So if it is intrinsic nature of these individuals
5 moving to MA plan, not utilizing the health care, we should
6 expect that 10 percent to go down, right?

7 Like, at the extreme, if fee-for-service, for
8 example, population becomes smaller and smaller, these --

9 DR. CHERNEW: Actually, in the extreme, if you
10 had one person left in fee-for-service and that person
11 spent a billion dollars, the selection would be much, much
12 bigger --

13 DR. METAN: Sure.

14 DR. CHERNEW: -- because everybody else spends
15 less than a billion dollars.

16 DR. METAN: But statistically speaking, as we
17 move more population from fee-for-service to MA, these
18 things to normalize. We should observe that because --

19 DR. CHERNEW: Only if you're comparing to the
20 average. If the tail remaining people are more and more
21 and more relative expensive, you're going to actually get
22 more selection, and then you get the --

1 I think we should go on because it's going to be
2 a lot of time. Other people might want to jump in, but I
3 think that's the mathematical answers.

4 MR. MASI: And just to add one piece of
5 information that's helped me thinking about this, because I
6 think you're making a really reasonable point, Gokhan, of
7 how this all kind of fits together in a big-picture way, I
8 think one important thing that I try to keep in mind is,
9 the MA payment system is calibrated just on the fee-for-
10 service population. That's both the risk model as well as
11 the benchmarks.

12 And so while it's true that the MA program has
13 more than doubled in size over this period of time, the
14 risk model has continued to be calibrated just on that fee-
15 for-service population. And as that fee-for-service
16 population shrinks, as Mike said, it's an empirical
17 question over whether the remaining people in fee-for-
18 service are more or less representative of the overall
19 Medicare population.

20 But again, just as the fee-for-service population
21 shrinks, it's not clear that they'll necessarily be more or
22 less representative, and so that's why we go through the

1 empirical exercise.

2 DR. METAN: Yeah. It just feels like if John Doe
3 moves from fee-for-service to Medicaid Advantage, he
4 chooses to kind of leverage, less leverage the system and
5 pays, you know -- but we as a, you know -- but they are
6 paying the compensating to Medicaid Advantage for those
7 efficiencies still. It just feels that way. I don't know
8 if I'm --

9 DR. CHERNEW: I think we should probably move on.

10 DR. METAN: Sure.

11 DR. CHERNEW: We'll have some time to talk
12 through this separately.

13 DR. METAN: Yeah. But I think my general comment
14 is I would like us to understand why this favorable
15 selection is still this persistent, and I would like to
16 kind of get my head around it. I think the chapter can do
17 a better job in that sense.

18 Thank you.

19 MS. KELLEY: Tom.

20 DR. DILLER: Yeah. Great section on this.
21 Fabulous amount of work.

22 My question is a little bit different, and I'm

1 focused on the relationship between the payers and the
2 providers relative to MA.

3 So, as payers contract with providers, providers
4 can win in those contracts by doing two things. One is to
5 maximize the HCC coding, and the second is to close care
6 gaps and hit a high star level. And so they're paid
7 bonuses to do that, but it requires an intensive
8 administrative effort.

9 And so the question I've got has to do whether --
10 is there any research out there? Is there any looking at
11 whether that administrative effort is of benefit? Because
12 it's not necessarily benefitting the beneficiaries at this
13 point. It's just additional costs. Any thoughts on that?

14 DR. JOHNSON: I think a couple ways of thinking
15 about that is, one, based on the effects on spending -- and
16 there's a section in the paper that discusses how much
17 lower the medical spending is for MA -- and that a lot of
18 the differences between MA medical spending and fee-for-
19 service medical spending are then offset by administrative
20 expenses so that the base comparison ends to be different.
21 So that there is probably some benefits to that that are
22 reducing spending, but generally, they're closely offset or

1 nearly offset by the administrative expenses.

2 I think the other way to think about it is the
3 effects on quality of care, and we have looked at some of
4 the literature in the past and found that there are areas
5 where quality is improved in MA and other areas where it
6 isn't. And there's sort of a mixed set of results on
7 whether the quality is better in MA or fee-for-service,
8 depending on which types of measures you're looking at and
9 which types of services.

10 DR. DILLER: Yeah. And unfortunately, the
11 quality metrics that are used are pretty weak in general.
12 There's a few of them that are very good, but most of them
13 are pretty weak. But thanks.

14 MS. KELLEY: Paul.

15 DR. CASALE: Thanks for a terrific report.

16 I apologize if I missed this in the reading, but
17 what is the percentage of beneficiaries that switch from
18 fee-for-service to MA per year, and has that been stable
19 over a number of years or not?

20 MR. SERNA: So in a given year, about two-thirds
21 of beneficiaries who are in MA will have had some
22 enrollment in fee-for-service during their time in

1 Medicare.

2 DR. CASALE: And then per year, do we know how
3 many per year go from fee-for-service to MA?

4 MR. SERNA: So new enrollees into MA tend to be
5 people who switch.

6 DR. MILLER: If I may, the switching population
7 is about 2.7 to 4.5 percent, I think, depending upon where
8 you look at. In states that have guaranteed issuance of
9 Medigap and renewability, it's around 4.5, and if they
10 don't have that, it's 2.7.

11 DR. CASALE: Thank you.

12 MS. KELLEY: Tamara.

13 DR. KONETZKA: Thanks for a really great and
14 complicated chapter.

15 My question is about the V28 risk model. Sorry
16 if I'm geeking out here. But it seemed sort of
17 surprisingly effective in addressing some of the coding
18 intensity issues, so two questions about that.

19 You know, my understanding of the model is that
20 mostly it worked by sort of constraining the coefficients
21 on codes that were sort of overused, and it was applied
22 then. These adjustments were applied sort of across the

1 board. The same coefficients were applied across the
2 board.

3 So two questions. One, I imagine that there will
4 be sort of a behavioral response to that and plans. I
5 mean, I think some codes are easier to over-code than
6 others, right? But there probably will be new codes that
7 plans find that one could use in the future that aren't in
8 the V28 model.

9 So one is, are there plans ongoing -- you know,
10 ongoing plans to update those coefficients and update that
11 model?

12 And the other one is, you know, we're clearly
13 concerned about heterogeneity, you know, those 16 percent
14 of beneficiaries are in those plans that are basically
15 getting penalized by this very blunt tool. Is there a way
16 possibly to account for the heterogeneity in this model and
17 not make it such a blunt tool?

18 So, for example, we have these nice graphs
19 showing that, you know, what the V28 model did in terms of
20 plans that had a lot more coding intensity in the prior
21 year. Could one use that information then to sort of make
22 adjustments moving forward that apply those penalties more

1 to plans that have a higher propensity to over-code?

2 DR. JOHNSON: So to your first question, there
3 are periodic updates to the calibration of the model.
4 Those will continue. In the past, they've continued to use
5 fee-for-service data to do that, meaning fee-for-service
6 diagnosis codes and fee-for-service spending. So those
7 updates will take place.

8 But the ways in which the coding intensity has
9 been addressed and addressing the variation coding
10 intensity, it does seem like a number of the codes that are
11 no longer in the V28 model were the ones that were being
12 more often coded. That is both an effect of constraining
13 certain coefficients but also removing some HCCs entirely.

14 And the other change that took place between V24
15 and V28 was V24 was originally calibrated on the ICD-9
16 diagnosis codes, and there was a crosswalk from ICD-9 to
17 ICD-10. V28 has been calibrated directly on the ICD-10
18 diagnosis codes, and it seems that the change in the
19 process has removed a lot of the diagnosis codes.

20 So one thing we plan to look into is just which
21 diagnosis codes in V24 were responsible for the largest
22 differences, and are they the ones -- are they still in

1 V28? Are there additional diagnoses or HCCs that could be
2 removed from the model and test whether or not that
3 improves, that has an effect on model accuracy while also
4 improving coding intensity?

5 So we also have some analysis of the use of HRAs
6 and chart reviews, which has some relationship between
7 plans that code more intensively and using those methods
8 more effectively.

9 That covered all your questions? I just want to
10 make sure.

11 DR. KONETZKA: So the latter part of what you
12 just said is that there are ways already in which some of
13 the heterogeneity through these chart reviews could be sort
14 of incorporated into the model. I just didn't quite
15 understand that.

16 Are there ways, more direct ways to sort of avoid
17 penalizing plans that don't over-code a lot?

18 DR. JOHNSON: I think new policies would need to
19 be put in place to eliminate the use of chart reviews or
20 HRAs or to continue to go further on the removing diagnoses
21 or HCCs. So there isn't current plans for those
22 approaches, but I think there are opportunities for

1 reducing that variation.

2 MS. KELLEY: Gina, did you have a Round 1
3 question?

4 MS. UPCHURCH: Yes, thank you.

5 Wonderful job explaining lots and lots of
6 information.

7 A couple of questions here. So we talk a lot
8 about -- and this is just giving it the history of the
9 MedPAC work -- about Medicare Advantage, end-stage renal
10 disease, Medicare Advantage, dual eligibility. What about
11 Medicare Advantage with people with permanent disabilities,
12 and have we looked into that in any way in the past and/or
13 people with ALS? Because people -- those folks don't have
14 a lot of choices in many states. They cannot afford a
15 Medigap. So they sort of don't have a choice. Have we
16 looked at those?

17 DR. JOHNSON: We have not looked specifically at
18 people with ALS. I think some of the work that Eric has
19 done about the institutionalized population might overlap
20 with looking at disabilities, but we haven't pulled apart
21 those analyses.

22 MS. UPCHURCH: Yeah, we often focus on older

1 adults when we know, you know, 16 percent, 17 percent are
2 not older adults that depend on Medicare for their health
3 care.

4 Secondly, the bottom of page 27, footnote No. 21,
5 it says Medicare Advantage plans do not allocate
6 administrative expenses or margins for Part B premium buy-
7 downs, Part D premium buy-downs, or Part D supplemental
8 benefits when submitting Part C bids.

9 So my question is, we mentioned that with the
10 medical loss ratio -- or just what Medicare Advantage plans
11 tend to have 10 percent administrative and profit. So my
12 question is, in that profit and administration, are we
13 including when they're paying vertically integrated groups,
14 number one, when they're administering things like food is
15 medicine, their administrative cost to administering those
16 benefits? Does that administrative cost go into the
17 administrative cost?

18 And then lastly, anything that's unused. So say
19 you have these extra benefits and 35 percent of it doesn't
20 get used, and that goes back to the Medicare Advantage
21 plan, is that considered programming dollars in the medical
22 loss ratio or admin profit dollars?

1 MR. SERNA: So this is just using the plan's
2 projections. The plans have what's called an admin profit
3 load. So we don't really have a window into how much more
4 or less it would be given vertical integrated arrangements.
5 It's strictly based on what plans report in their bids.
6 Plans do have an incentive to project accurately so that
7 they have the ability to offer more benefits. But we don't
8 have any kind of reconciliation for unused benefits or
9 benefits that were used more than the plans had projected.

10 MS. UPCHURCH: Okay. Either way. Either
11 direction. And the administrative costs for the extra
12 benefits, so like food and medicine, you've got to pay
13 somebody to administer that program, right. It's often a
14 third party, sometimes owned by you, but if it's separated
15 their admin costs there, I'm just wondering where those
16 admin costs get counted in medical loss ratio. Do we know?

17 DR. JOHNSON: I think generally they're just
18 included in the denominator but not in the numerator. The
19 numerator is just the medical expenses, and then everything
20 else gets --

21 MS. UPCHURCH: Okay. Okay. Thank you. And
22 there are two others. Just to point out, if I get this

1 right, you all said \$15.60 was what we think are the
2 projections for this overpayment to Medicare Advantage
3 plans. Just to point out to people, the premiums this
4 year, for most people, are \$202.90. So that's a 7.7
5 percent -- paying for these extra benefits when you're not
6 somebody who may not be benefitting from them. That's
7 significant. We don't have COLA going that high.

