MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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International Trade Center
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Washington, D.C. 20004

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10:33 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:33 a.m.]

DR. CHERNEW: I believe we are back, and we are live. Dana, is that right? That is right.

So as I promised, for those of you that heard me, we are expecting a very exciting MedPAC cycle, and true to form, we started in an exciting way. We are now going to continue our discussion of Medicare payment operations.

DR. FEINBERG: I am going to start with the roadmap, if that is okay, because --

DR. CHERNEW: I do want you to start there, except we have the slide that I see is the technical difficulty slide.

DR. FEINBERG: It will come.

[Pause.]

DR. CHERNEW: Are we ready?

DR. FEINBERG: I am going to start with the roadmap. In this presentation, we will describe improper payments, CMS's efforts to ensure proper payments in fee-for-service Medicare, CMS efforts to ensure proper payments in Medicare Advantage and Part D Medicare, and MedPAC's work to improve payment accuracy and the value of

Medicare's payments. The Commissioners will discuss this presentation at the end.

I will describe the meaning of improper payments. Improper payments include overpayments, underpayments, payments for an ineligible recipient, payments for ineligible services or items, duplicate payments, and payments lacking sufficient documentation to determine their appropriateness. I want to emphasize that these payments are not necessarily due to fraud, which is the intentional deception or misrepresentation of facts to receive unauthorized benefits or payments.

This segment will cover fee-for-service Medicare payment mechanisms. Medicare administrative contractors, or MACs, as they are called, enroll providers and process claims. They also perform prior authorization and pre-claims approval in certain circumstances. Medicare uses other contractors to perform post-payment reviews.

The magnitude of improper payments in fee-for-service Medicare reported in fiscal year 2024 was $32 billion. This represents 7.7 percent of Medicare fee-for-service payments, down from a high of 12.7 percent in fiscal year 2012.

MACs enroll and educate providers, process Part A and Part B claims. They audit cost reports, develop local coverage decisions, and perform the first level of appeals. Twelve MACs process claims in a geographic-specific area. Four separate DME-MACs process claims for durable medical equipment, prosthetics, orthotics, and supplies, called the DMEPOS, but which I will refer to as DME in this presentation.

In fiscal year 2023, CMS reported that MACs processed over 1.1 billion fee-for-service claims, totaling payments of $431.5 billion. Before a provider can send a claim to Medicare, the provider must enroll using the provider enrollment chain and ownership system, referred to as PECOS.

First, all providers must obtain a National Provider Identification, or NPI, and fill out an application. For physicians and non-DME suppliers, the MAC approves the application, and the provider can submit claims. DME suppliers must obtain accreditation before applying. Once the supplier is approved, they must post a surety bond before submitting claims.

For facilities, the facility must be licensed and

either inspected by the state survey agency or by one of the accreditation organizations to assure that it complies with the Medicare conditions of participation. The MAC and CMS review this information before issuing a certification number, which is used on claims to identify the facility.

When facilities, practitioners, and other providers furnish an item or service, they submit an electronic claim to the MAC. MACs have three levels of automated review. The first level is called "front-end edits," which verify the beneficiary, the provider, and dates of service. The second level of review is called "implementation guide reviews," which include checks for duplicate claims. The third level of review includes specific edits, including the National Correct Coding Initiative edits, local edits, and edits for national and local coverage determinations when they apply.

Clean claims are required to be paid within 30 days of receipt by the MAC. The MAC may also perform additional targeted prepayment and post-payment reviews for specific providers or specific services.

MACs perform prior authorization for some outpatient procedures, for some DME, and for non-emergency

ambulance transports. For prior authorization review, a provider submits a request and receives a decision from the MAC before the services are rendered. MACs will also perform prior authorization in the new WISer model in which private contractors will use artificial intelligence and data analytics to identify services for review scheduled to start in January 2026.

MACs conduct some pre-claim reviews for home health agencies and inpatient rehab facilities in some states in a demonstration in which providers are given the option to have pre-claim review. For a pre-claim review, the provider sends a preliminary claim to the MAC for review and receives feedback from the MAC before formally submitting the claim. The service can be rendered before the pre-claim is submitted to the MAC.

Two other contractors perform post-pay reviews of fee-for-service claims. The five unified program integrity contractors, called UPICs, investigate suspicious claims referred by CMS and the MACs. The UPICs review medical documentation and conduct interviews and on-site visits. They have boots on the ground.

The five recovery audit contractors, called RACs,

do in-depth reviews of topics approved by CMS. RACs perform complex post-payment reviews and can require providers to send the RAC medical documentation. If an error is found, the claims are sent back to the MAC for adjustment of the over- or underpayment. RACs retain a portion of their recoveries as payment for their activities. Beneficiaries and providers have the opportunity to appeal denied claims, as described in the paper.

Now I will move on to discuss Medicare Advantage and Part D. CMS pays MA plans' capitated monthly amounts, which are risk-adjusted using demographic and diagnostic information for each beneficiary. The improper payment error rate for MA reported in fiscal year 2024 was estimated to be 5.6 percent or $19 billion in improper payments.

Improper payments assess whether diagnostic data used for payments are supported by a beneficiary's medical record. Risk-adjustment data validation audits, known as RADV audits, are going to recover improper payments. Improper payments in Medicare Advantage are conceptually different from the estimates of increased Medicare

Advantage coding intensity that MedPAC estimates.

CMS pays Part D plans through capitated monthly amounts and cost-based payments. The improper payment estimates assess the appropriateness of the prescription drug event data used for payments. The improper payment error rate reported in fiscal year 2024 was estimated to be 3.7 percent or $4 billion in improper payments, mainly due to missing documentation.

And now Andy will continue the presentation.

DR. JOHNSON: Now we're going to turn to MedPAC's work to improve payment accuracy and the value of Medicare's payments.

MedPAC's role is to provide recommendations and advice to improve the accuracy and value of Medicare's payments. Our work is not focused on identifying improper payments, but it can help reduce those payments. The work we are highlighting today falls into two categories, recommendations to align Medicare's payments with costs of efficient care in a payment system and the identification of other opportunities to improve efficiency.

MedPAC annually assesses the adequacy of Medicare's payments across seven fee-for-service payment

systems. This assessment considers beneficiaries' access to care, providers' quality of care, and how Medicare payments compare with providers' costs, among other factors.

Two recommendations that the Commission has made consistently over the past several years are that payments for post-acute care are high relative to costs and should be reduced. Second, ambulatory surgery centers should submit cost data to allow for payments to be aligned with the cost of efficient care.

In addition to MedPAC's regular assessment of fee-for-service payment adequacy, the Commission has identified several other opportunities to improve efficiency, including to increase bundling of similar drugs in the outpatient prospective payment system, to improve payment for non-emergency ambulance transports, to evaluate alternative approaches for addressing potentially low-value care, to evaluate the rapid growth in Medicare spending on skin substitutes to determine whether payment reforms are needed, and to expand competitive bidding.

On the next two slides, I'll talk more about our work to better align payment across ambulatory care

settings and to improve the validity of MA encounter data and the diagnoses submitted for risk adjustment.

MedPAC has discussed aligning payment across ambulatory settings since 2014. In 2023, the Commission recommended that Medicare move toward more site-neutral payments for ambulatory services when doing so does not pose a risk to beneficiaries' access to care.

MedPAC's analysis identified 57 ambulatory payment classifications, or APCs, where freestanding offices had the highest volume of services. In these APCs, the outpatient payment system rates could be more closely aligned to the physician fee schedule rates. In nine APCs where ambulatory surgical centers had the highest volume of cases, outpatient payment system rates could be more closely aligned to ambulatory surgical center rates.

Statute requires that adjustments to the outpatient prospective payment system are budget neutral. so lowering payment to certain APCs could lead to an increase in payment for unchanged APCs.

The GAO has conducted work in this area and has recommended site-neutral payments for evaluation and management services across settings.

In MA, MedPAC has published several reports about the incompleteness of MA encounter data. Our most recent analysis published in June 2024 found that despite recent improvements, incomplete MA encounter data continues to be an issue.

In addition, higher coding intensity continues to contribute to higher MA payments. For the past several years, we have estimated the effects of increased coding intensity on MA risk scores, and the Commission has a long-standing recommendation that the Secretary fully address the effects of coding intensity.

The GAO has recommended steps aimed at improving the completeness and validation of MA encounter data, and has also recommended improvements to the verification of diagnosis codes used to determine payments to MA plans.

That concludes our presentation. We welcome any questions and feedback you might have on the materials presented today and on potential future analytic work. Now I'll turn it back to Mike.

DR. CHERNEW: Thank you all so much, and thanks, folks at home, for your patience. I'm looking forward to everybody's comments. For time reasons, we're going to do

one round of comments, and I think we're going to kick that off with Lynn. And then, Dana, you're going to manage.

MS. BARR: Thank you. Thank you so much for this work.

I have a question about the interaction between the MACs and the MedSup payments, and so we submit the claims to the MACs, right? How do the MACs and whoever makes the MedSup, the co-insurance payments interact?

DR. FEINBERG: The MACs pay what Medicare owns -- owes. The doctor can bill the patient for the copayment, I believe.

MS. BARR: Well, it goes directly to this supplemental. Anyway, the reason I bring the --

DR. JOHNSON: The plans --

MS. BARR: Go on.

DR. JOHNSON: The plans can enroll in a coordination of benefits in which they send a list of beneficiaries to CMS, and then they will forward the co-insurance amounts, the bill to the insurer who can pay their share of the cost sharing.

MS. BARR: Got it.

I bring this up because we were told about fraud

at the last session or one of the last sessions, where there was $11 billion in DME fraud, and that the MACs did not pay the $10 billion, but the MedSup plans paid the billion. So I'm thinking I'm a foreign actor. I'm like I'll just get a billion. I'm good. You know, I don't even have to worry about it. And I'm wondering if there's something to think about there. Like, why are we paying co-insurance if the MAC isn't paying the claim? That's my question.

DR. FEINBERG: And I don't think I can answer that right now.

MS. KELLEY: Tamara?

DR. KONETZKA: Hi. Thanks for this great chapter.

Three very quick points, mostly questions. First one, I found this just a dizzying array of organizations and levels of payment and review. And so if it does become a chapter, it would be really helpful to have a kind of flow chart, like the life of a claim, what might it be subjected to, you know, prior to the claim until it's actually paid and even post-payment review.

Then two questions. One, along the same lines,

you know, I think that having all of these different levels of review and then even at the same level of review, having different regions cover different parts of the country, I assume that some of that is just historical artifact. But are there concerns and are there attempts to sort of deal with potential inconsistency? Do we know that these different regional organizations sort of describe an improper payment in the same way, and are there systems in place to try to prevent that?