8 And then lastly, on page 19, we mentioned C-SNPs.
9 So anybody -- and this might be next meeting also, but the
10 chronic care special needs plans that people can join
11 anytime. So what we see now coming to our offices is
12 people going, "Hey, I've got this checklist. Can you help
13 me fill out this checklist, and then it goes to my doctor
14 so that I can get into the C-SNP?" So in my mind that's
15 coding, like, you know, sort of paying somebody to go into
16 your home and do it, and we're having people do it to get
17 into a C-SNP.

18 And I guess my concern is we did away, a few
19 years ago, because agents and brokers were calling people
20 in the middle of the year. They were in Medicare Advantage
21 plans and getting them to switch around. Duals, in
22 particular, to switch around. And we stopped that. But

1 now we're allowing C-SNPs to do it during the year. So C-
2 SNPs can get people in the middle of the year to go to
3 their plan, and everything is one this checklist. I mean,
4 you know, I can't imagine being someone who doesn't have
5 something that checks off on this checklist.

6 So do we know why we did that? Do we know why we
7 allow C-SNPs to have, you know, open -- because brokers and
8 agents are very busy getting folks in these plans.

9 DR. JOHNSON: I don't think it's a change in
10 policy, but there has been the shift in enrollment in D-
11 SNPs into C-SNPs, and I think Eric is going to answer all
12 your questions in the next session.

13 MS. UPCHURCH: There you go. Eric's is up next.
14 Thank you. Thanks for the great work.

15 MS. KELLEY: Lynn, did you have a Round 1
16 question?

17 MS. BARR: Two Round 1 questions. Thank you. So
18 can you talk a little bit about the profitability of
19 Medicare Advantage plans versus other insurance plans on
20 Medicaid, MAs and also commercial plans?

21 DR. JOHNSON: There is a Kaiser briefing that put
22 the profitability in terms of dollars, that I think seems

1 to be helpful in illustrating what the differences in
2 profitability are. Even if the percentages are not that
3 different and we have some concerns about being able to
4 estimate exact percentages, given vertical integration and
5 some other concerns about where we're getting those data.
6 But in dollar terms, the spending per beneficiary is much
7 higher in Medicare, so the same percentage goes a lot
8 farther, and those differences may not be consistent with
9 the increases in administrative costs for the plans, for
10 the Medicare versus others. So it does seem to be
11 suggestive that there is more profitability in Medicare
12 Advantage than other plans.

13 MS. BARR: Yeah. I read that study and I believe
14 it said that they were the most profitable plans in the
15 country. And I think that's of concern. But maybe that
16 might be a source of future work is to look at that and say
17 just how much money are we really giving away and are there
18 better ways to use those funds.

19 My second question is, to Tom's point, I think
20 that there are a lot of sort of large organizations that
21 have contracts with MA plans that get paid a lot for coding
22 and things like that. But in a lot of organizations they

1 don't want to have anything to do with, honestly, upcoding
2 patients and it's a [audio drop] in all our communities. I
3 never saw any of those contracts. But I am very aware of
4 industry acceleration of outsourced care management,
5 outsourced gap closure, and particularly with Medicaid
6 plans, as well, because it's so lucrative.

7 And I was just curious, do you have any sort of
8 idea of what the breakdown is of how much of this is done
9 internally versus externally, how much of this money
10 actually goes to the providers versus goes to the plans,
11 and is there like a growing cottage industry now about gap
12 closure and star ratings and things like that, that's also
13 kind of accelerating the costs of the systems?

14 DR. JOHNSON: I think the latter part seems to be
15 true, that there are a lot of companies focusing on
16 improving coding. Improving coding accuracy is the way
17 it's often termed. I don't think we have good insight into
18 how much money is passed on to providers who are engaged in
19 pay-for-coding programs or in conducting health risk
20 assessments. But we know that those activities occur. We
21 just don't have a good assessment of it.

22 MS. BARR: And I think it's also related to gap

1 closure, as well, I mean, quality. So it's also, because
2 we pay so much for the stars, so there are a lot of
3 companies taking risk on improving star ratings. Yeah, I
4 just see all of this just accelerating payments. Thank
5 you.

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

8 DR. CHERNEW: That's all that I had, and I think
9 Kenny is probably the first in Round 2.

10 MS. KELLEY: Yes, he is.

11 DR. CHERNEW: And you're going to read that.

12 MS. KELLEY: All right. So I will read Kenny's
13 comment, and he says he appreciates the updated analytical
14 framework that lowered the estimated MA overpayment from 22
15 percent in 2024 to 14 percent in 2026. While he agrees
16 that some MA plans may be overpaid, he worries that our
17 highly variable overpayment percentage continues to
18 introduce unnecessary instability into the market. These
19 payments are not a proxy for plan profits or administrative
20 margins. They largely support supplemental benefits,
21 Medigap-like coverage, and Part B.

22 The original 22 percent estimate, combined with

1 rising medical costs, likely contributed to a difficult
2 reimbursement environment, significant industry losses in
3 2024, 2025, and notable market exits. CMS now projects
4 that MA enrollment in 2026 may fall by roughly 1 million
5 beneficiaries compared with 2025, the first decline since
6 2009, with MA penetration slipping by several percentage
7 points. That trajectory raises valid concerns about
8 further consolidation in the sector.

9 Looking ahead, he strongly encourages deeper
10 reliance on objective financial sources, SEC filings,
11 insurance blanks, and CMS bids, to assess true MA
12 profitability. Despite raising concerns in the last two
13 January meetings about deteriorating MA economics,
14 supported by published Big Four accounting firm analyses,
15 those issues were not reflected in the prior MA status
16 updates. This is a stark contrast to how profitability has
17 been integrated into other payment update discussions.

18 And next I have Brian.

19 DR. MILLER: Thank you for this lengthy report.
20 To quote a friend, it's like "Medicare Geeks Gone Wild," a
21 C-SPAN movie. So thank you for that.

22 I am in directional agreement that some Medicare

1 Advantage plans are overpaid, but I do not agree with the
2 estimated magnitude due to material methodological flaws.
3 Payment changes must be practical, implementable, and
4 grounded in real-world business and clinical operations.
5 Our most effective approach as a group is to execute
6 payment rejections as policy improvements that strengthen
7 benefits programs for beneficiaries, support clinicians,
8 preserve viable plan operations, and reduce costs for
9 taxpayers together. This is fundamentally the core promise
10 of MedPAC.

11 I like that our updated report recognizes that
12 supplemental benefits, including integrated Part D and
13 Medigap-like coverage are critical and appropriate use of
14 MA rebates. These benefits are essential for lower-middle
15 income and middle income retirees, including union retirees
16 who need an affordable integrated retirement health
17 benefits package.

18 I personally consider it a privilege to serve
19 some of these union retirees for the state of North
20 Carolina at the state health plan, which offers both
21 Medigap and MA plan options.

22 Fee-for-service Medicare, with separately

1 purchased Medigap and Part D, primarily serves more
2 financially secure and less diverse beneficiaries. If
3 equity with fee-for-service is a policy goal, it is
4 important that MA policy be evaluated and improved
5 carefully rather than weakened through imprecise analysis.

6 The narrative that MA rebates primarily drive
7 profits is not supported by the data in this excellent
8 chapter. The average 2026 rebates of roughly \$2,660 per
9 beneficiary, or around 15 percent of plan payments, are
10 largely directed towards cost sharing reductions,
11 integrated Part D benefits, Part B premium relief, and non-
12 Medicare covered services such as vision, dental, and
13 hearing, which, as many of you know, that last bucket I'm a
14 little more skeptical of.

15 As 10 percent of rebates go to administration and
16 profit, the derived 1.5 percent for profit and
17 administrative cost is a small fraction of the 20 percent
18 overpayment metric from last year.

19 My concern is not with the conclusion that some
20 MA overpayment exists for some plans but with the false
21 precision of our estimates. Actuarial work suggest mild to
22 moderate overpayment for some but not all plans, yet our

1 methodology overstates confidence and undermines
2 credibility. The analysis relies on a narrow and biased
3 sample focused on one-way switchers while excluding reverse
4 switchers, long-term Medicare enrollees, and new Medicare
5 entrants, of which there were 2.8 million, on average, most
6 years. And also our analysis lacks a true control group.
7 Comparisons should be holistic, covering statutory
8 spending, benefits-level costs, and total health benefits
9 across programs.

10 Finally, the volatility in our estimates over the
11 past several years of favorable selection and coding
12 intensity across recent reports is troubling and weakens
13 the confidence in our results. If favorable selection is
14 the concern, we should differentiate between the products
15 of favorable selection versus improvements in spending from
16 MA plan care management activities and suggest parsing
17 regulations to address this difference.

18 If coding intensity is a concern, solutions
19 should focus on systems-wide improvements, such as
20 automation of diagnosis coding at the point of care with
21 clinical oversight and moving towards an encounter-based
22 risk adjustment system, applied across both fee-for-service

1 and MA, rather than abstract assumptions that are difficult
2 for us to reconcile with the real-world clinical and
3 business operational behavior that we hear and see from our
4 colleagues.

5 So MedPAC's strength lies in advancing credible,
6 implementable policy improvements, and to do so our models
7 must connect clearly to reality and to workable solutions
8 for all. Thanks.

9 MS. KELLEY: Betty.

10 DR. RAMBUR: Thank you. I really appreciated
11 this chapter and your hard work and analytics. And I just
12 want to underscore a few points. And I realize some of
13 these things are going to have to probably be in the
14 Medicare choice piece, but I just want to say them for the
15 record.

16 As you've heard me say before, the dizzying array
17 of opportunities I think is very confusing for
18 beneficiaries -- 39 plans for the average beneficiary. And
19 to me so much choice is actually not choice. It's just
20 confusion.

21 I do want to underscore something that I think
22 Brian has raised about the difference between HMOs and

1 PPOs. The definition we have on page 11 uses a CMS
2 definition, which I think very much makes sense. But I am
3 very concerned that beneficiaries don't understand the
4 difference between HMOs and PPOs, particularly given the
5 recent things I've read in the literature about brokers
6 driving people to HMOs.

7 I have a particular concern, if I may, as a
8 clinician, as a nurse, because I've seen this at every
9 state I've been in, in North Dakota, Vermont, Rhode Island.
10 There can be a high-tech procedure that actually can be
11 done in-network, and I'll just use Rhode Island as an
12 example. But you maybe do two a month, when 90 miles away
13 they do two a week, or a quaternary care system does two a
14 day. And Tom shared a beautiful article about the elegance
15 in an operating room when everybody is at the top of the
16 game, which was really beautiful. So it's not just the
17 skill of the surgeon in these high-risk things, it's the
18 whole team.

19 So I'm very, very concerned that as things
20 tighten down that people will not be able to really
21 understand the choices of what they're giving up. Right
22 now I know many people who can afford it will just take the

1 \$10,000 hit and go out-of-network for those kinds of
2 procedures. So I'm very concerned about that, as a
3 clinician, because I've been in both of those situations,
4 where it's a dance and it's a terror, and we all want to be
5 in the situation where it's a dance.

6 This did bring up something. This issue of out-
7 of-pocket maximum reminded me that Richard Nixon, in 1973,
8 I believe, recommended looking at out-of-pocket maximum for
9 traditional Medicare. And I wonder if it's time to
10 reconsider that in our conversations. In 1965, there were
11 reasons to have that 80 percent and 20 percent out-of-
12 pocket, and I think that has changed. So thank you for
13 letting me share that worry.

14 My other point relates to the things that have
15 been brought up about the weakness of the quality measures,
16 which certainly, if they were strong enough the in-network
17 outcomes would be addressed. But I don't think it can be.
18 But on page 112 you point out that despite the poor quality
19 measures, it was the basis for over \$16 billion increase in
20 2026. And I think we just have to feel a little sober
21 about that, and really think about what that means and how
22 do we help get stronger quality measures.

1 And finally, on page 115, I was initially
2 baffled, and I was glad you pointed this out, that the
3 quality payment system does not need to be budget neutral.
4 And in thinking about that, when MA was just getting
5 started there was an enticement for people to participate,
6 companies participate. That maybe needs to be
7 reconsidered, as well.

8 But overall, thank you for this really important
9 work and amplifying the conversation in this important
10 area.

11 MS. KELLEY: Scott.

12 DR. SARRAN: Yeah. Thanks, team, for truly
13 superb work. I tried to distill down all of my various
14 thoughts as much as possible, but I have five take-homes
15 and then five directional suggestions that may impacted our
16 future work. So I'll try to be brief on each of those.

17 In terms of my take-homes, first I think the
18 evidence that the MA program is at least somewhat
19 overfunded is persuasive. We can disagree about orders of
20 magnitude and methodology, but the overall directional
21 conclusion, I think, is quite clear. As well as that the
22 quality outcomes are variable and modest in terms of

1 improvement versus traditional Medicare. I wouldn't argue
2 that there are no improvements, no incremental
3 improvements, but I think it's hard to make the case that
4 across the board those improvements are always there and
5 that they're significant.

6 Number two, MA is, at best, a clumsy vehicle for
7 providing, in a relatively opaque fashion, a variety of
8 supplemental benefits of varying ability to impact the
9 health status or outcomes of the population.

10 Number three, the MA program does deliver
11 significant value financially, particularly to
12 beneficiaries with lower income or lower wealth, via low
13 upfront costs -- think zero premium -- and protection
14 against unrestrained out-of-pocket costs. And that's
15 significant, and no one wants to throw that baby out with
16 that particular bath water.

17 Four, specifically around the HCC system, and
18 I'll read a headline from all the papers from just a couple
19 of days ago, "Kaiser Permanente settles Medicare fraud
20 claims for \$556 million." Quoting one of the physician
21 whistleblowers at Kaiser, quote, "The cash monster was
22 insatiable." I'll repeat it. "The cash monster was

1 insatiable."

2 So the HCC system, I think, it's way worse than a
3 very expensive zero-sum game. If it were a zero-sum game,
4 it still would be wasteful because there are tremendous
5 amounts of resources at the provider level, the plan level,
6 and CMS, around playing and policing the game. But it's
7 worse than zero sum. It creates, as demonstrated -- and
8 remember, Kaiser is a non-investor-owned, almost
9 universally 4.5- or 5-star plan. They are the good guys.

10 So what we have to acknowledge, I think, is that
11 the HCC system, whether it's Version 24 or Version 28 or
12 Version 32, it creates irresistible incentives to play the
13 game, and to at least -- at least -- push the envelope, at
14 least. We can argue where the envelope ends and improper
15 behavior begins, but it is irresistible to play that game.
16 You have to do it, as a plan, if you're going to be
17 competitive. And if you're not competitive, you're not
18 going to be in business.

19 Fifth, it's a plus-one on Gina's comments and
20 concerns she raised about C-SNPs. The intent of the C-SNP
21 program was always to deliver improved outcomes to
22 populations historically left behind or poorly served in

1 both MA and fee-for-service, and the C-SNP program was
2 always intended to be built around a specialized model of
3 care, creative network structures with expert providers, a
4 benefit play across A, B, D, and supplemental that enabled
5 optimal access and care, and an expert dedicated care
6 management team at the plan. Increasingly of late, the C-
7 SNP program has become, as Gina mentioned, a vehicle for
8 annual enrollment.

9 So those are my five take-homes.

10 In terms of my five, again, very brief
11 directional, not recommendations so much as suggestions for
12 our ongoing work, first, I think the MA program can
13 reasonably be held increasingly accountable for delivering
14 on quality measures that are increasingly -- that's
15 compared to the current star programs -- more focused on
16 both outcomes and access. And access, in a way that really
17 enables, particularly for historically challenged
18 populations, challenged around their ability to access,
19 navigate, and navigate the system and advocate for
20 themselves, particularly MA plans should be particularly
21 held accountable and be required to demonstrate
22 improvements.

1 I mean, truly, for those challenged populations,
2 beating fee-for-service Medicare in measures around
3 navigation and care coordination and the resulting outcomes
4 that flow from that, that's a low bar. I mean, that's a
5 really low bar. They should be able to clear that bar. So
6 I think that's one workaround, basically going to call it
7 reforming the stars program.

8 Secondly, I think there needs to be way more
9 transparency around the managed care tools that plans
10 deploy, particularly around network adequacy and access.
11 And I don't mean just submitting and updating and keeping
12 accurate, although there is room for improvement there, the
13 list of providers, by time and distance. But, I mean, true
14 access.

15 And I'm especially concerned, as Betty and Gina
16 have continued to remind us, of the access needed, in a
17 meaningful way, for beneficiaries who have care needs --
18 cancer increasingly being one of those -- that requires
19 quaternary care provider for optimal outcomes. I mean, the
20 correlations between expertise and volumes on the provider
21 side and outcomes in areas such as many cancers, a lot of
22 cardiac programs, et cetera, that's been well proven, and

1 there needs to be much more transparency around how plans
2 manage the tools around that.

3 Also, increased transparency around the basic
4 managed care blocking and tackling around utilization
5 management denials, appeals, processes, et cetera, and
6 transparency improvements around supplemental benefits, the
7 use of those by beneficiaries, and the value, even if it's
8 just in the mind of the beneficiary, received from those
9 benefits.

10 Third, the HCC system. The approach to an
11 insatiable monster is not to modify the formula. It's to
12 get rid of the monster. So again, this is just a
13 directional suggestion. I don't think the solution is the
14 Version 32, or 33, or whatever. It's to change the whole
15 way we approach risk adjustment, and it's a way bigger
16 discussion.

17 Fourth, beneficiary protection. Again, I
18 particularly want to highlight Betty and Gina's comments.
19 The need for access to what you may or may not have at the
20 time of your decision-making about enrollment or re-
21 enrollment, a disease that really requires quaternary
22 access for optimal outcomes, there needs to be more

1 beneficiary protections at the front end of the enrollment
2 process. Secondly, when there is an out-of-network request
3 made by the member to seek care at a quaternary center that
4 may be out-of-network, there needs to be more transparency
5 and protection around that. And third, I think we really
6 need to tee up the whole issue of guaranteed issue for a
7 member disenrolling from MA and wanting to return to
8 traditional Medicare with a Medicare Supp, when the reason
9 for that disenrollment is around access to quaternary care.

10 Fifth, I think the C-SNP program, analogous to
11 how you've done it, and we're going to go on to this great
12 dive into D-SNP, I think we need at least -- it could be a
13 smaller dive into C-SNP and the overall intent and promise
14 of that program versus the current reality. Thanks.

15 MS. KELLEY: Cheryl.

16 DR. DAMBERG: So this was a very rich chapter,
17 and I so appreciate all the work that went into it

18 And one thing that I would hope, because there's
19 so many important messages throughout the chapter, that you
20 focus a bit more on the executive summary in terms of
21 really pulling in those key points in the chapter, because
22 I think some people may not want to read the whole thing,

1 because it's quite long. But I wouldn't want them to lose
2 the key points or the key takeaways.

3 One thing that I appreciated, in particular, was
4 the detailed description or discussion of the favorable
5 selection and coding intensity. I think you guys have done
6 tremendous work there, both to explain what you did and to
7 work to improve your analyses, so very much appreciate
8 that.

9 And I guess I was heartened by the consistency of
10 your results, with the results that others externally have
11 found, and it would appear that the shift to V28 risk model
12 is sort of moving us in the right direction, but there's
13 still a gap to be closed in terms of the effects,
14 particularly of coding intensity.

15 And in that coding intensity space, I know
16 there's a comment that MedPAC has made recommendations
17 about shifting to some type of tiered adjustment. That
18 could be done by, say, quartiles. But I am very much in
19 favor of having differential adjustment based on the
20 differential coding intensity across plans.

21 I find myself, you know, zeroing in on some of
22 the distortions that are created in this whole rebate

1 space, and they create these perverse incentives for
2 upcoding risk factors. And I think -- and those drive the
3 increases in the benchmarks.

4 So I think we have to step back and say, you
5 know, how do we start thinking harder about fixing that
6 space, because those rebates are financed by taxpayer
7 dollars and through fee-for-service beneficiaries and their
8 Part B premiums, and yet those beneficiaries and fee-for-
9 service don't accrue the same benefits that those people in
10 MA are receiving by virtue of that financing.

11 So this comes at a very substantial cost to the
12 American public, and it creates a very uneven playing field
13 between MA plans and the fee-for-service portion of the
14 program.

15 In addition to the increase in coding that leads
16 to larger rebates, sort of layered on that, because the
17 rebates are financing these supplemental benefits that have
18 their own set of administrative costs to operate, again,
19 that's adding costs to the program.

20 So I think we collectively need to rethink this
21 space, and, you know, things that I've been thinking about
22 would include something like creating a flex spending

1 account for beneficiaries, you know, that it's a cash
2 transfer. They would get to spend it within bounds. It
3 gives any beneficiary flexibility in terms of how they
4 spend it within those bounds, and it sort of takes it out
5 of the planned space of having to administer that benefit.

6 In the meantime, you know, between where we are
7 today and sort of rethinking that space, we clearly need to
8 move beyond the data that CMS is receiving about how those
9 supplemental benefits are being spent to something that's
10 more detailed. I would support person-level data on the
11 use and spend in that space, because we don't really have a
12 sense of what the value of those expenditures are.

13 Again, I think given that this is so heavily
14 financed, you know, by taxpayers, we really have to
15 understand that value and make some, you know,
16 determination about how much we want to spend in this
17 space.

18 I want to plus-one on Betty's comment on the
19 dizzying array of plan choices and how that creates so much
20 complexity for consumers in making decisions about which
21 plan to choose, as well as choosing between MA and fee-for-
22 service. So I certainly look forward to MedPAC's future

1 work on trying to think hard about how we can reduce the
2 complexity of plan choice.

3 I want to plus-one on Scott's comment -- or
4 actually it might have been Betty's comment about the
5 quality bonus payment of \$16 billion, and I fully support
6 shifting this to being budget neutral. Absent that, it's
7 continuing to add to taxpayer spending, and again, I think
8 that program creates a whole range of perverse incentives
9 and needs a rethink.

10 The other thing that I flagged in the chapter --
11 and I'm really pleased that you spent time talking about
12 this -- is the area of health care consolidation and
13 particularly vertical integration. I do think that CMS
14 should make data publicly available on ownership
15 relationships between the MA plans and their providers. I
16 think that that would help both MedPAC, as well as the
17 larger policy community, carry out the work that's needed
18 to understand the effects of vertical integration, which
19 could be either positive or negative.

20 I thought it was interesting, the information
21 that you spotlighted on the degree of vertical integration
22 in terms of provider-owned plans versus insurer vertical

1 integration in this space, and I was wondering how those
2 two different types of entities differ in terms of their
3 market share. So while the insurer provider integration
4 may be smaller at this point in time, I suspect it's going
5 to change over time and consist of more market share. So I
6 would look forward to MedPAC continuing to monitor that
7 space and really understand how much of the market the
8 insurer provider vertically integrated organizations
9 possess.

10 Then one last comment around patient experience.
11 I noted a sentence that said that I think you were unable
12 to look at the experiences of those with serious health
13 needs, but I'm not sure that that's the case. I think in
14 the MCAHPS data, at least at sort of an aggregate level,
15 not on a plan-specific level, you can pull out information
16 on the different clinical risks of the people who are
17 completing that survey, so whether that's, you know, by
18 disabled versus not, dual versus not, number of chronic
19 conditions. So I think that's something that you could add
20 in the future.

21 DR. CHERNEW: Thank you.

22 MS. KELLEY: Stacie.

1 DR. DUSETZINA: Great. Piling on the thanks for
2 this exceptional work.

3 So I'm going to try not to repeat too much of
4 what others have said. I think when you read this chapter,
5 it's hard not to be shocked at the total amount of money
6 going into MA rebates, the coding issues, the lack of data
7 on extra benefits, and recognizing how much those are
8 costing the taxpayers and all Medicare beneficiaries. I
9 think it's incredibly important that we know more about
10 those.

11 I think it would be hard for most of us to look
12 at \$76 billion in potential overpayments and not think that
13 that could be spent more efficiently or better to suit the
14 needs of Medicare beneficiaries.