And let me go ahead and ask you my other question, which is, I was really struck on page 19 when you're talking about some of the sort of experiments and pre-claim and pre-payment review, and on page 19, you talk about the experiment with IRFs in Pennsylvania and Alabama. And the conclusion here was that from 2023 to 2024, Medicare reported a 20 percent decrease in payments to IRFs in these two states, which seems huge. I mean, that seems really dramatic to me. So my question there is, what do we know about those decreases in payments? You know, given the context of sort of rapidly expanding freestanding for-profit IRFs, is it certain IRFs that are responsible for that 20 percent decrease in payment, or is it certain

diagnosis categories, et cetera? Like, how much information do we have to dig into that, which may inform the broader context of IRF payment?

Thanks.

DR. FEINBERG: So briefly, there is -- at the CMS level, they do get the MAC contractors together to discuss things. But there is not, I believe, a requirement that they all follow the same coverage, and that dates back from the beginning of the program when they thought that they needed to allow for regional variation in medical care, you know, to the extent that that is not written about, but, you know, I know that these meetings occur.

On the type of IRFs, I don't know what the -- what that demo has done. I haven't seen results of it. But I can tell you that the results of the CERT investigations, which look at improper payments for IRFs, it's pretty much the only setting where medical necessity problems are the reasons for improper payments.

MS. RAY: Yeah. I just want to emphasize, over the years, in more recent years, there's been greater emphasis for the MACs to have consistent local coverage determinations.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you very much for this chapter. I certainly learned a lot.

I have a handful of questions, and I know we're time-short here. But I was kind of curious, as we think about these improper payments, are there certain providers within each of the care settings who disproportionately represent the majority of improper payments? So is there like an 80-20 rule? And so, like, CMS could target its activities in terms of education and enforcement?

DR. FEINBERG: That information was not available on CMS's website. My guess is the Center for Program Integrity does know some of that information, but it is not -- it doesn't broadcast it.

DR. DAMBERG: Okay. And I guess relatedly, if I'm remembering this correctly, there was a sentence that said SNFs account for the largest amount of improper payments, and I was kind of curious why that might be the case.

DR. FEINBERG: That was quoted directly from the CMS website. My guess is there was something in the payment systems that when they checked and they didn't

verify that the claim was submitted correctly. But I do not have any additional information.

DR. DAMBERG: Okay. And then I was also noting that a very small fraction of these improper cases are appealed, and again, I was trying to figure out, like, why that's the case.

DR. FEINBERG: That, I do not know. But those are the data that are on the CMS website.

DR. DAMBERG: Okay. And then lastly, there was a sentence that said the results of the RADV audits of MA contracts are mostly unreported. Again, do we know why that's the case?

DR. JOHNSON: So far, the RADV audits have been pretty slow to get going. Now, that's changed in the last year. So I think the progress on those first couple years of the RADV audits has just been slow, and the reporting has been slow. So I think we're seeing a change now in the information available about the audits that are currently going on or currently being initiated for 2018 and 2019, but the older years were just on a slower time frame.

DR. DAMBERG: But eventually, that information will be publicly available?

DR. JOHNSON: We think some information will be available. So far, the reporting that has been made available is just at a contract level. What is the total overpayment amount?

DR. DAMBERG: Yeah.

DR. JOHNSON: So we may not have information about information like the number of beneficiaries in the audit sample, the number of HCCs audited, and the share of them that were supported or not supported. But we'll have to see if that changes in the new set of -- this new effort to stand up the RADV audits.

DR. DAMBERG: Great. Thanks. And I just want to plus-one on Tamara's comment about the flowchart.

MS. KELLEY: Greg.

MR. POULSEN: Thanks. Very informative, and I appreciate the information. I think it was terrific.

I'd like to step back a little bit from the enforcement and recovery parts to basically remind us that complexity provides the fuel for payment inaccuracy, whether it's fraudulent or unintentional. And we often -- even we MedPAC, but certainly the federal government often participates in creating greater complexity with the

thought that it may increase in some way equity or some other noble virtue. And it often ends up achieving just the opposite of what its intent is by adding more and more details to make sure that we are providing some service more and more in keeping with what we would like to achieve, and it often goes just the opposite direction.

I'd like to just give a couple of examples, although the examples are so numerous that we could spend the whole day talking about them, but we don't want to do that.

Let me just talk about two. One started clear back in 1983 when we introduced DRGs, and that was the idea of paying the lesser of billed charges or the DRG. And so what happened over the next little while? Well, people went from having -- hospitals, in this case, went from charging a reasonable markup, 30 percent over cost, to charging a completely ridiculous markup so that they would never get caught paying the lesser of billed charges.

And I found an example of a hospital that has an average markup of 900 percent over cost on their billed charges, and although that one may be extreme, probably the average is still in the hundreds of percent higher than the

average.

And if you look at any EOB from an insurance organization, what you see is here's the billed charge, here's what we're going to pay, which is 80 percent less than that. And there's no argument because the numbers were silly to begin with.

So we've kind of done that to ourselves with what ended up being, with good intent, a payment mechanism that was intended to make sure that the federal government didn't pay more than was necessary, and it ended up messing up the payment structure, not only for the federal government, for everybody else as well. So that's one.

I would argue that the more pernicious and more painful one that we're facing today is the complexity that goes into the risk adjustment in MA, and that it's virtually impossible to -- even with V. 28, which I think is a terrific step in the right direction, it's still so easy to play games with. And the rewards for doing so are so massive that we see enormous variation with two different organizations that are treating essentially comparable populations, and yet one is being -- is claiming that their risks are 40 to 50 percent higher than the

other. And we see that. The MedPAC analysis has shown that repeatedly.

So again, anytime we add complexity, we add the opportunity for errors, either inadvertent errors or intentional errors, and so I'd just like to make that point. And you brought that out in the chapter to a degree, but I think it could be even more clear. Thanks so much.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you guys very much for this work.

I also feel like a lot of this work are entities that I know about but hadn't really read about in this way. So I think this is a very valuable chapter.

Tamara hit the nail on the head with the flow chart of how these groups relate and possibly, like, how are they compensated, because I think one of the more interesting parts from this is how we pay some of the entities. Like the RACs, I think you mentioned, get paid a percentage of recovered dollars.

So, you know, like, in the pharmacy world, we see all the interrelated companies in the chain, and I think

seeing a clear documentation of who does what and when we think about trying to recover any of these funds or deal with over- or underpayments or fraud, what are those entities, and where do they come into the process?

You know, the other thing that that just reminded me of is, maybe going to Greg's point, about, like, adding complication or adding even more actors into this chain is something like the WISer model that you guys do a good job of covering in the chapter.

My understanding is that would be, you know, external companies working to basically get paid based on denied care and what we believe is mostly low-value care. But you could imagine ways in which fraud could pop up where you had more people getting prescriptions or getting orders for that care that then gets denied and enriches a group rather than just having kind of their normal flow of claims coming through that then get denied.

So I think having that description of who all these groups are, how do they get paid, and how are they engaged would be incredibly helpful for people thinking through the way we can manage overpayments, underpayments, and also kind of a nod to the keeping good access to care

for beneficiaries, which I know is not directly part of this but very much mission driven.

MS. KELLEY: Brian.

DR. MILLER: Two technical comments and then some thoughts.

Technical comment number one. We also need another flowchart on the provider enrollment process. I spent all summer reading about fee-for-service administrative operations. So it's familiar to me but it's probably not going to be familiar to most of our readers.

I also wanted to point out that our MA coding intensity comment on page 34 isn't accurate, because we note that all differential payment is improper payment, and we fail to consider that some of it is due to differential coding incentives.

Okay. Broader thoughts, sort of three comments. One is fighting fraud, waste, and abuse in fee-for-service, and I would frame that as a focus on solutions through efficient and effective prior authorization. No one likes prior authorization whether you're a patient, doctor, or hospital. No one enjoys it. I don't enjoy it. I've been prior-authed in all settings. It's not fun.

So we had some stats in there which I think were helpful which I want to highlight. We said 10 percent of claims are denied. Forty-five percent are favorably reviewed at the first level of appeal, and at the second level of appeal 30 to 50 percent are favorable depending upon what type of claim it is. That was on pages 14 and 15.

I wanted to say that's really actually not that much different than the private sector, and I also think it's interesting that those numbers, especially at the appeal level, are worse than MA. So it means that the fee-for-service prior auth when they do it is much harsher. There's less of it, but it's harsher. So it's just spinning the dials differently on the nuclear power plant, right? Like, the Far Side cartoon.

So I think that limited prior authorization use in fee-for-service Medicare has been remarkably effective at addressing things that most clinicians know are probably overused: facet joint injections, power wheelchairs, knee orthoses, and other items and services. The WISer model by no means is perfect, but I think that expanding efficient and effective prior auth in fee-for-service is something

that we need to do. We can quibble about -- and we should quibble about the details of the WISer, model but we should be happy that someone was willing to step on the electric third rail of the Metro and say I'm going to put in more prior auth and fee-for-service and try and target it better. So I think in general we should be supportive of that sort of ethos of making it efficient and effective can -- can and should argue about the details, but that someone actually has the political willpower to do this, I think is something that we should be proud of, right? Because it's not easy to do. The little bits that have been added over the past 20, 30 years always evoke cries of outrage, understandably.

I wanted to also note that the IRF review choice demonstration might be a prelude to a Gold Card program which is something that many states and members of committees of jurisdiction have talked about.

I will note that an initial 100 percent claim review is probably a little bit unfairly burdensome if we review 100 percent of claims for anyone's business. Whether it's a doctor, an LTCH, a SNF, that's probably sort of burdensome, and we shouldn't be really thinking that

way. But that as a prelude to Gold Card fee-for-service, if we have more prior auth, I think that's a good thing that we should think about.

I want to say fighting fraud, waste, and abuse in Medicare Advantage, the RADV diagnosis coding, it's good that we have RADV audits. I think we actually need to promote automation of diagnosis coding at the point of care with the oversight of the clinician. It really shouldn't matter whether you're in fee-for-service or MA. Like, you either have the -- for not all diseases, but many diseases you either have the disease or you don't. You have the complication, or you don't. You're at CKD 3b, or you're at 3a. Those are sort of binary things.

And so that should be something that's part of routine clinical care that ensures that patients are completely and accurately coded at the point of care. You don't want doctors and nurse practitioners and physician assistants spending their time doing that or driving to your house to ask you about diseases. That's not a good use of anyone's time. So we should make that sort of an automated operational process with the oversight of the clinician at the point of care.