15 I think the incentives for increased coding and
16 the lack of validity in some of the coding is incredibly
17 concerning, and others have highlighted this.

18 I also really appreciate the breakdown of how
19 this varies by plans and recognizing that not all plans
20 behave the same way when it comes to coding intensity.

21 And I am glad to see that the V28 risk model
22 helped, and it also kind of helped to pull in some of the

1 highest coding groups.

2 But I was trying to think through, as Scott and
3 Tamara have indicated in their Round 1 and 2 comments, how
4 do we think about getting this better, and should we be
5 putting forward some suggestions for that?

6 So I think, Andy, you mentioned that new policies
7 would be needed for some additional changes, and we should
8 think about what those policies would be to be more direct
9 at getting the higher coding groups down more and not
10 penalize those who are coding, kind of what we think is
11 more of an accurate reflection of what's going on for
12 beneficiaries.

13 I also noted the effort to pull in the ESRD
14 estimates. That seemed like an incredibly large task based
15 on the details in the chapter, and I wondered how much that
16 might be needed in future years or if it's a, you know,
17 few-years-task rather than adding it onto this body of
18 work, given the additional effort and the relatively small
19 amount of total spending that that adds to the pot. So I
20 felt like the conclusion, seeing that they were consistent
21 when you add in the ESRD estimates, it just felt that that
22 might not be necessary every single year, given it's not

1 going to change the conclusion someone would draw from this
2 work.

3 To Cheryl's point about beefing up the summary of
4 the chapter a little bit, I think it would be great to have
5 some of those recommendations from the very last page of
6 the chapter before we get to the references up front, so we
7 see what MedPAC has said over the years about the different
8 recommendations around MA, just having that for readers
9 before they dive into the chapter would be great.

10 The two last things I want to point out are, you
11 know, access to plans and access to care. I think going
12 back to Betty's comments and comments we've heard from Gina
13 and others previously; there are way too many plan options.
14 So I'm not worried about people not having enough plan
15 options here. It's like the very opposite. Too many
16 plans, you can't tell how they're different from one
17 another, and the plan shopping experience is pretty
18 terrible.

19 The fact that if you go through the Part D plan
20 finder, then you're not really able to see the networks
21 without going outside of that tool, that's a mess. The
22 provider directories also concerning. And I feel like

1 that's the case not just for the medical benefits provider
2 directories, but thinking about the supplemental benefits,
3 like, can I actually find a dentist near me who would take
4 these benefits? I don't know. And that's a lot of
5 shopping work for people to do.

6 For access to care, I know we all kind of bemoan
7 the fact that access-to-care information is pretty poor in
8 general, and here, I really worry about a couple of things.
9 One is thinking about some of the tools that the MA plans
10 use that might create additional administrative burden or
11 access issues, so your prior authorization, for example. I
12 am definitely not opposed to the use of these tools. I
13 think it helps plans to be more efficient and sometimes to
14 definitely get the lowest cost and best value treatment for
15 people, but I worry about what that means for the burden on
16 health systems and on patients and delays in care for
17 certain types of treatments that people need.

18 I also worry a lot about changes in contracts
19 during the year and people losing their benefits, and then
20 that has implications for them having higher out-of-pocket
21 costs if they shift to a plan that, you know, covers their
22 providers.

1 So I think that future work, it would be nice to
2 kind of have a better sense of how that's going. I know
3 the measures we have, things look pretty okay for most
4 people, but I definitely worry about those things that we
5 hear about and we maybe all experience when we use our
6 health insurance.

7 So that is my last plug, but just thank you guys
8 very much for this absolutely fantastic work and all of the
9 efforts. It was a heroic effort to read the chapter. I
10 can't imagine writing a chapter.

11 MS. KELLEY: Gina.

12 MS. UPCHURCH: Yeah, I'll pile on. Thank you so
13 much for this great work.

14 I'm not going to repeat a lot of the things that
15 I've said in the last few years. Many of you have repeated
16 some of them. And plus-one on many of the comments that
17 have been made.

18 I did find myself as I was reading this, you
19 clarified some things that I thought had been fuzzy in the
20 past. I really want to thank you for that.

21 And I want to acknowledge, as Greg would always
22 remind us, there are different kinds of Medicare Advantage

1 plans, ones that are driven by provider groups, ones that
2 are driven by insurers.

3 And I do hope that we can move away from this
4 gaming with coding and trying to figure out what's
5 happening, more to claims and true data to drive some of
6 the risk adjustments over time.

7 On page 2, you know, when you're talking about
8 the summary and you say it later, just to read something,
9 it says the Commission strongly supports the inclusion of
10 profit plans in the Medicare program. I would actually
11 like to adjust that. Given what we know now about how they
12 have been rolled out, can we adjust this to strike the word
13 "strongly supports the inclusion of profit plans" and then
14 say "and wants meaningful and transparent competition"?
15 Because we're not getting that. We're not getting
16 transparent and meaningful competition in the system. So I
17 hope we can add those words.

18 You mentioned -- even a little bit later, you
19 mentioned how extra payments to Medicare Advantage distort
20 the nature of plan competition. So we're just
21 acknowledging it there. So I would just want to point that
22 one out.

1 The other thing that we've just seen over the
2 last year -- again, for those of you who don't know, we're
3 a SHIP site. So we do Medicare insurance counseling. And,
4 you know, when I hear about favorable selection, getting at
5 Gokhan -- some of his questions, but we have noticed that
6 people that have behavioral health needs and people that
7 might need skilled nursing/rehab, they're often looking to
8 traditional Medicare, original Medicare, or leaving
9 Medicare Advantage trying to get back because of those
10 needs and the networks that exist for them. So I just want
11 to make sure when we're talking about favorable selection,
12 we reflect that.

13 I definitely believe, because of all the mid-year
14 network changes, which are really truly painful, and the
15 special enrollment period is -- it doesn't happen until
16 after the fact. So the stress that it causes people -- you
17 announce this hospital system is breaking up with this
18 insurance companies. You have to wait until after it
19 happens to make changes, most people. That is super
20 stressful to people who are very sick.

21 So I believe that the MOOP, the maximum out-of-
22 pocket, for medical needs to travel with the individual,

1 just like TrOOP for the drugs does. It's not fair that it
2 does not. People have to start over the middle of the
3 year. It's already stressful enough that your provider is
4 not in network. To lose the money you've already paid into
5 the system makes no sense to me.

6 We need more user-friendly special enrollment
7 periods that protect the consumer when mid-year breakups
8 happen.

9 On page 30, we talk about Medicare savings. You
10 talk about D-SNPs. I just want to make sure people
11 understand all D-SNPs are not the same. If you're a full-
12 benefit dual, full-benefit Medicaid, that means you have
13 all the wraparound services with Medicaid. The Medicare
14 savings programs, MQB-B, -Q, and -E -- call them different
15 things, SLMB, QMBs -- some D-SNPs will allow those folks to
16 join. Some will not. And you don't know until you think
17 you've enrolled them and you think you've done the right
18 thing. Then, in January, you get this notice, oops, they
19 weren't eligible. That needs to be more clear.

20 When you go to enroll somebody, you need to know
21 what level of Medicaid, partial or full Medicaid, or what
22 level of Medicaid they can have to enroll in this program.

1 Sadly, people don't often know what level of Medicaid. If
2 they have partial Medicaid, they often do not know if they
3 have MQB-E, -B, or -Q. That's really a state thing that
4 the state DSSs should be helping people with, but they're a
5 little overburdened right now.

6 And I just want to leave with a quote from a
7 farmer, and, you all have heard it from me before, but I
8 told him I would carry this forward. He said, "Ma'am, I
9 like choice. Choice is great, but I wanted to choose
10 between paper and plastic, not all of this mess." So as
11 much as we can do to continue to streamline and make the
12 decision simpler for the consumer -- and I think that means
13 not only standardizing things, but stabilizing them so that
14 every year they're not massive changes.

15 In some way, Cheryl's suggestion -- and we've
16 talked about in the past -- this flex card, because I do
17 believe that people know how to use their money best,
18 right, instead of having to go to different programs, so
19 flex card helps do some of that standardizing and
20 stabilizing.

21 Thank you again for a great chapter.

22 MS. KELLEY: Lynn.

1 MS. BARR: Thank you. Great work and very
2 depressing, as always, as we think about the cost and how
3 this is affecting our deficit in the American taxpayer.

4 I agree with Brian that we really need to go back
5 to encounter-based coding. There are so much better
6 options, and the fact that MA plans are paid on -- they
7 have different rules for how they code and they're paid on,
8 but the HCC codes are set in fee-for-service. That makes
9 no sense to anyone.

10 I'm really happy to see the impact of V28, but I
11 bet you that your projections of continuing decline will
12 not continue. They will find a way around it, and the
13 problem is it's just so profitable. Working with the plans
14 for 10 years, trying to engage them in ACOs and all kinds
15 of things, and they left me out of the room. I mean, they
16 can make so much money on coding that they're not doing
17 what we want them to do, which is reducing the cost of
18 care, better management of patients.

19 Actually, the promise of MA plans, what they can
20 actually do for this country is great, but we have to take
21 away the incentive for them to do everything but that,
22 right, and that's where things have to change. So plus-one

1 on Brian for that.

2 I do think that the literature supports your
3 work. I do think that there's really no question that
4 we're paying way too much for Medicare Advantage because of
5 these distortions, and we need to really focus on this.
6 And I really do support the idea of us getting away from
7 how we're doing HCC today and do it and have one system of
8 HCC for all providers that is all the same.

9 And I would also suggest that we ask the MA plans
10 to report what they pay for coding and for quality measure
11 improvement, both internally to their vendors, you know,
12 what's their overhead on that. I mean, this all goes into
13 the cost, and I think if we found out those numbers, we
14 would realize what we're leaving on the table for the
15 American -- for Medicare patients, and hopefully, we can
16 redirect that to better use.

17 Thank you very much for great work.

18 MS. KELLEY: Tamara.

19 DR. KONETZKA: In some ways, I'm not saying much
20 new, because I think people have very eloquently expressed
21 a lot of what I'm thinking. But I just want to express
22 support for a few things on the record, a few of these

1 bigger-picture items. And I would organize it in sort of
2 short-term versus long-run goals.

3 And I think, you know, it's natural, I think, to
4 get caught up in some of these short-term necessities, you
5 know; for example, about the risk adjustment. I do think
6 in the short run, it is, you know, necessary for us to
7 think about the V28 model and maybe incorporating
8 heterogeneity so that we're not penalizing plans that don't
9 engage as much in the coding intensity and to continue to
10 tweak those models. But in the long run, I really hope we
11 can rethink the whole model and get rid of the HCC system,
12 as others have suggested, and think about a different way
13 to sort of provide risk-adjusted payments.

14 That's clearly hard, right, and so I think we
15 can't sort of stop doing the short-run things, but I'm kind
16 of hoping that we can make room in MedPAC's sort of scope
17 of work over the next few years to not let those sort of
18 big-picture fundamental changes sort of get lost, because I
19 think there's a lot of agreement that we need to do those.
20 But there's so much work on the short-run stuff that sort
21 of has to happen because that's the way the system is set
22 up now.

1 So I'd really love to -- you know, I feel like
2 this group is the group to be able to think about what some
3 of those long-run changes might look like and how that
4 might play out.

5 And, you know, in a parallel sense, I think a lot
6 of people have raised already -- and I agree completely --
7 that, you know, we need to know a lot more about those
8 supplemental benefits that are financed by the rebates.
9 You know, we don't really know anything about the value of
10 those benefits and whether we should be, you know, using,
11 you know, \$6 billion in subsidies from fee-for-service
12 beneficiaries to finance those benefits for MA enrollees
13 and whether we should be using some of the sort of bigger
14 overpayments, you know, for other things and to improve the
15 Medicare program.