That's a solution that technically could be done today and would also address a lot of our concerns about coding intensity, because it would mean that people are more accurately coded, because a lot of coding is good clinical communication. And I can tell you as someone who practices in a hospital, like, documentation -- this is not to disparage myself or my colleagues. Documentation is terrible because it takes a lot of time, and you want to spend your time with the patient. So things like ambient AI, voice dictation, that will help that, but automating that diagnosis coding would make it a lot easier, because a lot of clinicians aren't going to know GFR cutoffs for chronic kidney disease. Like, you know, the nephrologist might and some of your internists might, but there's no need for the surgeon to know that.

And so making that process seamless and efficient so we have that good clinical communication will make the diagnosis coding in MA better. It will also make coding and billing, frankly, in fee-for-service for DRG-based payment a lot better.

And I think we actually want to keep diagnosis-based risk adjustment. We just want to make it more

efficient and effective and not have it be a burden on doctors and hospitals and, frankly, health plans too.

If we move towards a demographic system, I mean there's a lot of research that CMS did 15, 20 years ago which shows that demographic risk adjustment just doesn't work in the Medicare market, and there's a lot of work from ASPE showing that there's a lot of combinatorial disease complexity in the Medicare population which is different from the commercial population. So I think we want to keep disease-based risk adjustment or, you know, the categories, make that process more efficient and effective and less burdensome on providers of all types, including payers, and then that would ensure accuracy and also empower good auditing.

So then I also wanted to make one more set of comments and apologies for talking so much. I read a lot about the MACs this summer because I was super excited, and so I read a bajillion GAO reports on the MACs, and it was really interesting. And if we actually look at the MACs -- and there's a lot of positive potential here for improving fee-for-service Medicare -- the MACs right now are actually provider-focused program. So fee-for-service Medicare is

provider-focused. We should be beneficiary-focused. It's not that providers don't matter, but ideally, you know, the whole point of the Medicare program is to serve beneficiaries, not just to pay people. Like, people do need to get paid, and they need to get paid in a timely fashion.

And we have lots of problems with fraud, waste, and abuse in fee-for-service Medicare. Could we push more of those fraud, waste, and abuse functions back to the local, regional level with the MACs, recognizing that some variation in the practice of medicine is good and some is bad, and that some of that variation across the country is okay? And you don't necessarily need CMS deciding that. You need the MAC, which has the relationship and understands the area.

And then what you could do is you could use those fraud, waste, and abuse savings in the region to do something like, say, reduce Part B premiums for beneficiaries in fee-for-service, because fee-for-service has become very expensive for beneficiaries.

We've also focused on other areas like the star quality ratings program and MA, where we've noted it's a

handout to the plans to some degree. Well, why don't we get a fee-for-service star rating program in the MAC regions, and MACs could manage that. And then you could have a star quality rating for fee-for-service and MA, and it could be two-sided risk. And the MACs are a natural vehicle for that.

Where also a lot of us have expressed concerns about the Plan Finder and provider directories, right, that could be another function that MACs do.

So I think that there's a lot of -- and this might not necessarily be in this chapter, but there are a lot of things that we could think about for improving MAC functions and allowing MACs to be a competitive marketplace, because one of the concerns that longstanding CMS concern has been, when you switch a MAC contract, you break -- you're at the risk of breaking fee-for-service Medicare, because if you have one MAC in the region paying billions of dollars in claims and you switch to a different business operator for a vendor, you're putting at risk accurate and timely payment for fee-for-service Medicare.

And so having multiple MACs operate in a region and compete could actually increase not just the efficiency

of the program but also the effectiveness and sort of the core operational risk of having fee-for-service contractors.

So I think there's a lot of positive opportunity to give MACs additional tools and make it a more innovative and competitive marketplace that will better serve beneficiaries.

Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks so much for this chapter. It was very informative. I do agree that we need the flow chart of all the players involved and how the money flows and what people are incentivized to do or not do. And I totally want to plus-one to Greg's comment about simplifying. I have trouble with these regional differences. I shouldn't live in Kansas and get something different than I do in North Carolina if I have Medicare. I just think that's wrong. It's a federal program. Yeah, so I think less complexity, less variation will lead to less fraud, waste, and abuse.

Many of you may not know this but I am a patrolman. I am a senior Medicare patrolwoman. I'm with

the SHIP program, and we are trained to be SMP. So the main point I want to make here, yes, we need to simplify the system. We need to engage consumers better, and it's really hard when the EOBs, the SOBs, Summary of Benefits are so complex.

As an example, somebody goes to the hospital, rehab, comes home and gets home health. You get many of these documents from CMS saying, "This was the A benefits that you received," a separate document, and "Here are the B benefits," different dates, different time frame. Oh, here's your DME on another statement. Too much. It's too much. There are lot of words. A lot of them don't make sense to people. We try to help people. We try to engage people to report fraud, waste, and abuse, or what they didn't receive.

As an example, me being the wonderful daughter that I am, my father recently got something, and it was from Palmetto Oxygen. I thought, I've got them, fraud, waste, and abuse. It was for his wheelchair. The name of the company was Palmetto Oxygen.

So it just needs to be super clear what it was for. This is company that's called Oxygen but they

actually delivered a wheelchair to your father, and that is true, but I had, meanwhile, spent a lot of time arguing with BlueCross BlueShield that they shouldn't have paid that for that event.

So we need to make it much clearer to consumers with these documents. For CMS to do that would make a huge difference for people. And in some ways, I think we need to consolidate how the government communicates with consumers. So all of those different A, B, Summary of Benefits, put it in one. Make it timely so that people can remember if they received those things. Don't have it dragged out so long. But we need to consolidate that information and make it in more plain English for people.

In particular, I think we have learned that you need to pay attention to people, or family, or claims after someone dies. A lot of people take advantage of that. As an example here, after someone died, you ordered a bunch of COVID tests, fake companies, and we know this, with the catheters. We know this with the skin types. But just pay attention. I think we need to pay attention to deceased people and how that get abused by fraud, waste, and abuse.

When we help people with Medicare and making

Medicare decisions we tell them, "Social Security will never email you unless you ask them something first." That's no longer the case. So now CMS and Social Security seem to be sending emails to people, and I think it's a recipe for a lot of fraud, waste, and abuse to begin. Because I can no longer tell people, "Unless you tried to contact them first, they should not email you." That's no longer the case.

And last, and this is a question, do we know how all of this -- if I'm a company or if I'm a Medicare Advantage plan, that they look at fraud, waste, and abuse in what I'm doing, does that count in the medical loss ratio as administrative cost? How does that get counted? Is it CMS expenses, or does that get allocated to the people they're looking at as administrative cost?

DR. JOHNSON: I think we'll have to get back to you on that. There are some special rules about how costs get allocated in the medical loss ratio that we'll have to double-check.

MS. UPCHURCH: Right. So companies that do get audited a lot, that might be okay that it gets put on their administrative function, submitting clean claims or

whatever. Thank you.

MS. KELLEY: Lynn. Lynn?

MS. BARR: I'm sorry. I'm going to withdraw my comment. Thank you.

MS. KELLEY: Okay. Josh.

DR. LIAO: This is an important topic, and thank you. Thank you for this work. I'll just say that I would love to see this topic fleshed out in future work and maybe just layer on top of a few of my colleagues' comments with three things I'd love to see in that work.

The first, I guess I'll plus another plus-one, plus four or five for this issue of the flow chart. You've heard things about kind of where in the process, and in the media, pre-, post-payment. You've heard about where the money flows. I think two other things I'd love to see would be what processes are currently automated versus manual. Even if it may not have AI or machine learning there are things that are automated already, so understanding that would be helpful.

And then the second is there are certain things that are based on just what's on the claim, what’s attached to the UTN and discrete deals there, and then there are

processes that pull the health record, right. So I think a sense of which groups at which point look at which materials I think would be very useful, as well. That's the first.

The second is I underscore this point about MAC variation, and I think in prior MedPAC work we've highlighted how the predecessor to local coverage decision determinations, LMRPs, I think drive a lot of determinations outside of, you know, discrete payment systems. So I'd love to see that elevated and discussed. I appreciated your comments about how there are more efforts to standardize those. I don't quite have a great feel for where that is, but I think that is really salient to the points that other Commissioners have made. So I'd love to see that discussed, as well, in future work.

And then the third regarding this kind of WISer model, I think it aspires to something veery important in terms of reducing waste and protecting the program and taxpayers as well as patients from unnecessary care. You know, I was struck by what was on page 14 about how, you know, if you look at Part B in fee-for-service, 10 percent are initially denied, but then 45 to 50 percent of them are

favorably determined. I don't know what that represents, but it represents something about an improvement opportunity, because so many of them kind of receive favorable approval.

So I think the WISer model, to the extent that it focuses on automation, is very good. I do think as we go towards that, I'm not saying this would be the focus of the future material, but if and as material becomes available about that model, the concern might be from the kind of legacy human reviewers to kind of this black box technology. So I'd love to see if CMMI has this information, information about bias in the training data. To that point about variation in MACs, you can imagine if you trained those models on those data, variably across regions, you would lock those differences in, and I'm not sure that's actually appropriate or not. I'd love to see how they would like to handle that.

And then the second is, you know, how are we determining that these models are working if WISer gets scaled up in the future. Again, just based on information, but things like are they using AU-RUC, are they calibrating this a certain way, to create transparency so that we don't

say what we learned from this is a black box. So I think WISer elevates these issues of kind of MAC variation, but I would love to see information there. Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. I think you took a really complex topic and actually boiled it down succinctly in a way that really can be consumed, so thank you for that.

Two broad comments. One has to do with this whole issue around improper payments. You defined it well at the very beginning, discussed the oversight functions that are involved with improper payments. But then towards the end we introduced a new concept, you know, coding intensity. And I think they're kind of different in this context, because improper payments and the oversight function is a little bit different than how we think about coding intensity relative to how MA, for example, is able to generate sort of regional margin to reinvest in themselves, to say it politely.

While there's a Venn diagram between the two, I think the solutions for each are entirely different. So I think coding intensity needs to be discussed, I think,

separate from improper payments. That's my advice there.

The second area is that because of the complexity, this is overly, not only burdensome but very expensive. And I don't think anybody clearly knows exactly how much the government spends on all these different oversight functions in order to claw back as much as they can around an estimated $50 million. But it has to be pretty significant.

And there are two sides to this. There's what the government spends, but there's also what health systems spend on all of this. So we talk about the need for case management resources, that utilization management function to make sure that hospitals and providers stay out of trouble is really done by case management. So a lot of those resources are really eaten up there. And then when there are these audits that occur, it's case management, it's compliance, it's medical records that are really intensely involved in all this. And then there's a physician component, as well.