16 So the short-run problem there is that we really
17 need to know the value of those supplemental benefits. The
18 long-run problem -- and I think Cheryl's comments were
19 getting at this -- is that perhaps we really need to think
20 the whole rebate system and how -- not just the sort of
21 details of, like, just the quality bonuses being not budget
22 neutral, et cetera, but really just sort of rethink from a

1 basic standpoint the whole way that MA plans are financed.
2 So that's another short-run, long-run thing.

3 I would love for us to start thinking through the
4 policy options for different ways to sort of finance MA
5 that can get back to some of the principles that we really
6 like about managed care, right, the sort of care management
7 part of it, and not just the utilization controls and the
8 extra benefits.

9 And then two other things I just wanted to
10 express support for, one is thinking about ways to improve
11 choice and competition and not sort of have beneficiaries
12 have to struggle with lots of different choices that aren't
13 meaningfully different from each other, and also want to
14 express support for the idea of guaranteed issue for people
15 who want to switch back from MA and need a Medigap plan in
16 fee-for-service. You know, I think that's not as easy as
17 it sounds when we recommend it, because there are big
18 adverse selection problems then. But I think looking into
19 that issue a little bit more to see if there are ways to
20 sort of manage the adverse selection and still provide
21 guaranteed issue in specific circumstances, that at least
22 would be something that I'd be in favor of.

1 Thank you.

2 MS. KELLEY: Greg.

3 MR. POULSEN: Thank you.

4 I've been uncharacteristically quiet regarding
5 Medicare Advantage, which you all know I have strong,
6 strong feelings about, and it's because so many of you have
7 said so many of the things. First off, the chapter was so
8 excellent. Thank you. And so many of you said the things
9 that I completely agree with and fully support.

10 I just would remind us -- a couple of people
11 mentioned it obliquely, but I wanted to hit it straight on
12 -- unlike any other population group in the country, we
13 know CMS knows what's happened to Medicare beneficiaries
14 over the last few years, assuming they've been in Medicare,
15 all but those people who have just entered Medicare. We
16 know what's been going on with them. There's enough
17 information there to do remarkable risk adjustment that
18 asks for no intervention on the part of the plans
19 whatsoever. And that is a remarkable capability that we
20 are not using, and if we did, we would be able to overcome
21 the issues that so many of us have mentioned as being
22 perverse and disruptive and destructive.

1 The other points are, if we look at the things
2 that people can do that don't add clinical value, the other
3 ones that we didn't mention explicitly or that we haven't
4 mentioned as a group are claims denials and prior
5 authorization that is intentionally obstructive. There's
6 certainly prior authorization that's appropriate, and there
7 are definitely appropriate claims denials when care is
8 being provided that is unnecessary or inappropriate. But
9 the fact that those are being used as mechanisms to --
10 well, it turns out that all three of those -- risk
11 adjustment, claims denials, and prior authorization that is
12 intentionally obstructive -- are all cheaper ways to get an
13 ROI than actually managing care more effectively. Reducing
14 all three of those, I think, would start to reward people
15 who do, in fact, help people to get better health care, to
16 keep people healthy, avoid the need for unnecessary and
17 inappropriate interventions that come later, and to keep
18 people both healthier and happier.

19 If we were to take steps in those directions --
20 and I think we have the tools to do that. I think there
21 are mechanisms. We talked about them in prior meetings, so
22 I won't go into them here. I think that would be something

1 that would help what a number of the folks around the table
2 have said, which is MA has huge opportunity. It has the
3 advantage of having some structure that is tremendously
4 beneficial, can be beneficial to beneficiaries, and a few
5 of the plans have demonstrated that capability, but that
6 the incentives to do the wrong thing are so strong right
7 now.

8 Scott talked about an example of that, that it
9 overpowers the motivation to do good in many, many
10 instances, and if we can help to get in the way of changing
11 that, we can do tremendous good for many, many people.

12 DR. CHERNEW: I think that was the end. Is that
13 right, Dana?

14 Great. I'm going to make a few closing comments.
15 Thank you for the chapter to Grace, Luis, and Andy. Thank
16 you for all the comments. That was a passionate and
17 thoughtful discussion. There's a lot to go through there.

18 A few, very quick, some small, some bigger-
19 picture comments. The first one is the change in our
20 estimated number -- I just want to emphasize this to those
21 at home -- is not because of a change in the analytic
22 framework. We have made some refinements, but the impact

1 of those refinements were relatively small. The big change
2 is time moved on, more V-28 years were under the belt, but
3 the analytic framework is largely the same, apart from some
4 continued methodological refinement, which we will continue
5 to do.

6 Second thing -- and I say this in parts because
7 people in public might want to know -- this issue that
8 Gokhan raised at the very beginning about how you can still
9 have selection, Matt Fiedler from Brookings has a great
10 piece on that. If you want to check out what Matt did to
11 talk about the math about how that can work, we can
12 obviously talk amongst ourselves specifically, but for
13 those of you at home that might want a non-MedPAC
14 reference, look at Matt's work.

15 I think one of the big-picture questions, from my
16 personal view, is not so much how much value we're getting
17 from the extra benefits, which matters, it's what would be
18 lost if we changed the way payment was done, because the
19 plans will adjust in a bunch of ways. So you really need
20 to understand if we made a payment change, what would
21 actually be lost and what we would care about it, and so
22 which of that value would go away if you changed payment.

1 That actually matters a lot.

2 And the last thing I'll say is there are a ton of
3 really big-picture comments about issues of the Medicare
4 Advantage market, a lot of really good big-picture
5 comments. And so I'll just call out for those at home, we
6 do have ongoing work on the complexity of choice, the role
7 of networks, what's going on with prior auth, what's
8 happening on the effect on providers. We have a very long,
9 very rich, very deep MedPAC MA agenda, that some of which
10 you will see in March and April, some of which you will see
11 when someone else is sitting here. But nevertheless, given
12 the prevalence of MA in the Medicare program, these issues
13 are not going to go away.

14 So again, thank you.

15 Let's take about a two-minute break and come back
16 to do -- well, because we're going to end at noon on time.
17 So if you want to talk about and not get messages about
18 time, let's get back quickly now so we can have time to
19 talk about D-SNPs.

20 [Recess.]

21 DR. CHERNEW: Hello, everybody, and welcome back.

22 We are now going to wrap up with more discussion of

1 Medicare Advantage with a particular focus on D-SNPs. And
2 given the time that we have, I'm going to be brief and just
3 say Eric, take it away.

4 MR. ROLLINS: Thanks, Mike. For our last
5 presentation, I'm going to talk about two related topics.
6 The first topic will be a mandated report on dual-eligible
7 special needs plans, or D-SNPs, while the second topic will
8 be an update on a group of MA plans known as D-SNP look-
9 alike plans. The material from this presentation will
10 appear as a chapter in our March report.

11 Before I begin, I'd like to remind the audience
12 that they can download these slides in the Materials
13 section at the top right of the screen.

14 About 12 million people have both Medicare and
15 Medicaid coverage. These people are known as dually
16 eligible beneficiaries, and they represent about 18 percent
17 of the Medicare population. As a group, they are more
18 likely than other beneficiaries to be in poor health and
19 tend to have higher costs. However, they may receive care
20 that is fragmented or poorly coordinated because of the
21 challenges of navigating two distinct programs.

22 Given these concerns, policymakers have developed

1 several types of health plans that aim to better integrate
2 care for these beneficiaries by providing both Medicare and
3 Medicaid benefits. The basic idea is that integrated plans
4 will have stronger incentives to manage and coordinate care
5 than either program has when acting on its own. Most of
6 these plans are D-SNPs, which are specialized MA plans that
7 only enroll dually eligible beneficiaries.

8 Nearly half of dually eligible beneficiaries are
9 enrolled in D-SNPs. The share of dually eligible
10 beneficiaries enrolled in these plans has grown rapidly in
11 recent years, rising from 14 percent in 2014 to 46 percent
12 in 2024. However, D-SNPs vary in their level of
13 integration with Medicaid, meaning the extent to which they
14 provide Medicaid benefits. There are actually three
15 different types of D-SNPs. I'm going to describe them very
16 briefly here, but there's more detail in your meeting
17 materials.

18 First, you have coordination-only plans, which
19 have the lowest level of integration because they don't
20 have to provide any Medicaid services. These plans cover
21 27 percent of the dually eligible beneficiaries and account
22 for a majority of D-SNP enrollees. Second, you have highly

1 integrated D-SNPs or HIDE SNPs, which cover 15 percent of
2 dually eligible beneficiaries. These plans provide
3 Medicaid long-term services and supports and/or behavioral
4 health, and you can think of them as having a medium level
5 of integration because they provide some but not all
6 Medicaid services. Finally, there are fully integrated D-
7 SNPs or FIDE SNPs, which have the greatest level of
8 integration because they provide a broad range of Medicaid
9 services. These plans cover about 3 percent of dually
10 eligible beneficiaries.

11 The statutory requirements for D-SNP integration
12 have gradually become more extensive. When D-SNPs were
13 first created in 2003, they did not have to meet any
14 specific requirements for integration. Then in 2008,
15 Congress required all D-SNPs to have Medicaid contracts
16 that meet certain minimum requirements, such as specifying
17 the plan's service area, the Medicaid services the plan
18 provides, if any, and the plan's responsibility to
19 coordinate the delivery of Medicaid services for its
20 enrollees.

21 In 2010, Congress created the FIDE SNP
22 designation. Finally, in 2018, D-SNPs were required to

1 meet one of the integration standards that I described on
2 the previous slide -- coordination-only, HIDE SNP, or FIDE
3 SNP -- and to have a unified grievance and appeals process
4 where possible.

5 In 2013, the Commission recommended that D-SNPs
6 be required to have a high level of integration.

7 The Bipartisan Budget Act of 2018 requires the
8 Commission to periodically assess the relative performance
9 of D-SNPs and other plans that serve dually eligible
10 beneficiaries. To the extent feasible, this analysis
11 should compare five types of plans. The first three types
12 are D-SNPs, divided based on requirements that are similar
13 to the three categories I described on the previous slide.
14 The fourth type are Medicare-Medicaid Plans or MMPs, which
15 were highly integrated plans for dually eligible
16 beneficiaries that were part of a demonstration that just
17 ended this past December. The fifth type are other MA
18 plans, but looking only at the dually eligible enrollees in
19 those plans.

20 The mandate language lists HEDIS measures, which
21 were developed for health plans by the National Committee
22 for Quality Assurance, the CAHPS patient experience survey,

1 which was developed by the Agency for Healthcare Research
2 and Quality, and encounter data as potential data sources
3 for this analysis.

4 As part of the mandate, we must provide a report
5 every two years from 2022 to 2032, and then every five
6 years starting in 2033. This is our third report under the
7 mandate.

8 We analyzed three kinds of quality data for this
9 report: HEDIS clinical quality measures, HEDIS risk-
10 adjusted utilization measures, and the CAHPS patient
11 experience survey. We have used the HEDIS clinical quality
12 measures and CAHPS surveys in previous mandated reports,
13 while the analysis of utilization measures is new. We used
14 2024 data for our analyses and assessed plans' performance
15 using a combination of statistical significance and
16 practical significance, which were instances where a plan's
17 score differed from the overall average by at least 3
18 percentage points. CMS has used this threshold in some
19 HEDIS analyses to signify when scores are meaningfully
20 different.

21 I'll use the next three slides to summarize our
22 findings from each analysis.

1 With respect to the HEDIS clinical quality
2 measures, we found that each plan type performed better on
3 some measures and worse on others. For this analysis, we
4 calculated scores for 28 measures. One caveat to keep in
5 mind about these measures is that most of them are process
6 measures that are not tied to clinical outcomes, so they
7 provide limited insight into plan performance.

8 Overall, we found that HIDE and FIDE SNPs that
9 have aligned enrollment had the best overall performance of
10 the five plan types. Aligned enrollment means that
11 everyone in the D-SNP must also be enrolled in a companion
12 Medicaid managed care plan offered by the same insurer,
13 which allows the insurer to provide a higher level of
14 integration. In contrast, we found that other MA plans had
15 the worst overall performance, and that MMPs had the
16 greatest variation in performance, doing well on many
17 measures and poorly on many others.

18 For the HEDIS risk-adjusted utilization measures,
19 we looked at measures that focus on four different aspects
20 of hospital use: inpatient discharges, emergency
21 department visits, all-cause readmissions, and potentially
22 avoidable admissions. When plans report these measures,

1 they report both actual service use and an estimate of
2 expected service use after applying a set of risk-
3 adjustment models that are developed by NCQA and predict an
4 enrollee's service use based on such factors as age, sex,
5 and the presence of various clinical comorbidities.
6 However, these models are calibrated on a broad sample of
7 MA enrollees and may not be as accurate for dually eligible
8 beneficiaries, so our results should be interpreted with
9 caution. Notwithstanding this limitation, HIDE and FIDE
10 SNPs that did not have aligned enrollment had the best
11 overall performance on these measures, while MMPs had the
12 poorest performance.

13 Finally, we found relatively little variation in
14 scores on the CAHPS patient experience survey. We focused
15 on six composite measures, which combine scores on groups
16 of closely related individual measures, and five measures
17 where enrollees give an overall rating for a key feature of
18 their health care experience. We found that coordination-
19 only plans, which have the lowest level of integration
20 among D-SNPs, had the best overall performance, followed by
21 HIDE and FIDE SNPs that did not have aligned enrollment.
22 However, the differences in scores across the five plan

1 types were relatively small and may not be very meaningful
2 for beneficiaries. For example, scores on the overall
3 rating for the enrollee's health plan ranged from 87 to 90
4 on a 100-point scale. Other analyses have also found that
5 CAHPS scores for many measures tend to cluster within a
6 narrow range.

7 Stepping back a bit, the results from our three
8 analyses were mixed, and drawing broader conclusions about
9 the relative performance of D-SNPs is challenging, for
10 several reasons. While nearly all beneficiaries had access
11 to a D-SNP, the most highly integrated plans, FIDE SNPs and
12 MMPs, were only available in a limited number of states.
13 Thus, differences in scores across plan types could be
14 influenced by factors such as regional differences in state
15 Medicaid eligibility requirements and physician practice
16 patterns. The characteristics of the beneficiaries who
17 enroll in each type of plan may also differ.

18 Finally, MMPs had different quality incentives
19 than MA plans, which may have contributed to their
20 relatively poor performance on some measures. Two recent
21 reviews of the literature on integrated care programs have
22 also found mixed results and noted that one particular

1 challenge is controlling for the effects of selection, due
2 to the limited availability of many programs and the fact
3 that enrollment is typically voluntary.

4 Okay, now we're going to switch gears and talk
5 about what are known as look-alike plans, which are MA
6 plans that are not D-SNPs but still target dually eligible
7 beneficiaries. The rationale for look-alikes is that MA
8 insurers find it profitable to enroll these beneficiaries
9 but may not be able to offer a D-SNP in some states. Since
10 all D-SNPs must have a Medicaid contract, states can limit
11 the number of insurers that can offer D-SNPs as part of
12 their efforts to develop integrated care programs. For
13 example, a state might choose to sign D-SNP contracts only
14 with insurers that offer Medicaid managed care plans for
15 dually eligible beneficiaries.

16 In response, some insurers may offer look-alike
17 plans as an alternative. These plans have some of the same
18 features as D-SNPs, such as their coverage of supplemental
19 benefits, but they aren't required to have a Medicaid
20 contract. In its June 2019 report, the Commission
21 expressed concern that look-alike plans could undermine
22 state efforts to develop integrated care programs.

1 CMS has taken steps to limit the use of look-
2 alike plans. Starting in 2022, the agency began requiring
3 MA insurers to close a conventional plan when the share of
4 enrollees who are dually eligible exceeds a threshold that
5 is now set at 60 percent.

6 One limitation of these restrictions is that they
7 only apply to conventional plans, which could allow
8 insurers to use other types of MA plans as look-alikes.
9 One such type of plan is the chronic condition special
10 needs plan, or C-SNP. C-SNPs are specialized plans that
11 limit their enrollment to beneficiaries with certain
12 chronic conditions, which could be a single condition or a
13 group of closely related conditions.

14 Overall enrollment in C-SNPs was relatively flat
15 for many years but has since grown quite rapidly, with
16 total enrollment rising from about 400,000 in 2021 to 1.3
17 million in 2025. The vast majority of enrollees, about 95
18 percent, are in plans for beneficiaries with three
19 relatively common conditions: cardiovascular disease,
20 chronic heart failure, and diabetes. We estimate that the
21 use of C-SNPs as a new type of look-alike plan accounts for
22 about 10 percent of this overall growth.

1 Several factors suggest that some C-SNPs are
2 being used as look-alike plans. First, the number of C-
3 SNPs where the share of enrollees who are dually eligible
4 exceeds the look-alike threshold began growing after CMS
5 started limiting the use of conventional plans as look-
6 alike. Second, much of the initial growth in C-SNPs with
7 a high share of dually eligible enrollees was clustered in
8 states that limit participation in their D-SNP markets to
9 insurers that also offer Medicaid managed care plans.

10 Third, the C-SNPs that enroll large numbers of
11 dually eligible beneficiaries have features that differ
12 from those typically seen in other C-SNPs, such as a high
13 MA out-of-pocket limit, the maximum allowable Part D
14 deductible, and a non-zero Part D premium. These features
15 are not attractive to non-dually eligible beneficiaries due
16 to their added costs, but they are less important to the
17 dually eligible because those costs are covered by either
18 Medicaid or Part D's low-income subsidy.

19 Overall, we estimate that the number of C-SNPs
20 that function as look-alikes has grown rapidly, jumping
21 from 5 plans in 2021 to 92 plans this year, and that
22 enrollment in these plans grew by about 100,000

1 beneficiaries between 2021 and 2025. These figures are
2 based only on plans that target cardiovascular disease,
3 chronic heart failure, and diabetes.

4 CMS has recently expressed concern about the
5 growth in the number of dually eligible beneficiaries
6 enrolling in C-SNPs. As with conventional plans, the use
7 of C-SNPs as look-alikes may undermine state efforts to
8 promote integrated care, and as a result CMS may want to
9 broaden the restrictions on look-alikes to cover C-SNPs.
10 As part of such a change, there could be exceptions for C-
11 SNPs that target certain conditions, such as end-stage
12 renal disease, HIV/AIDS, or mental health conditions, where
13 the share of affected beneficiaries who are dually eligible
14 is very high.

15 That brings us to the discussion. I'd like to
16 remind everyone that this material will appear as a chapter
17 in our March report. I'll be happy to answer any questions
18 about this presentation and then would like to know if you
19 have any comments about potential future work that we might
20 do related to D-SNPs or dually eligible beneficiaries.

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

1 DR. CHERNEW: Great. And in interest of time I
2 just want to jump right to the queue, and I think Stacie
3 had the first Round 1 question. Is that right?

4 DR. DUSETZINA: Great. Thank you so much, Eric.
5 And the academic in me is going to end up turning this into
6 a comment and sort of a question, and I apologize.

7 Table 15.1 in the chapter, where you show the
8 distribution, or you show the average per capital spending
9 for Medicare and Medicaid for duals versus non-dual
10 beneficiaries, and I just wondered if it was possible to do
11 more of a distribution of spending by those payers. But I
12 found myself getting a little tripped up looking at it and
13 thinking, oh, okay, I thought Medicaid spending would be
14 quite a bit lower for a lot of beneficiaries. And then
15 later on under there you explained that a lot of what's
16 happening is a lot of spending in nursing homes and for
17 some beneficiaries is that's driving the Medicaid part.

18 So I guess it's just a question about if it would
19 be reasonable or reasonably easy to provide more of a sense
20 of a distribution in addition to the per capital.

21 MR. ROLLINS: We can look into that. In terms of
22 the data that we have sort of kind of easily accessible;

1 the distribution may be harder to get. But I do take your
2 point. We will look into that.

3 MS. KELLEY: Scott.

4 DR. SARRAN: Eric, great job pulling this
5 together. I want to ask, when you look at all the data you
6 pulled and synthesized so nicely around whether there is or
7 is not a correlation between, on one hand, the degree of
8 integration and on the other hand downstream results,
9 whether they're quality related or utilization related, it
10 wasn't clear to me that there's a solid correlation.
11 What's your take on that?

12 MR. ROLLINS: I think, as we noted in the paper,
13 I think the evidence is mixed. I think one of the
14 challenges is there are many different ways that higher
15 integration can happen. So it's a little hard to say if
16 you do this one thing versus this other thing then you can
17 really look at the difference, because there is a range of
18 levels of integration that you're comparing all along the
19 spectrum of these five types of plans that we had to
20 compare. So that's one challenge.

21 And then again, to sort of expand on a point that
22 was in the paper, we had the MMPs as one of the groups

1 where a demonstration program, and they had a very
2 different set of incentives in some respects than MA plans.
3 And so they were very highly integrated. All their
4 enrollees were fully dually eligible, the plan provided, by
5 and large, all Medicare benefits except hospice, and in
6 most states largely all of the Medicaid benefits, as well.
7 So it's kind of if you dreamed up an integrated plan, it
8 would probably look something like that.

9 But, you know, their quality incentives were
10 different than MA, and I think to expand on one point that
11 I think Tom made earlier, the plans are very much aware of
12 which quality incentives feed into their payments, and they
13 will quite reasonably focus on those over the ones that
14 they may be required to report, but don't necessarily
15 affect their payment.

16 So I think exactly what the integrated thing is
17 can vary so much that it is hard to take away sort of an
18 overall impression. But I do think one thing that is an
19 important part of integration that is harder to measure,
20 sort of the user convenience. And I think in all of these
21 highly integrated products it can be somewhat easier for
22 the enrollees themselves to navigate the system, if they

1 don't feel like they're having to sort of deal with two
2 entirely separate programs at the same time.

3 MS. KELLEY: Tamara.

4 DR. KONETZKA: Thank you so much. You know, it's
5 a really fascinating area, and there is just so little,
6 even in the academic research, that really gives us good,
7 solid evidence on these plans. So I really appreciate all
8 the work you've put into these comparisons.

9 I have three brief R1 questions, and I'll start
10 with one that follows on almost directly to what Scott's
11 question just was, or your answer to that. And that is on
12 page 31, when you're talking about insurers that don't have
13 access to the D-SNP market, et cetera, you said D-SNPs
14 largely appeal to beneficiaries because of their coverage
15 of extra benefits rather than their ability to offer a
16 product that integrates Medicare and Medicaid coverage.

17 And to me this was a really striking sentence
18 because of what you were just saying. I mean, in the long-
19 term care world, for sure, for people who are trying to
20 have to navigate getting access to HCBS, et cetera, that
21 coordination piece is usually huge. And this sentence
22 would imply to me that it's really more of a policy goal.

1 They want these integrated programs maybe to make things
2 more efficient and avoid duplication of services, et
3 cetera, and that it's not something that is really of value
4 to beneficiaries.

5 So I guess I'm wondering where that sentence came
6 from, what data we are drawing that from, and am I
7 misinterpreting.

8 MR. ROLLINS: I think in terms of the data, I
9 think that's a somewhat impressionistic statement, but when
10 we have talked to integrated plans, they have said that in
11 terms of like marketing the plan and explaining what the
12 plan will offer you, you know, why you should enroll in the
13 plan, the seamless experience, the care coordination, that
14 is very hard to explain to beneficiaries in a way that they
15 can see sort of a very tangible benefit contrasted with
16 like the extra benefits that like an MA plan will offer.
17 But they'll say, you know, we have dental coverage, we have
18 an over-the-counter allowance. And it's -- you know, it's
19 very specific. You know, you'll have no premium for your
20 Part D benefit.

21 So it's not that the care coordination isn't
22 worthwhile. It's that in the plans that we have spoken to

1 over the years find it hard to explain. It's sort of hard
2 to have that be the thing that sort of gets beneficiaries
3 to sign up, and we would talk to plans who would say, you
4 know, it's very important for us once we have these
5 enrollees in the door that we start acclimating them and
6 showing them sort of what this care coordination is going
7 to look like. And so they start to see that, you know,
8 part of the plan is something that they might find
9 beneficial, but they found it challenging to explain it
10 sort of before you -- prior to enrollment.