So again, the cost, when you look at it from the provide side as well as the governmental side, is unknown, but it's highly inefficient in terms of how it's

structured.

I do agree with Brian that probably a more efficient way of doing this is through a pre-claims review, prospectively, rather than trying to do this after the fact and having people jump through hoops. And it also would make it less burdensome for health systems to structure themselves if they know they're partnering with these oversight functions in a proactive way, prospectively, before a claim is dropped.

So those are my thoughts, but thank you for really, I think it's a good chapter in terms of really explaining the complexity of all this.

MS. KELLEY: Okay. I have a comment from Tom next. Tom says relative to higher-than-appropriate coding there are two issues. The first is the HCC codes to document population risk. This is addressed through the RADV audits. The second, however, is the CPT coding escalation, which appears to be significant. He doesn't see a CMS approach to addressing this version of upcoding.

The second issue is the site-neutral payment. In general, this makes sense. However, clinically there are times in which a patient should be managed in an HOPD at a

higher cost than in an ASC. This is dependent on both the condition of the patient and the risk of the procedure in the HOPD versus the ASC, and the capability of the local health care delivery system. Incentives are needed to move patients to ASCs, but higher cost HOPDs are necessary for some patients.

And I have Paul next.

DR. CASALE: Thanks again for the chapter. Just a couple of comments and a couple of comments of support. I also agree the flow sheet would be really helpful.

I just want to emphasize Robert's comments which I think are really important, about the costs to the system, both Medicare and then, importantly, to the physician, hospital, and health system, to ensure compliance. Understanding more about that I think would be really helpful.

On the prior authorization, certainly, as Josh pointed out, improving the process of prior authorization would be really helpful. I do have concerns around why is there, and the potential for a slippery slope around how that is expended.

A comment about gold carding. You know, at least

in the world of cardiology, on the commercial side we've been working with commercial payers for probably two decades on the idea of gold carding and centers of excellence. Although philosophically they are supportive, they never seem to be able to actually accept that, because again, prior authorization has been an important tool for them to manage utilization, whether appropriate or inappropriate.

And then my last comment around automating diagnosis coding, which again, AI, there's a lot of reasons where we could be much more efficient. But at least in my institution, our compliance office says no codes can go out without a physician reviewing them and agreeing to them. And for a lot of physicians, despite education, you don't always understand the rules around that and whether they can actually send those codes. So I think there is more work to be done around that. I think clearly trying to automate it makes sense. But at this point the physician really, at least in most places, I think the compliance is they need to have that oversight before they're sent out.

But thanks again for this chapter.

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

queue, unless I've missed anyone. Oh, I'm sorry, Scott. Go ahead.

DR. SARRAN: Thanks, team, for really good work. I thought I knew this space reasonably well, but I learned quite a bit from your materials.

One comment on prior authorizations and one on fraud, waste, and abuse. I think it's worth, in terms of prior authorizations, highlight in all our work that unlike a post-service claim review, where the only potential harm is to the provider, prior authorizations offer -- if that's the right term -- or can generate harm to the beneficiary. It's just worth highlighting that. And that's true whether the prior authorization is on the traditionally small list of procedures done by MACs, which I think evolved over time to be sort of logical based on procedures that have a high incidence of not being medical necessary, being cosmetic, et cetera, and being unfounded. So that small list. The WISer program, which I think does generate some real concerns, or as performed by MA.

The biggest concern I think I have about prior authorizations, in general, again, whether MAC performed, traditional, WISer, or MA, is that we create a have-and-

have-not dynamic. So noting that as you also noted, that a lot of denied services, denied via prior authorization, are appealed successfully, right, what really happens then is that when the provider-beneficiary dyad has the ability and the wherewithal to pursue an appeal, many, most times, they get the service originally requested.

And so what's happening then is the prior authorization is creating this class of patients and providers who, by virtue of lacking the infrastructure and the wherewithal to pursue the appeals process, aren't getting the service for the beneficiary that the provider wanted. And, by the way, that also augments the whole provider consolidation, because providers that have a back office infrastructure capable of generating and pursuing an appeal, are able to get that work through. So I think it's just worth highlighting the potential beneficiary harm in all the prior authorizations process.

On the fraud, waste, and abuse, what's always struck me is that ideally, we'd want data sharing between the MA plans and MACs on fraud, waste, and abuse. So if you think about population of, whatever, 60 million beneficiaries, the MACs have fraud, waste, and abuse data,

each on some segment of 29 or 30 million, whatever the fee-for-service number is. And I don't know how well they share that between them. The MA plans have fraud, waste, and abuse data on the other 30-or-so million, and they definitely don't share with each other, or with the MACs. And so what we're missing then is the potential for data to be reviewed on all 60-or-so million beneficiaries.

I know there would be a lot of issues in getting there, but it's probably worth at least highlighting that to the extent that we could consolidate the data on fraud, waste, and abuse, potential fraud, waste, and abuse, across all beneficiaries, we'd be more successful in identifying cases earlier on. Thanks.

MS. KELLEY: Gokhan.

DR. METAN: Yeah. I would like to emphasize Scott's comments on the data. Having led the fraud, waste, and abuse analytics teams in one of the major health insurance in my past, data is very important, and typically in these circumstances you are dealing with real events. In the data, you really need a lot of cases to build good quality models. And typically data-sharing between insurance companies or MACs are typically nonexistent.

So I think we can really benefit from that data-sharing insights, maybe even model-sharing, to actually build some of these models collectively rather than separately. Because in many cases, these models, you have error rates. Like you can detect some of the positive cases, but there are a lot of negative cases. And then you run into the issue of return on investment, do I take action on this, do I not? So really, data-sharing, model-sharing is key to automate and capture some of these kinds of things.

And the second thing is, fraud is ever-evolving. You are always chasing that. So any time you catch a fraudulent activity, that changes colors. So it's really kind of like have these models to be really adaptive and also informed by this collective data-sharing is very important in data-sharing. Thank you.

MS. KELLEY: Betty.

DR. CHERNEW: Betty is going to have the second-to-last word.

DR. RAMBUR: Thank you. I'll be very brief. Thank you all for your comments. I just wanted to make two points. In reading about the complexity, I sort of have

the same thought that Robert and Paul did, about, you know, the investment. And in a later part of the document it talks about how every dollar spent in enforcement and review saves Medicare $8.3 dollars. I think that's really important to amplify.

And then the other thing I just wanted to be on the record, I'm very supportive of this becoming a chapter, and I'm very enthusiastic about anything we can do to help the reader sort out the difference between waste, fraud, and abuse, because they're very, very different. And we have the piece that MedPAC has addressed about waste, and I think if that could be amplified, because it becomes an amalgam. And thanks for all your comments.

DR. CHERNEW: Thank you all for your comments. I think there's a lot of enthusiasm around this general topic about Medicare operations, proper payments, and improper payments. So for those at home, please do reach out to us with your thoughts at meetingcomments@medpac.gov, or there are a number of other ways you can reach out to us, because we really do want to hear what you have to say.

It turns out that the organization that's responsible for oversight of a lot of this is the GAO, and

we're fortunate, in a moment, we're going to take a break, and then we're going to have Comptroller General come and speak with us, and we're very excited about that.

So please turn off your cameras, stay on the session, turn off your cameras. You can turn your cameras back on in a minute. And Laurie, Nancy, and Andy, thank you so much for this. I'm really excited that we're going into this topic. And we'll be back at 11:45.

[Recess.]

DR. CHERNEW: Welcome back, everybody.

We are really privileged today to have the Honorable Gene Dodaro join us. Since 2010, he has been the Comptroller General of the United States, and for folks who may not know at home, GAO does a lot, a lot, a lot of things.

I will just mention two. One is they appoint us. That's not why he's here, but we are very grateful. I, in particular --

UNIDENTIFIED SPEAKER: [Speaking off microphone.]

[Laughter.]

DR. CHERNEW: Right. Well, it's rare you have your bosses come talk to you.

Anyway, I am personally very appreciative because MedPAC wouldn't function if we didn't have wonderful Commissioners, and GAO is responsible for us having wonderful Commissioners, which makes my job easier. So again, just broadly, thank you, and thank you to your staff for that.

But more importantly, GAO is an independent, nonpartisan agency that works for Congress. They work across a whole range of areas. They're broadly, I guess, informally considered the congressional watchdog, and they really play a central role in the issue we were just talking about, about making sure that Medicare payments are proper.

And obviously, we have a lot of overlap in that interest. So we thought if we'd have the Comptroller General come, we could then have a discussion and maybe ask him some questions about all that's going on and get his opinions on things.

So again, thank you so much for coming, and the floor is yours.

MR. DODARO: Yeah. Thank you very much, Mr. Chairman. It's very good to be with all of you today.

The first thing I'd like to say is thank you for serving on this Commission. It's a very meticulous process that we use. So congratulations on being selected. A lot of people strive to serve on this Commission, and so we're fortunate to have a lot of well-qualified applicants for the job. And it's difficult trying to make final decisions, but I'm very pleased with how the Commission is operating.

I also appoint the MACPAC Commission for Medicaid Physician Payment Commission, Health Information Technology Commission, the PCORI, Patient-Centered Outcome Group. So there's about six commissions. Congress keeps wanting to give us more responsibilities in these areas, and while we don't seek those opportunities, we certainly want to support the Congress, and it's very important, particularly in the health care area, to have good advice on that issue.

Now, as it relates to improper payments -- and Michael is right. GAO's scope is across the entire breadth of the federal government's operations, and one of our responsibilities also is to audit the financial statements of the federal government. There were no financial audits of individual agencies or the government as a whole until

1996. We'd work with the Congress to get legislation passed, and in those first audits, the Department of Health and Human Services Inspector General was doing the audit. And of course, even in those days, there was always concern about how much fraud and improper payments there were in the Medicare program.

Actually, we keep a list of the highest risk areas across federal government for fraud, waste, abuse, and mismanagement, and Medicare was a charter member from 1990.

So in this first financial audit, the Inspector General and we worked together to come up with the very first estimate of improper payments in the Medicare program. That estimate at that time was $23 billion, and after a while, we felt the process for doing the estimate and dealing with trying to reduce improper payments was really a management responsibility. It wasn't the auditor's responsibility.

So we kick-started the process, and then we worked with the Congress to pass legislation in 2002 that required all federal departments and agencies, based upon a list of high-risk areas that OMB would designate, to start

estimating improper payments. And over time, there have been subsequent legislation to refine how that's done, the scope of the responsibilities to give the Inspector Generals more responsibilities for reviewing the estimates done by the agencies, to build in more accountability, and to notify Congress if the rates are above 10 percent. There are special requirements that need to be put in place. And so this applies broadly across government.

However, we still, in doing the audit of the federal government's financial statements, the consolidated statements, have, since 1997, said the federal government really doesn't know the full extent of improper payments across the federal government nor have a plan to deal with those improper payments.

Now, since 2003, when that was the first year agencies had to make estimates, the cumulative amount that's been estimated by CMS and previously HCFA -- I'm dating myself here -- has been the total amount of improper payment estimates for Medicare is over $880 billion over that time frame. It's a significant amount of money. The last couple of years, it's been around $50 billion.

I've been very pleased that also the Congress

adopted legislation that we had suggested on how to prevent fraud in the programs. Now, the difference between fraud and improper payments is improper payments is defined as a payment that should not have been made or was made in the wrong amount. They can be overpayments; they can be underpayments. Most, the vast majority, are overpayments in the estimates.

Now, fraud, all fraud by definition is an improper payment. Not all improper payments are fraud.

Now, the fraud estimates, we became very concerned during the pandemic. So we did our very first-ever estimate of fraud in the federal government. There's not enough information to do it based upon individual programs except in the unemployment insurance area, because they had collected a lot of historical data. But our estimate for 2018 to 2022 was the annual estimate of fraud during that five-year period was between $233 billion and $521 billion for the entire federal government. It's about 7 percent, all right, which is consistent with some estimates made in other countries. But during the pandemic, fraud was epidemic. And we basically -- there's so much money available, and the moves by agencies to

distribute it very quickly resulted in an epic fraud, in my opinion. So we've been working hard on fraud.

So there's legislation now passed in 2015. It's called the Fraud Reduction and Data Analytics Act, and it put GAO's framework in place where you needed a designated entity and the agency focused on fraud. You did risk assessments, risk mitigation strategies, et cetera.

Now, most of the improper payments in the Medicare area center on a number of different areas: the skilled nursing facilities, home health, hospice, some outpatient physician care. So there's different categories that they make where they hone in on some of the elements and then try to have strategies to reduce the improper payments in these high-risk areas. But those are the ones that have very high rates of improper payments.

The other point to make is that a lot of times the agencies -- and not necessarily Medicare, but across government -- will say, well, you know, the big category is lack of documentation. Either there isn't enough adequate documentation or no documentation at all. And this is after repeated efforts to get the documentation from the providers. The last time I checked, it was like four or

five different attempts to get the information. But this is concerning, and -- but a lot of people want to portray it as a paperwork problem.

And my response to that is if you get audited by the IRS and you don't have documentation; the federal government will take your money. But we should not spend the taxpayer money or federal funds without documentation. That's not appropriate.

Now, we've always had a recommendation that CMS look at whether or not the documentation requirements are really necessary and to coordinate them particularly between Medicare and Medicaid. And so far, they haven't really taken that to heart yet, because if there's documentation requirements, if they're paying and it's not made, maybe it's not a necessary documentation requirement. But right now, it's in the rules and regulations, and it causes improper payments.

Another big category is medical necessity. They'll do a sample. They'll look. They'll have physicians look at other physicians' designations. That's maybe about 17 percent of the improper payments where they conclude that the claim was not medically necessity --

necessary based upon a diagnosis in those areas as well.

Now, CMS has done a lot. They're probably among the agencies we look at across government. They have one of the most active programs. They've tripled the number of people they have working on these issues in their Center for Program Integrity, and so I've been very pleased there.

We're continuing to evaluate their efforts. We have an effort underway right now to see if they've implemented fully all the recommendations we've had for a good fraud preventive program. Fraud continues to be a problem in Medicare, and there's a special task force led by the Department of Justice. And every year, they bring charges against several hundred people, and the adjudicated fraud is anywhere from 2- to $5 billion a year. But that's only the amount that goes through the judicial process. It doesn't count how many settlements that are made. It doesn't count other civil cases that are brought. So it's a big problem, as you see from our estimate that we've made government-wide.

Now, what we've made also is a recommendation to the Treasury Department and the Office of Management and Budget that they should work with the Inspector General

community to make fraud estimates on all major program activities that are at risk. So they've agreed with that recommendation, but they're just beginning to take a look at how to do that.

So I'm hoping that, in addition to having improper payment estimates in Medicare and Medicaid, for that matter, there's a fraud estimate, and then they can work against the fraud estimate to find out what are the causes of the fraud. A lot of cases, there are services that are billed but aren't provided at all. There's other overbilling that occurs and upcoding, and there's all sorts of relationships.

But what happened during the pandemic is that, in actuality, a whole new group of fraudsters got trained. And it's international as well as domestic, and it's organized crime as well as the entrepreneur, if you will. And so it's more sophisticated. And I've worked to try to have a group that works with the IG community on analytics across programs, because likely, if a fraud is perpetrated by someone on Medicare, it's also potentially Medicaid, unemployment insurance as well. So you need to have a broad look across these programs and sharing some

information.

Also, I worked for about 10 years to get Congress to pass legislation to require the Social Security Administration to give a full death master file to the Treasury Fiscal Service. As odd as it seems, they wouldn't do it and under the guise of privacy. And so finally, there's a pilot now, and it's showing saving millions of dollars. I never thought it'd be so hard to get the agencies and Congress to agree to stop paying dead people. I mean, it just didn't seem -- and, you know, there everybody agreed on the medical diagnosis.

And so now we're saving millions of dollars. I'm trying to get the pilot put in place permanently so that this is -- and to share that information with the states who are making the payments on Medicaid as well.

So also, there are a number of providers that were admitted to the Medicare program and Medicaid during the pandemic under less than stringent standards, and so now they have to go back and recertify. So there are about 200,000 providers yet that CMS has not recertified, and we think that ought to be a priority. They ought to figure out how to do that as quickly as possible.

Now, within the last couple of weeks, as I do with every new administration that comes in, I go to meet the top leadership in the agencies across the entire executive branch. So a couple of weeks ago, we met with Dr. Oz at the Center for Medicare and Medicaid Studies along with his team, and we talked about our open recommendations that we have in these areas and working with them closely to try to get all of our recommendations implemented. I can provide a list of all our open recommendations to the Commission for your full review. I'd be happy to answer any other technical questions.

But I was very pleased. They're focused on this. They have an effort specifically on fraud. They know some of the characteristics of the perpetrators. I've put them in touch a little bit more with this group across the IG community.

What happened with this group, just as an aside, some of you remember -- you know, Chairman Michael mentioned I became Comptroller General in 2010, but that was when I was confirmed. I was Acting Comptroller General since 2008 when the global financial crisis happened, and during that period of time, because of all the money that

was given, the $700 billion available to work with the financial institutions, the auto companies, there was another $800 billion that was in place on the Recovery Act to stimulate the economy because of the Great Recession.

The Congress created an Inspector General group, Recovery Accountability Transparency Board, gave them $80 million, and their job was to help prevent fraud in the Recovery Act. And they did a pretty good job of stopping fraud, and there was nowhere near the amount of fraud in those two big efforts that we had during the pandemic. But they were only in effect for so many years after the Recovery Act, and then Congress did extend them because of the big storm, Sandy, that hit north New Jersey and the New York area and so a lot of additional federal money there. But in any event, they were expired in 2015.

Treasury had the ability to pick up that group, and there was a lot of very sophisticated software and data analytics. And they would -- you know, if somebody applied for a federal contract or something and just had a post office box, there really wasn't anybody there, a physical presence, they spotted it early, just to give you an example.

And so I went to the Congress -- or Treasury. I went to them first. I said you should pick this up. No, we don't, you know, want to -- you know, we're not law enforcement, et cetera. So I went to the Congress and I said, look, I said, they don't want to pick it up. There's big investments already made. We have ongoing improper payment problems. We have ongoing fraud issues across government. You should make it permanent. If you invest $2 million a year, they can keep this operating. No. It wasn't successful.

So five years later, what happens? Pandemic comes. Groups disbanded. The first efforts in March 2020, where the first $2 trillion were given out, the group wasn't established. It wasn't until 2021, and by the time they got established, there was already a couple trillion dollars out of the door. And so they re-created the group. It's up and running now, but I'm trying to get still to have it made permanent because of this problem.

They've been extended a little bit through this recent reconciliation bill and broaden their authority beyond just the pandemic funding to cover all the funding that's available under the Reconciliation Act. In any

event, that's sort of a side issue.

But to go back to CMS, I was very pleased. They have a couple people back that we've worked with before, also at CMS. They're on the Hill. They really understand these issues. They just need to continue to focus on this. We're continuing to do reviews to give them suggestions on how to refine and improve their efforts in this area.

And I'm very concerned because in auditing the federal government's financial statements, we also look at the sustainability of the federal government's fiscal policies over time. And for many years now, we've concluded that our government is on an unsustainable fiscal path, and the big driver for a lot of this is health care costs and changing demographics. And of course, the Medicare Hospital Insurance Trust Fund, now with the latest estimates from the trustees, is that it will be depleted in 2033. Social Security is not very far behind, and of course, a lot of people pay for their out-of-pocket costs and copays and stuff from their Social Security. You've got a lot of people that are either primarily -- that's their primary source of income or only source of income. A lot of people have not saved on their own, and a lot of

people that work in the private sector have not had access to a pension plan at all. And so this is a big problem, and we've made recommendations to address this issue.

But the growing fiscal debt is a huge problem, and the interest costs to service that debt this year will hit a trillion dollars. Only probably 2021 or '23, around that time, it was $353 billion to service the debt. So it's tripled over this period of time, and of course, the debt's growing faster than GDP, which is why we say it's an unsustainable fiscal path.

And so I recommend that Congress have a plan, put some fiscal rules in place. Like, we have no guidelines. How much debt to GDP do we think we should have as a country? If we then set that target, how do we achieve the target or move toward the target over time?

Also, I've made recommendations for the last decade that we change how we deal with the debt ceiling, which is the authorization for Treasury to borrow money to pay for bills that Congress has already authorized. It's divorced from the funding decisions, and we've come close to running up to the last minute. And to increase the level, you know, I'm afraid at some point we're going to

stumble into default, which would be catastrophic for us and the rest of the world as well that rely on treasuries as one of the main reasons for this.

So I say this to say that we have to find every way possible to reduce health care costs to deal with our deficit situation. You know, two-thirds of the federal government's budget is on autopilot. You know, the 12 appropriation bills deal with less than 30 percent of the federal government's financing, and so these things are important.