11 DR. KONETZKA: Thanks. Yeah, that's somewhat
12 surprising to me.

13 The second question, a related question about
14 that is, so, you know, they're duals, so they don't really
15 care about the co-payments, right? So the plans are
16 getting people who are very, you know, sort of highly
17 reimbursed and who aren't very price-sensitive in terms of
18 the premiums and co-payments, right? And so the
19 supplemental benefits that they're getting, what do we know
20 about those? Is it like the dental/vision or like what --
21 you know, is it anything that is particular to this
22 population, like supplemental long-term service and

1 supports kind of benefits that are in Medicaid?

2 MR. ROLLINS: There could be a little of that,
3 but the easy example is sort of dental, vision, and
4 hearing. Your D-SNP is more likely to have both coverage
5 of those benefits, and their coverage of it will tend to be
6 richer.

7 So, for example, a lot of times in MA plans, your
8 dental coverage may have a dollar cap on the benefits you
9 can receive over the course of the plan year, and those
10 limits will tend to be higher in a D-SNP, for example.

11 DR. KONETZKA: One last question. Also, on that
12 same page 31, you were talking about how states sometimes
13 restrict insurers from offering a D-SNP if they don't -- if
14 they're not one of the companies that has a Medicaid
15 managed care plan in that state. Do you have any sense of
16 how often that happens? Like if, you know -- they have
17 those restrictions in a handful of states that you
18 mentioned in the chapter, but like how often do states sort
19 of deny an insurer the ability to start a D-SNP?

20 MR. ROLLINS: I don't have a specific number of
21 states off the top of my head. I would guess that the
22 order of magnitude right now is somewhere in like 10 to 12.

1 DR. KONETZKA: Does it happen often in those 10
2 to 12 states that, you know, there's like only one insurer
3 or something that can do a D-SNP, and the rest are
4 rejected?

5 MR. ROLLINS: So no. So if you want to do -- in
6 Medicaid managed care, there's one or two very minor
7 exceptions, but the big difference -- well, one of the big
8 differences between Medicaid managed care and Medicare
9 managed care is that in Medicaid, enrollment can be
10 mandatory.

11 But if this -- the rules in Medicaid are, if you
12 want to do that, you have to offer them at least some
13 choice of plans. You have to have at least two plans in
14 the market. And in practice in most states, they will try
15 and contract with at least three plans. That way, they can
16 keep doing mandatory enrollment if for some reason they
17 have a plan exit.

18 So there's usually some level of choice. It's
19 never going to be in a mandatory situation where there's
20 just one plan available.

21 MS. KELLEY: Gina, did you have a Round 1
22 question?

1 MS. UPCHURCH: I do. Three, exactly.

2 Thank you so much, Eric, for this great work, per
3 usual.

4 Just to follow up on Tamara's question, do we
5 know how many states have managed care Medicaid?

6 MR. ROLLINS: For which population?

7 MS. UPCHURCH: Well, for people with Medicare.

8 MR. ROLLINS: Very roughly, maybe half.

9 MS. UPCHURCH: Okay. So about half the states.
10 All right. Thank you.

11 So North Carolina is a coordination-only state.
12 We don't have any HIDE/FIDEs. So I'm coming from that and
13 asking these questions.

14 So when it's a coordination-only plan, it's
15 somebody that's in a D-SNP. It's a Medicare Advantage
16 plan, D-SNP. So their Medicaid benefits are from fee-for-
17 service Medicaid, and they have a DSS caseworker, and they
18 just rely on coordination there. Is that correct?

19 MR. ROLLINS: That is correct.

20 MS. UPCHURCH: Okay. So can you explain? So I
21 understand integration has to do with having a contract
22 with the Medicaid system for capitated services for long-

1 term care service supports and potentially behavioral
2 health services, and alignment means it's the same company,
3 right? So how do we explain and how does it work if
4 something is an unaligned FIDE? I'm having a hard time
5 wrapping my head around that.

6 So it's got a contract with Medicaid, but it's
7 two different managed care companies, sort of coordinating
8 care? How is that coordinated if it's two different
9 companies?

10 MR. ROLLINS: So you have a couple of things
11 floating around in there. So the concept -- the situation
12 of the FIDE SNPs where the enrollment was not aligned was
13 very rare. And as we noted in the paper, starting in 2025,
14 CMS said, no, you can't have that anymore.

15 MS. UPCHURCH: Okay.

16 MR. ROLLINS: If you're going to be a FIDE SNP,
17 everybody in the plan is also in the company. They're
18 getting both their Medicare and Medicaid through the same
19 company.

20 So to the extent that you have sort of unaligned
21 enrollment, it's usually going to be with these HIDE SNPs,
22 which is more often going to be a case of a large insurance

1 company that on the one hand has the D-SNP, but has a
2 companion, completely separate Medicaid plan.

3 And your enrollment, like it's not a condition
4 that to get one, you have to have the other. So you can
5 have cases where people are enrolled in both plans from the
6 same company. So their enrollment is aligned, but you can
7 have cases of somebody who picked Company A's Medicaid plan
8 and Company B's D-SNP.

9 MS. UPCHURCH: Okay, okay.

10 MR. ROLLINS: And as we noted in the paper, CMS
11 is taking some steps with what they call the one D-SNP
12 policy to try and get --

13 MS. UPCHURCH: Right, right, right.

14 MR. ROLLINS: -- those two sides lined up a
15 little more closely.

16 MS. UPCHURCH: Okay. Thanks.

17 And then the last question is, with C-SNPs, they
18 allow mid-year, you know, joining C-SNP? You have this
19 condition. It couldn't be a condition you've had for a
20 while, but now you're documented and you can join the C-
21 SNP. Do we know why that is allowed?

22 MR. ROLLINS: That is a longstanding policy

1 across all types of special needs plans. If you start
2 getting Medicaid in the middle of the year, you can enroll
3 in a D-SNP, for example. So it's not a new policy, and
4 it's not specific to C-SNPs. I think the underlying logic
5 has been that these are plans for people with sort of
6 specialized health needs, and that if you suddenly find
7 yourself in that situation, they wanted to allow you to
8 have access to a specialized plan, you know, sooner rather
9 than later.

10 MS. UPCHURCH: Thanks so much.

11 MS. KELLEY: That's all I have for Round 1. Mike.
12 I'll go to Round 2?

13 DR. CHERNEW: Yeah, perfect.

14 MS. KELLEY: All right. Brian, you're first.

15 DR. MILLER: Thank you. Love this chapter. I'm
16 going to keep my comments at a high level because there are
17 lots of fun details.

18 So some thoughts from my fellow Commissioners,
19 the late Jeffrey Kelman at CMS and now retired Jim Sorace
20 at ASPE did some research looking at the Medicare
21 population, noting over 2 million disease combinations.
22 That's a lot, quite a bit of variance.

1 And when we think about duals as even more so --
2 and I think the chapter got into this -- they're a
3 population of populations. So there are islands of
4 related, sort of disease families and combinations in D-
5 SNPs and also different populations in duals for other
6 reasons too, and so they're an expensive population. I
7 think we all agree that they do not do so well with care
8 delivery in fee-for-service Medicare, which lacks --
9 generally lacks coordination.

10 And so increasing coordination and integrating
11 financing and care delivery is really what we look for.
12 It's that sort of holy grail that we're looking for, for
13 ourselves, our family members, and friends. I care for a
14 lot of duals clinically. It's a hard population who's a
15 great population and a great privilege to care for them.

16 And so there are lots of ways that we can sort of
17 organize financing. First of all, I wouldn't really over-
18 index on C-SNPs as a problem. Rather, I'd think about how
19 different markets can serve different people, and then if
20 we don't think that those markets are doing a good job
21 doing so, can we refocus them? So I look at C-SNPs as an
22 opportunity to focus on specialized care and benefit design

1 around a specific need.

2 Now, C-SNPs have been historically neglected, I
3 think, from a regulatory perspective and a policy
4 perspective. So there's a lot of, I'd say, positive
5 opportunities to fix that.

6 Heart failure example for my colleagues, which
7 policy will love this. Heart failure with your DCF, heart
8 failure with preserved DF, distinct clinical energy
9 entities, some cardiologists do better with others and
10 other cardiologists do better with HFpEF. And I went to
11 medical school, and we had a HFpEF cardiologist who's
12 incredible, and all the HFpEF patients or heart failure
13 with preserved DF patients went to him, same for
14 arrhythmias.

15 And beneficiaries know this, right? Like,
16 patients instinctually know on some level if their doc is
17 sort of at the edge of their knowledge or if they're well
18 within the edge of their knowledge. See, the way I would
19 think about C-SNPs is that's a sort of lens to sort of push
20 that forwards for benes.

21 And then we note, you know, we're concerned about
22 C-SNPs being a lookalike plan. Benes can fit in many

1 markets, and they may end up in a different market than we
2 think that they should be. And if that's the case, we
3 should think about why that happened. Was there a
4 regulatory issue? Was there a benefit design issue, or was
5 something else that was not being met that we didn't know
6 that moved this population into a different market? Sort
7 of, what is the emergent order from sort of the chaos of
8 life?

9 And so my research team and I have actually spent
10 a lot of time thinking about the arc of the dual eligible,
11 which is why this chapter was fun. As a Game of Thrones
12 fan, I joke that duals are sort of the many-faced god, and
13 here's the example that I think of. And this could be a
14 potential arc for a dual eligible. If they're independent
15 and dwelling in the community and have some conditions,
16 maybe they're in a FIDE SNP.

17 As the sort of clinical wheels start to come off
18 the bus and more care is needed, more care at home, more
19 care integration, maybe they end up in the PACE program,
20 and if the PACE program is unable to preserve them living
21 in the community, maybe they end up in an I-SNP, right?
22 And that dual eligible has then gone from a D-SNP to a PACE

1 program to an I-SNP, and that could be a potential
2 progression. And perhaps if they have a singular chronic
3 disease that's dominant, perhaps they end up in a C-SNP.

4 So I would encourage us to think about the duals
5 as the population of populations and think about how that
6 population moves over time throughout their care arc and
7 their life arc and think about that.

8 I'd note, you know, the Senate has done a lot of
9 work on D-SNPs. So I think our work here is particularly
10 salient. And they have pushed all of us to think
11 differently about this population, and so I'm super
12 supportive of this work and also very grateful to my
13 research colleagues.

14 Thank you.

15 MS. KELLEY: Tamara.

16 DR. KONETZKA: Okay. A couple of brief comments.

17 One, to me, in this chapter, there's a lot going
18 on. I mean, a lot of comparisons you do, but selection
19 issues or potential selection issues are obviously huge.
20 So I don't think you're probably going to turn to some kind
21 of causal model, but one thing that I would find very
22 helpful is if you had a comparison, just a basic

1 descriptive comparison, what I think of as like a table one
2 in a paper, of the characteristics of people who are
3 enrolled in these different plan types, right? Because
4 then one can see sort of immediately, are there sort of
5 obvious differences in the characteristics of the
6 population? So that would really help in interpreting
7 which ones of those comparisons are potentially valid and
8 which ones are probably just about selection.

9 That may also help to sort of triage some of
10 those results a little bit more, which I think you did well
11 to the extent you could, but there's still sort of a ton of
12 comparisons.

13 My second suggestion is, you know, I find what we
14 really don't know enough about is what beneficiaries are
15 getting out of these different plans. I mean, I think in
16 the abstract, we think more coordination and integration is
17 the goal, right, is what we all want, but beneficiaries
18 aren't always signing up for these. And we need to know
19 more about why, what they're looking for, and what they're
20 getting out of these.

21 I think two ways we could do that. One is some
22 of the literature that's out there, it's a kind of fast-

1 moving area, and so obviously we need to keep up with
2 what's going on in the literature as we always do.

3 Even some of the reviews that you cited, like the
4 Eric Roberts review, there's some studies in there that
5 weren't sort of drawn out in the chapter, but that show
6 that people in FIDE SNPs, for example, tend to use more
7 Medicaid home- and community-based services, right, and
8 that integration there, that greater level integration may
9 play a role.