Now, this Commission, I commend you for making some recommendations to deal with some of the funding issues. The site-neutral payments, I think very important. We have that same recommendation. I've been hawking that for a long time. You know, it's big money.

Also, the risk adjustment factors where we're paying, overpaying for Medicare advantage compared to fee-for-service, those are important recommendations.

So I encourage you to keep, you know, focused on this. One thing I learned in my job is that you have to be persistent over time to get things in here and look for targets of opportunity, and those targets will continue to

come up, particularly as the trust fund gets depleted. And there'll be more efforts to focus on reducing these costs.

So anyway, this is a short capsule summary of what we've been up to for a while, and I'm happy to answer questions.

DR. CHERNEW: So, Gene, thank you so much. That was really informative. I think there's a lot of overlap and certainly a lot of overlap in our objectives to make sure that payments are appropriate and people can access care that they need.

So we have a queue, which is how we do things, for questions, and so I think we're going to start with Paul.

DR. CASALE: Thank you so much for the comments. You know, I think your experience and perspective is so valuable in this area of ensuring appropriate proper payments and reducing fraud.

In your comments, you mentioned about medical necessity being a significant issue around the payment. I was curious, you know, with the new WISer model, which is the first foray into the idea of prior authorization in the traditional program -- and I was interested in your

perspective around sort of the prepayment review prior authorization in traditional Medicare.

MR. DODARO: Yeah. We've been very supportive of encouraging the pilots that have been done on prior authorization. They have to be done in a smart way so it doesn't interfere with service.

And as an aging person, I'm very familiar with prior authorization from a personal level, and sometimes it works fine, and sometimes it's not so fine. So I know there are pitfalls to it.

But I know CMS just announced another pilot in a number of states on prior authorization. Technology can -- if designed properly and operating properly, can really help ensure that it doesn't interfere with somebody's ability to get their service, as well as competent people are making the decisions, but it's got to be timely. And so we think there's a lot of opportunities there, but it has to be done and crafted properly and designed so it doesn't interfere with service to individuals.

In the prepayment area, we have a recommendation regarding recovery auditors. Now, they've been using them mostly for post-payment reviews. They did a pilot that

showed they could be successful in prepayment reviews as well, but they need to get authorization from the Congress. So we have a recommendation to the Congress. We make recommendations to them as well as the agencies to authorize them to use recovery auditors for prepayment reviews.

Now, we mentioned this when we met with CMS recently, and they think some of the things that they're doing will in effect do the same thing without incurring the cost of the Recovery Act. But we asked them to look at it again, you know, going forward, because it was found to be cost effective.

But I can tell you, the screams from the provider community of -- you know, when you send more reviewers and auditors in and you're dealing with one of -- from my standpoint, one of the most effective lobbying operations in the world, you know, it's tough to be able to do it. But I think both issues, Paul, are really good things to pursue, but it has to be done properly so you don't have human outcry about, you know, Uncle George is not getting his service. A few of those things to the Hill is all you need to unravel that. Sure.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks.

Really appreciate you coming today to speak with us, and I learned something. I'm actually quite surprised that we didn't have financial auditing before 1996.

MR. DODARO: That's another case where it took us 10 years to convince the Congress. It was 1990. We didn't have chief financial officers either. So that set that whole structure in place.

But then there were pilots done. So it wasn't until we got the legislation passed in '94 to require major departments and agencies to begin in 1996.

We're the last section of our economy, federal government, that might -- federal government wouldn't give money to state and local governments without a financial audit. So, in any event --

DR. DAMBERG: Yeah. That's --

MR. DODARO: -- we're on par now. We're on par.

DR. DAMBERG: So interesting. And that 7 percent figure also struck me as like a wow.

But I was kind of curious. So I read your testimony, which was also very interesting, and in there,

you comment that a number of the recommendations that you provided haven't been implemented. And I guess I'm trying to get some sense, and you've mentioned some of the barriers, but what do you see as sort of the barriers, challenges? Is it really kind of a funding issue that's preventing some of this from moving forward?

MR. DODARO: I don't believe so. Even though the agencies might posit that, I don't believe so, particularly in the health care area, because they're well financed through the operations and the fact that it's on a mandatory spending level.

A couple of things. One is the agencies sometimes feel like, you know, they get the same pushback if they want to have oversight as if you had auditors in there, and I think you need to have more independent views coming in, because sometimes people who regulate industries become close to the people they're regulating. And that causes some problems, or they get a lot of pushback too. And so that's one of the problems.

Secondly is, as you have different administrations come in over time, some of them take a different tact than the other ones. So there's no

consistency over time on how -- what CMS's position is on different issues, and so that's an impediment as well.

Congress receives a lot of comments from people on the matters that we make before the Congress. There's been some incremental changes over time, like, for example, on site-neutral issues, but the people who were already vested into the program still haven't been changed, which is a lot of the best money. So it's not a funding issue. It's a political will issue. And from the agency standpoint, in my view, it's consistency over time in the positions that have been taken by CMS during this period of time.

I've had certain areas who have more success with one administration than I will in another administration. I never give up. So you got to look for targets of opportunity, which I do, and so over time, you can get -- like, just to give you a good example, I talked before about the death master file. But in Medicaid, we've long said that the demonstrations that are made there aren't budget neutral, even though there's a policy to make them budget neutral, and some administrations are more willing to make changes in that area than others. And a lot of the

growth in Medicaid spending is due to these demonstrations. I mean, it's almost half of the total funding for the program are under demonstrations, and it really hasn't been a lot of evidence shown that the demonstration actually improved anything.

The only thing that's clear is it costs way more money than what was done previously, which it wasn't supposed to. So some of this is dealt with now in the reconciliation bill, where if there's a proposal for a demonstration, the CMS actuary has to sign off and verify that. So you bring in a more independent view of that.

In some of those cases, they were using hypothetical costs rather than actual costs. I mean, it just didn't make a lot of sense from a fiscal standpoint.

So what I do, though, every year, I send a letter to the head of every major department agency in the government with a list of open recommendations that they haven't addressed. About 70 percent, maybe a little bit more, of our recommendations are implemented, but some are not. And then I prioritize ones where there's big dollar savings or improvements in public health or safety or something, that type of criteria, so -- plus, we list them

all.

And CMS over the years, compared to other agencies, had a much lower implementation rate than the government-wide average, but that's coming up now. They're focused more on that, on meeting with us, and we meet with them on a regular basis to try to encourage them to implement these recommendations.

It was way more adjustment pushback than I expected on the risk adjustment score, you know, because basically what they're doing there is just the minimum that's required. They could have a much higher level. They weren't, using current beneficiary information was up-to-date. It wasn't, you know, as much focused on gender differences. Beneficiary characteristics weren't everything that they need to do. Anyway, we've had a heck of a time over time.

I talked to Dr. Oz about this when I met with him. He seemed open to looking at the issue. So we'll see what happens.

MS. KELLEY: Kenny.

MR. KAN: Thank you for your service, leadership, resilience, and adaptability for the past 17 years.

Accordingly, we have to find every health care target of opportunity to reduce national debt, and you cited site neutral opportunity as one possible target of opportunity. It is a topic that is very controversial, with many competing stakeholders. There is, unfortunately, an asymmetry between election cycles, stakeholder politics, and implementation lags.

So if you had a magic wand, what accountability mechanisms or performance metrics should Congress or CMS adopt to prioritize achievement of this site neutral framework in a clinically sound, actuarially justified, and politically feasible manner. And as a follow-up to that, MedPAC has done a lot of work on this. How can MedPAC help?

MR. DODARO: First, if I had a magic wand I would have worn it out by now.

[Laughter.]

MR. DODARO: I think we can give you more details on it. I'd like to talk to our experts on it, the answer more specifically, on your question. It's a good question. But what people haven't focused on as much is that if you go into an organization for service, or say an evaluation

service, you have a health problem and they want to get it evaluated by a doc, if you go to somebody aligned with a hospital, you know, Medicare pays you more than if you go to just a private practice. But it also costs the beneficiary more money, too. That part hasn't been as focused on as what could be saved and what you pay the provider. But this costs individuals more, so part of the metrics ought to be cost to the beneficiaries as well as the government, and those costs over time.

And then you'd have to, in a number of areas, there are good measurements, and this could be one, to have access. You know, are they getting access to the services they need to be able to do this. And then, you know, a lot of the arguments are around the cost effectiveness of the providers. You'd have to have something there for balance purposes, as well.

But given the financing trajectory of this thing, something has got to give. You can't afford to keep doing this. And it's not like with all this investment we're making our health care outcomes are much better than in other countries that pay far less for these services. So that, I think, has to be part of the benchmarks too, at

what kind of quality are getting for the level of investment that we're making, not just in site neutral but across the board, for these services.

So I think some thinking by this Commission about how do you compare what we're doing versus other countries, what are some of the differences in the payment processes and the outcomes. I mean, because if you focus just on the cost, you're missing the big picture of what we want. We want better health care outcomes, and we're not getting those outcomes. So I don't think we have a good set of performance measures on the health care outcomes that we have, and then you could focus on how much we're paying to get that outcome and how we can make tradeoffs to get better outcomes at less money. I mean, that's the optimum. That's where the magic wand needs to be pulled out and used.

MS. KELLEY: Brian.

DR. MILLER: So this is fun. I watched your testimony back in April, so it was fun rereading the recommendation, and, you know, prepaying claim reviews in Medicare, sort of thinking about that. I also worked for a venture capitalist during medical school, 15 years ago,

working for a tech company suggesting prepayment claims review in Medicaid going to state program integrity offices suggesting that.

So I love all of these recommendations, and I really liked your -- and it sort of described what I thought when you answered Cheryl, and you said the challenge is political economy. It's not getting these things -- it's not whether it's the right recommendation. It's the political economy of getting it done.

And so I was looking through your recommendations, and the theme that came for me for your recommendations is flexibility, because your recommendations were about taking static systems and making them into dynamic systems, where there is a system that identifies the payment problem, that then puts a process in place to address that payment problem, which then also is staffed by people to maintain that system to address that payment problem.

And the recommendations that you had were not just about payment levels, right. Sometimes you recommended other tools, which was either a change in law, sometimes a change in regulatory policy, and sometimes a

change in industry business operations. So you ran the full gamut of tools, recognizing that different problems required different tools. They're all physical problems and all oversight problems, but that you need different levers available.

So looking at the Medicare program, when we think about MA, which definitely overpaid, perhaps risk adjustment is something that needs automation as part of it, so that the patient is coded accurately and completely, whether they're in fee-for-service or Medicare Advantage, and then you can reduce gaming. There's still software gaming, but easier to audit that.

In fee-for-service, I spent the summer, at the best of my graduate students, reading all the GAO reports on MACs, and, you know, the audit asking CMS, CMS retirees primarily, you know, the retirees can often be more honest about the problems, because when you talk to civil service, they're great. They do a great job running the program. But they get a little anxious if you start asking questions sometimes. And that there are huge operational risks, which the GAO reports, showed in the MACs, because if the MAC goes down, you've lost payment for the region. And

then when you try and switch from one MAC contractor to another to promote innovation, improvement in business operations, you also have huge operational risks to the program.

So there's lots of, I think, regulatory and business operational, from a CMS perspective, to think about how to make that MAC program work better. Can MACs do more in fraud, waste, and abuse? You know, Stars, which is a handout to the MA plans, could that be a two-sided risk program, and could you also have MACs do Stars for fee-for-service?

And, you know, same for prior auth. Could the MACs do more prior auths. We probably do need more prior auth. I've been subjected to it as a patient. Not fun. I've been subjected to it as a physician. Still not fun. And, you know, I get angry text messages from all of my doctor friends whenever I say anything nice about prior auth and, in fact, I'm sure my phone is vibrating right now with angry text messages as I talk about prior auth and say that we need more of it. But we need to be efficient and effective.

So I guess my question for you is, with all this

background, one of the things that we hear, as Commissioners tend to do, is we tend to focus exclusively on payment levels. And I look at your recommendations, which are very different, that said there are payment levels, there are a lot of changes, there are regulatory policy changes, they're pushing industry. Do you think that we, as a Commission, need to think more holistically about the tools that we recommend and apply to achieve those outcomes, recognizing that the political economy is the issue, and sometimes like, yeah, cutting payment is definitely often frequently the right answer. But if we tell Congress to cut payment and there's a huge political economy of incumbent interest, that's very hard to do, and maybe changing regulatory policy or maybe changing a program executional structure might be a better way to achieve the same goal. So that we, as a Commission, can then be more efficient and effective at stewarding the Medicare dollar.

You know, I joke that as probably the youngest person on the Commission I have the greatest interest in making sure that Medicare is still there by the time I retire. And I joke with my wife that I hope that we have

enough savings and that there's enough fiscal responsibility over the next 25, 30 years, so that I'm not stuck on an MA-HMO.

MR. DODARO: Well first, the basic answer to your question about can you do more, yes. I think that would be a very good, thoughtful way to approach it. And while I'm not young enough, I do have children, and I have nine grandchildren, so I hope you guys are successful for them, as well, going forward.

So yeah, no, I think you should do that. I mean, that's what we try to figure out, all the tools that are available. And the other thing you can help on is incentives. And this isn't just true for Medicare, but the incentives for the program people, they get into more difficulty with negative feedback for not paying somebody, as opposed to paying somebody too much or paying somebody who they shouldn't be paying. And incentives need to be better aligned with them, as well. So whatever you can do in that area, I think, would be helpful, as well.

But take a broader look. I think that would be very helpful. And thank you. Part of what you said there, I can use for a commercial for GAO.

DR. MILLER: You're welcome, and thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: Yeah, like others have said, thank you so much for being here, and thank you to the GAO broadly for your work. It's so valuable to all of us.

I wanted to go back to the issue of the overpayment and waste and the human and machine interaction, because it seems there's, you know, obviously a lot of interest in bringing more technology in to try to detect certain waste and abuse. But it also strikes me that there are probably places where we max out on our ability to do that without human intervention. And I think especially as we've seen more reductions in workforce within the federal government, I'm just curious how you think those kinds of converging factors, maybe more technology but fewer experienced people with like that long depth of knowledge, will interact and affect your measurement of these overpayments and waste in the future.

MR. DODARO: Yeah. I've been very concerned about the federal workforce writ large for a long time. Of the 38 high-risk areas I mentioned earlier, one of them is on strategic human capital management. Twenty of the 38

areas are on the high-risk list because of skill gaps and shortages. And it's not just volume of people. It's the right people. We need a higher skill level. As the federal government particularly has devolved, more responsibilities to contractors are state and local governments, and Medicaid is a good example. And those programs have grown. You need a different type of skill level.

And so I'm concerned about that. And that trend is accentuated by wanting to use greater technology tools that are available, whether it be AI or some other kind of tool that's available. Data analytics, for example, needs to be a bigger part of this. They're doing a lot more at CMS, and I'm pleased about that. But you need different people. So you've got to have the right technology. You definitely need human intervention, particularly in the health care area. I think of all of the areas -- well, maybe defense and space, too -- but health care area.

So I think you're spot on in understanding it. But I think we start in the hole a little bit because our skill levels haven't been adjusted in the federal government with more enlightened workforce policies,

payment policies. You know, the incentives are for federal employees that work for contractors, and you lose your duty of loyalty in there.

So, you know, you have to have what are the right skills that you need. Well, a lot of agencies don't do good workforce planning. And then I was very, you know, concerned, and I said this in February when I testified on the high-risk area, of the current approach which is mass firings of people. That was not best practice, and we should have figured out what kind of responsibilities we want the government to have, and then you figure out what kind of people that you need in order to carry them out. And in all cases, people ought to be treated with more dignity and respect. I probably said as much as I should.

MS. KELLEY: Robert.

DR. CHERRY: Thank you very much for being here. We really appreciate your advice.

Among the many issues that Congress will be discussing over the course of this month, one of them is telehealth. And to be clear, I think there is broad support for telehealth, both inside of government and outside the government, for reasons that I think are

probably pretty clear to everyone.

One of the unresolved issues of telehealth, and the reason why it's not a permanent solution yet, is because there's this nagging issue of fraud and abuse, and it does have a potential for that. And interestingly, in your remarks, you mentioned other high-risk areas in Medicare, like skilled nursing and home health and palliative and outpatient services, but you didn't mention telehealth specifically. And I was just wondering if you had any insights in telehealth in terms of what you're seeing in terms of what the risk is, that could be helpful for us as we deliberate and advise Congress around permanent solutions for telehealth.

MR. DODARO: Yeah. I think, you know, we issued some reports on it, and I'll make sure those are available to you, on how it was used during the pandemic, in particular. We also, and I should mention this too, the other areas on the high-risk list, many are health-related issues, as well. One is veterans' health care. Another is oversight by FDA of medical products and safety, including drugs. We've been very concerned about that, particularly since a lot of the drugs come from other countries, and we

haven't been able to do good reviews in those areas. The participation of HHS, or their leadership and coordination to prepare for public health emergencies is on the list. Indian Services provided to the Indian Tribes and their members. So there are about six or so of the areas are health care-related.

Now, in telehealth, I think there are tremendous benefits, particularly -- and this is my opinion. I don't know if we've done work on this or not. I'll find out later. But we have such a shortage of mental health providers, behavioral health area. I know this is a very important issue at VA, for example. We still have 17 veterans a day committing suicide, on average. I think it's a national disgrace, and we need to do more in that area. And telehealth providers could be a good solution there, but you have to have enough people to begin with in those areas.

You need safeguards in place, and we've suggested more studying of what went on in agencies and what the experience was so they could have an evidence-based analysis of what worked well and what didn't work well in using the telehealth areas.

But I think some of the medical services lend themselves more to telehealth than others. So that would be my suggestion. But I'll ask our team to provide the Commission with all the information we have on the telehealth areas.

I remember one. During the pandemic I think I had to have -- this is my allergist, and I take allergy injections. It really helps. But he's getting into the telehealth thing. He wants to look up my nose. And I was like, how is this going to work on the screen? I'm going to get a back problem from the consequences of this thing. So, you know, some things don't lend themselves to it. So I think you'd have to have some guidelines, you know, on what works and what's well. But we have some experience in the federal government on this, and, of course, there's broader experiences, as well, where there needs to be further study and evaluation. Sometimes not enough evaluation goes on that's evidence-based evaluation by federal agencies. If you did another typology of GAO recommendations you'd find a whole lot of them. They didn't really evaluate how well many things are working in the federal government from an evidence-based solution.

MS. KELLEY: Gina.

MS. UPCHURCH: I want to pile on to thank you for all that your team has done. Just a couple of questions. First of all, I really appreciated your comment about quality of life and how important that is. It feels like we have so many silos in our government, and I know you're frustrated by that, and we're not talking across each other.

You stole my tagline, which I was trying to say, you know, compared to other countries, you know, we hear this all the time, we spend twice as much on health care. But what we don't often say is we spend half as much on social care, so the housing, the food.

I work with older adults with limited incomes. I'm a pharmacist, health educator, consumer advocate. And there was a slide recently from Kaiser Family Foundation that went in with some of the work that we shared earlier today. But out-of-pocket health care spending accounted for 39 percent of per capita Social Security income for people with Medicaid in 2022. Thirty-nine percent of their money, of their Social Security. And most of the people that I work with, that is what they rely on is their Social

Security. So it's a huge health care cost.

So I really appreciate what you said. You know, we have these silos and MedPAC is in its box. But when you think about health care spending and just spending that improves health in our country, a lot of it at the community-based setting is around long-term care services and supports. And no politician wants to touch that, I mean, on either side of the aisle. So I'm just wondering, has the GAO done any work on long-term care services and supports, getting people things in the home that provides for quality of life, but are not medical care? So that's one thing.

MR. DODARO: Right. Right.

MS. UPCHURCH: And then you had, in your testimony --

MR. DODARO: Yes.

MS. UPCHURCH: Let me ask that question. Yes.

MR. DODARO: The answer is yes, and we'll provide that information. I just confirmed it. I was going to say yes anyway, but I thought since they're there, I might as well have them help me.

MS. UPCHURCH: Right. Well, thank you. It's

just very practically something that needs to be addressed. We truly are looking at quality of life for older adults and adults with disabilities.

MR. DODARO: Yeah.

MS. UPCHURCH: In your testimony that we were reading, you said in 2021 -- and this is a little different question -- 43 percent of Medicare beneficiaries and over 70 percent of Medicaid got their care through managed care. But the 43 percent of people in Medicare, it was 45 percent of Medicare funding, but for the 70 percent on Medicaid, it was just 58 percent of Medicaid funding. So in other words, people in Medicaid that were in managed care, there were more people and they had less spending, but it's the opposite.

Can you see any differences in managed care and how it's being applied to Medicare beneficiaries to Medicaid, and why they would be different?

MR. DODARO: Yeah. We've done some work on, you know, people in the last stage of life, and they shift.

MS. UPCHURCH: Yeah.