10 And they also, in FIDE SNPs, tend to have delayed
11 nursing home entry, right? So that might all sort of hang
12 together. So we might be able to dig out a little bit more
13 interpretive information about some of the differences in
14 these plans, just in the literature that exists.

15 And then moving forward, whether it's for C-SNPs
16 or some of these other types of SNPs, if there's any room
17 in future iterations of this report to do some qualitative
18 work, to actually talk to consumers, since we might not
19 solve the sort of causal inference part of it, I think it
20 would be helpful to actually hear from consumers, their
21 views on the coordination issue and what they're getting
22 out of these, whether they're still valuing sort of extra

1 benefits versus the coordination aspect of it.

2 I think, to me, all of that sort of comes back to
3 the long-term care and using the Medicaid benefits in the
4 right way, because that's really the sort of guts of it.
5 The dual eligibles, I mean, what they get out of Medicaid
6 is the long-term services and supports. So I think the
7 more we can drill down on that and find out what's actually
8 of value to beneficiaries, that would be helpful.

9 Thanks.

10 MS. KELLEY: Scott.

11 DR. SARRAN: Three brief points.

12 First, I'm not surprised that we haven't seen
13 strong correlation between the degree of integration and
14 broad -- underline broad -- measures of quality and
15 utilization. And, Eric, you went through some of the
16 reasons for that.

17 It doesn't mean, though, that there isn't either
18 current or certainly potential future value via
19 integration. That's a whole absence of evidence. It is
20 not evidence of absence sort of thing. But it's more a
21 reminder that integration of enrollment and benefit
22 processes are not -- or is not the only and may not be the

1 strongest way to create value for these challenged
2 populations, underlying populations, plural, because I want
3 to give a plus-one to Brian and Tamara about the importance
4 of heterogeneity among duals.

5 One of the best examples I can think of is the
6 distinction between trying to, as a plan, service the need
7 and improve outcomes for someone who is a dual, because
8 they're disabled due to their serious mental illness versus
9 a very highly educated, high health literacy, relatively
10 healthy, low-income senior living in their own house or
11 apartment. Two completely, completely different sets of
12 needs, right?

13 Second, I'm less concerned about the dual versus
14 lookalike issue. I'm just more concerned in getting the
15 results and holding plans accountable for the results than
16 how they get there. So again, I'm just not as concerned
17 that that's something that requires a lot of attention.

18 Third, the C-SNP. Just a reminder, C-SNPs, for
19 them to really deliver on the overall intent of the C-SNP
20 program, the population needs to be fairly finite. So this
21 idea you can do D-SNP around cardiovascular disease broadly
22 defined and then label everyone over the age of 65 with

1 cardiovascular disease because they have either
2 hypertension or hyperlipidemia, it's just absurd. It
3 defeats the whole purpose.

4 C-SNP, the population needs to be finite, and the
5 population definition needs to be an organizing principle
6 for the plan. Again, just to reiterate a little bit of
7 what we discussed previously, an organized principle for
8 the plan around model of care, around network approach,
9 around benefits, and around care management.

10 So again, I'm less concerned about whether these
11 populations are served by an MA plan, a C-SNP, a dual, but
12 on the C-SNP, in particular, let's try to make sure we are
13 doing everything we can to remind and reinforce the
14 original intent and organizing principles around the C-SNP
15 program.

16 Thanks.

17 MS. KELLEY: Lynn.

18 MS. BARR: Thank you, Eric, for this excellent
19 work.

20 You know, it's my fifth year in MedPAC, and I
21 think more and more about incentives every year and how are
22 the incentives driving the behavior.

1 I thought it was really interesting that you made
2 the comment about without aligned enrollment, the
3 utilization measures were best. I think about we have a
4 whole industry that's emerged in the last 10 years that are
5 working for the Medicaid managed care plans that are
6 managing the Medicaid patients to maximize their Medicaid
7 payments, right? So they're working on HCC, and they're
8 working on the quality measures that get them paid the
9 most, right?

10 So I'm wondering, like, by having an MA plan
11 that's like doing this to them for their payments and
12 you've got an MA Medicaid plan that's working on them to
13 maximize their payments, the result is we see better
14 outcomes in utilization, because there's just more effort.
15 I don't know how that feels as a beneficiary, because
16 you're getting called by two different companies that are
17 now managing your adherence to medication, et cetera. So I
18 just think it's interesting.

19 If you start looking at -- you know, if there's a
20 way to tease out sort of the correlation of work that's
21 being done that they get paid for versus work they're not
22 getting paid for, you know, by the plans that are not as

1 lucrative, is there a pattern there that helps us better
2 understand something that really doesn't make sense? Or
3 maybe it's better not to be integrated, because you've got
4 the two care coordinators, but how does that affect the CAB
5 scores and the satisfaction of the beneficiary?

6 So there's something to unpack there that I don't
7 really understand, but I sense an incentive, a financial
8 incentive that underlies that makes me a little nervous.

9 I'm concerned about the cherry-picking of
10 beneficiaries. For ACOs, provider-based health plans, et
11 cetera, everyone wants to take away the beneficiaries that
12 have the greatest opportunity, right? So who's left?
13 Right? Who's left in the ACOs? Who's left for -- because
14 those were the same patients we would focus on, because
15 that's where your highest costs are. So we'd focus on the
16 duals, and we'd focus on the chronically ill. And I'm
17 worried about how does the ecosystem work when the only
18 people left in fee-for-service ACOs are healthy patients.
19 How are you going to get meaningful returns on that? So I
20 think that's just something to think about from a policy
21 perspective.

22 Thank you very much for this excellent work. I

1 learn so much from you guys all the time, and it's a real
2 pleasure to be a Commissioner. Thank you.

3 MS. KELLEY: Gina.

4 MS. UPCHURCH: Thanks again, Eric, for this great
5 work. I would argue that one of the reasons there are a
6 lot of look-alikes is not necessarily intentional but is
7 they shift coordinating site for, in Durham, North
8 Carolina, brokers and agents are just people trying to help
9 others or beneficiaries themselves going on the Plan
10 Finder. It's not really clear. The Plan Finder now says,
11 sometimes, the state is paying your Part B premium. So
12 when you go on the Plan Finder you can find that, and
13 you're like, "Oh, good. They have some level of MQB." But
14 you don't know what level they have, or they have full
15 Medicaid.

16 So I think what a lot of brokers and agents do,
17 they're like if that's not there and the person doesn't
18 know, or you're not even able to -- you're just going to
19 put them in a plan that's not exclusive to that group,
20 because you're not sure if they have it.

21 So I think what would be super helpful is the
22 Plan Finder could actually say, instead of the state's just

1 paying your Part B premium, what level of Medicaid the
2 person has. It seems they should know that, and it could
3 really help us steer people to the right plans, because we
4 know what level of MQB or full Medicaid, partial Medicaid,
5 they have.

6 Also, the plans need to make super clear on the
7 Plan Finder tool, the details, and very bold and clear.
8 Only if you have MQB-Q and full benefit Medicaid, not MQB-
9 E. You know, this needs to be super clear with the Plan
10 Finder tool, so we cannot waste our time. I mean, these
11 appointments take 45 minutes to an hour easily, easily, and
12 if you're putting them in a plan that doesn't even work for
13 them or is not the best benefit for them, it would be super
14 helpful if the Plan Finder would help direct that for us.

15 And lastly, I just need to say that I agree with
16 Tamara that talking to the beneficiaries and family members
17 of people that are in these plans could be very insightful.
18 And I also just add the state Medicaid programs and the
19 care coordinators with the state Medicaid programs probably
20 have some keen insights too.

21 Thanks again for this great work.

22 MS. KELLEY: Cheryl.

1 DR. DAMBERG: Thanks, Eric, for the great work.
2 I'm going to plus-two on Tamara, so one on her comment on
3 the selection issues and trying to better understand the
4 differences in the subgroups and each of these plan types.
5 The other plus-one was on doing some qualitative work in
6 this space. I think that could be really informative.

7 The other thing for future work is I noted this
8 comment about interest in comparing to fee-for-service.
9 And there is a path forward in doing this for the MCAHPS
10 data. There are folks who have been involved in running
11 CAHPS, MCAHPS. They have done this. They have a
12 methodology. So you might want to reach out to them.
13 There is a bunch of published literature, and I can point
14 you in that direction. So just a comment there.

15 And then there was one really minor comment about
16 wording use on page 29. You talk about the CAHPS score and
17 clustering, and it talks about clustering is one of the
18 weaknesses of the Medicare star ratings. I might replace
19 the term "clustering." So CAHPS, in the computation of
20 Medicare star ratings, is not done through clustering, but
21 I don't think that's what you mean here. I think you just
22 mean that there are minimal differences.

1 MS. KELLEY: Robert.

2 DR. CHERRY: Yeah, great report. I'll be brief,
3 in the interest of time, and focus my comments on a
4 methodology suggestion, specifically it concerns Table
5 15.5. You already commented on that, is that the scores
6 there are probably not granular or differentiating enough
7 to be helpful in terms of making informed decisions around
8 what's better for a particular beneficiary.

9 I think what's intriguing, though, even if you
10 kind of look at it for what it is, the coordination-only
11 members seem to put a premium on their primary physician,
12 their specialist, prescription drugs, but getting the care
13 that they need or getting that care quickly is not as
14 important to them. Whether that's an accurate statement or
15 not, I'm not quite sure. You probably also would agree,
16 just because the scores are relatively compressed.

17 So I do have one suggestion maybe of kind of
18 adjusting in a way that allows for conclusions to be drawn.
19 One thing is kind of looking at the turnover of the plans.
20 And I know between enrollment periods, switching plans is
21 difficult, and you've highlighted that in the pre-read
22 materials. But perhaps during the open enrollment period

1 that could be tracks. Let's suppose, for those
2 coordination-only members, that they do have the best
3 overall score. You would think, intuitively, then they
4 would probably have a lower rate of switching plans during
5 the open enrollment plan, so that could help validate that.
6 But what if we find out they're average or they switch
7 plans fairly often? Then it means we need to pay more
8 attention to that metric around getting the care that they
9 need and getting it quickly becomes more important, because
10 they're willing to switch plan, perhaps, to get that
11 service.

12 So maybe by looking at enrollment turnover that
13 may be a way of creating some sort of adjustment to the
14 scores that could also help all of us in terms of
15 interpreting the information.

16 Otherwise, thank you. It's a great report.

17 MS. KELLEY: I think that all we have for Round
18 2.

19 DR. CHERNEW: Because everyone here is perfect.
20 I'm about to cry.

21 [Laughter.]

22 DR. CHERNEW: Eric, thank you. This was a

1 shorter session, but I think it isn't meant to mask how
2 much interest there is in this work. I think it's really
3 important and will lay the groundwork for a lot of stuff we
4 plan to do going forward. So thank to you.

5 Before I forget, those of you at home who want to
6 comment, please reach out to us at
7 meetingcomments@medpac.gov. We do like to hear from you.
8 Thanks to all the Commissioners for their really terrific
9 discussion. I will say, in my remaining 30 seconds, one
10 comment.

11 The challenge here, as was pointed out, is
12 there's a lot of heterogeneity, and we want to allow
13 flexibility for different people to do things, but we worry
14 a lot about the selection. And I think one of the core
15 questions is, do you allow that flexibility to occur within
16 the same program, so we have a standard MA plan that's just
17 more flexible, or do we create these different types of
18 program with different rules, which creates a lot of
19 challenges for how we do things? And when there is
20 selection potential, it's really hard to figure out how to
21 do that. I won't jump to any conclusions about what the
22 right answer is, but I think you all nailed the exact

1 issue.

2 So again, thank you all very much. I appreciate
3 everyone coming. It's great, great, great to see you
4 again. And we will be back in March. To the staff, thank
5 you. To those of you who joined us at home, thank you.
6 And travel safe.

7 [Whereupon, at 11:55 a.m., the meeting was
8 adjourned.]

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