MR. DODARO: They shift from Medicare Advantage to fee-for-service. And that's particularly true in

Medicaid. You know, when you run out you have to have your home, you know, gone, liquidated and stuff. And a lot of the spending is in the last year of life or so. That's, I think, the right answer. And if not, I'll have the team provide clarification on that issue.

You know, one thing, most of the work that we do at GAO is as a result of a mandate and a law or a committee or a conference report or a request from committee chairs and ranking members. Now, we provide a strategic plan, so a lot of it is a shared agenda. It's just we put out a report. But I do have authority to do certain things on our own. And this point about the integration and this stuff, I took it from a children perspective. I said there's too many silos. We're not looking collectively. We don't have a national strategy for children. And when you really think about it, as Brian pointed out, I mean, a lot of this health care starts at children's level, and good care and good habits, and we've got an obesity problem here.

So most of the things I do on my own I get thanked by people. This one, I was like, you know, don't you have enough to do? Why are you doing this? And I'm

still trying to get some integrated -- you know, one in five children in the country live in poverty. I mean, I just think that's, you know, not good. And of course you're not going to get good health care if you're in there. They probably get some things. But we need to look more holistically at things, and our systems aren't set up to do that. And one of the reasons GAO is, by default, a reservoir of institutional knowledge, is because the Comptroller General has a 15-year term. So that's set up mostly for political insulation, so you can be independent, but also provides continuity, over time. And we can look across the government and compare government to the private sector, compare it to other countries, and whatever. There's really not an entity in the executive branch that does that. So anyway, there's a little philosophy there, too. I'll throw it in, at no extra charge.

MS. UPCHURCH: Thanks again.

MS. KELLEY: Gokhan.

DR. METAN: Thank you very much for being with us today and benefitting us with your wisdom and guidance.

I have two questions. One is more external looking, and another one is more internal looking.

External looking, you kind of touched to this, that we, as a country, spend a lot of money on health care and not necessarily getting better outcomes than other nations. Are there any learnings from other nations that we should borrow and use those learnings to make some of our recommendations? Any guidance that you can provide us. That's my first question.

And then the second one is, where do you see as technology and AI advancements in this field more promising and less promising to make an impact?

MR. DODARO: Yeah, sure. Well first, we've done work over in the past. I'll have the team go back and we'll do a little summary for you of what we've done. But I don't think we've done a lot recently looking at other countries. And we can do more in that area, but we're constrained in resources just like everybody else.

On the second point, I've tripled the size of our science and technology experts in GAO. And we did a three-part study with the National Academy of Sciences and the National Institute of Medicine on AI and how it could expedite drug development, how AI could be used in second installment with diagnostics, and then the third,

treatment. So we've done that, and I can make that available to you, as well.

We're doing a lot more work in the science and technology area and infectious disease modeling, brain augmentation issues, and a wide range of others. And at some point, if it fits into your agenda, you might want to have our chief scientist at GAO come and talk to you about the work that we're doing over there. He's got biohealth background to begin with, so you'd find that very illuminating.

MS. KELLEY: Lynn.

MS. BARR: Thank you so much. This is a little bit of a softball, but I get asked all the time, "How do you become a Commissioner? I've applied 10 times." And I never know what to say. So can you tell us, how do we get here?

[Laughter.]

MR. DODARO: That's definitely not a softball question. Well first, there are certain requirements in the law. You always have to have an actuary, okay. And there are only so many positions that can be operated on there. There are consumer representatives. So there are

specific requirements in the law that we have to consider.

We also take input from the congressional committees that work in the health care area. You know, what type of expertise would you like to have on the Commission? We talk to the Commission itself, from having insights there, be able to do it. We go through the Federal Register process. Some people are recommended by associations, by members of Congress, some are self-nominated. We take them all, and we go through, and we spend a lot of time. I have our senior executives do that interviewing, and we vet people, and go through a very careful process.

There's also a financial conflict of interest kind of scenario. There's litmus tests on how far out there somebody is in their social media, you know, because you have to consider all these things, and we balance it. So it's a very deliberative process. There's no magic solution to it. And I've had people apply over the years and eventually we find it's the right time to apply. I always encourage people to keep applying, and to apply for some of these other commissions, too. You know, this isn't the only one. I know in most people's minds this is it,

okay. This is it. Michael is shaking his head. But it's not it, exclusively. So that would be the best advice I have. You never give up, and you be flexible, as Brian says.

MS. KELLEY: Tamara.

DR. KONETZKA: So this is a bit of a return to or a follow-on to Gina's questions that she asked earlier. And it's about the intersection between Medicare and Medicaid, with just a little bit more specific angle on some of the things she was talking about.

It's something we run up against constantly in our MedPAC discussions, because we know it's really hard sometimes to discuss just Medicare policy in the context of Medicaid's existence. It comes up in instances in post-acute care, for sure, for example, in nursing homes where, you know, Medicaid payments affect provider behavior, and there's a lot of cost shifting where people get hospitalized because that cost gets shifted to Medicare. It came up in some of your testimony, in a broader context, where there's this lack of coordination between uncompensated care payments between Medicaid and Medicare and providers maybe getting sort of double paid because of

that.

And then there are instances where, you know, for example, four out of five Medicare beneficiaries are not duals, and they don't have access to some of the long-term care kind of services that Medicaid provides, and how should we think about that sort of lack of services for people who aren't duals, as well as the lack of coordination for people who are duals.

So I guess the question there is, both for MedPAC, to what extent would you find it helpful, or do you think we should be sort of digging a little bit deeper into those intersections between Medicare and Medicaid and really sort of considering some of the effects of Medicaid on Medicare policy. And are there other sort of administrative changes or changes that you'd like to see within like CMS in the administration of those two programs that could really help the coordination?

MR. DODARO: Yes. First of all, I think it would be very helpful to have more dialogue between the two commissions, and I don't see why you couldn't have a study group put together by a subset of people to study that, and present it to both commissions. And I think the

intersection is going to be getting greater going forward, not less. And so I think that would be a very good idea.

Now, within CMS, I don't think we should specifically look that much at it, but I know we talk to them a lot of time about trying to equalize the policies. Part of the problem with the Medicaid is you have the states design their individual programs. Like for example, I've been trying for years to get CMS to use the state auditors, who audit the process, who know what their state's design of the program is, to do it. The improper payment estimates on Medicaid, they get the 50 states over a three-year period. So you have a lag time built into improper payment estimates on Medicaid.

I don't think there has been enough dialogue, over time, as the managed care portion of Medicaid has grown exponentially over time, with the lessons learned in Medicare Advantage to Medicaid Advantage. And there's not enough sharing of best practices among the states in Medicaid. So you've got an extra complication with Medicaid with the state involvement.

We focus mostly on Medicaid with the states, but there is more that could be done across both of the

programs. So I think your idea is excellent. We've got a lot of people who know a lot about this, and I don't see why some joint enterprise dialogue between the two commissions wouldn't be very beneficial.

DR. CHERNEW: Dana, that was the end of my queue.

MS. KELLEY: That is also the end of my queue, Mike.

DR. CHERNEW: We had the same queue. That's efficiency. So anyway, Gene, thank you so much. You could hear both the tremendous gratitude and real substantive interest in all that you've done. It's very clear that even within health care, the GAO is quite broad in the set of things you do, and, of course, health care is just one piece of a much broader portfolio. And as you pointed, and as you will see in the discussion we're going to have after this, on the context chapter, the fiscal concerns that you raised are really top of mind in everything we do.

So in addition to thanking you, I will just make a few general points. One, I appreciate your acknowledgment of incentives, as an economist. You should know that we are front and center, thinking about how to get the incentives right. I think better incentives can

help solve some of the problems, and some simplification of regulations and other things can solve the problems and we focus on those on those types of issues and those types of strategies too. So again, I really appreciate that.

And so I think on behalf of all of us, thank you very much for being available. As you know, there is a dialogue we have in general. This happens to be in public, but it's certainly not the only time we engage with GAO, and very much appreciate it.

So we're going to take a break now and go to lunch. We will be back to talk about some of the context, the context chapter which relates to some of these issues. And again, for those at home, thank you for listening. And again, to GAO and to you, Gene, particularly, thank you very much.

MR. DODARO: My pleasure. I enjoyed spending time with all of you, and please keep up the good work, especially for the next four months to the end of my tenure. Take care. Thank you. Thank you for your service.

[Whereupon, at 12:55 p.m., the meeting was recessed, to reconvene at 2:15 p.m. this same day.]

AFTERNOON SESSION

[2:20 p.m.]

DR. CHERNEW: Hello, and welcome back to our

afternoon session.

Every year in the March Report, we have one of my favorite chapters, which is the context chapter, and we are now going to discuss it. I think it's particularly fitting given how our morning went.

But, Rachel, I think you're going to start. And, Alexandra, I think -- welcome. I think this is your first. Am I right about that?

DR. HARRIS: I was at the retreat, the first presentation.

DR. CHERNEW: Yeah, that's what I mean, your first presentation.

So great. So we're ready to go. Rachel, take it away.

MS. BURTON: Thanks, Mike.

In this presentation, we'll provide some context for Medicare payment policy, meant to serve as a backdrop for Commissioner discussions this cycle. This information will be included in our March Reports to the Congress, along with our recommended updates to 2027 payment rates. A PDF of these slides is available on the right side of the webinars control panel in the handout section.

Today I'll give an overview of spending trends and discuss drivers of Medicare's recent spending growth. I'll also talk about Medicare's funding sources. Alex will then give us an update on what is known about provider consolidation, fresh off her PhD dissertation on this topic. I'll then close us out with a discussion of the health care staff workforce.

We'll begin by looking at some big-picture spending trends. In 2023, the U.S. spent $5 trillion on health care. Since national health care spending usually grows faster than the U.S.'s gross domestic product, health care spending has made up an increasing share of GDP over time, as shown here. National spending temporarily diverged from this historical trend during the pandemic, sharply increasing as a share of GDP in 2020, due to new pandemic related spending that occurred while the economy was shrinking. And then in 2021 and 2022, spending as a share of GDP sharply fell as health care spending grew modestly in the latter years of the pandemic, while the economy grew.

n 2023, spending trends returned to historical norms with national health care spending growing faster

than GDP. One of the reasons health care spending accelerated in 2023 was the share of the population with health insurance reached an all time high of 92.5 percent.

Another driver was the fact that volume and intensity of services delivered per patient grew, and service utilization post pandemic rebounded.

Here we focused just on Medicare spending in the last 20 years and show projections for what it could look like in the next 10 years. We see that in 2023, Medicare spending, not including beneficiary cost sharing, reached $1 trillion. It is expected to reach $2 trillion by 2031, according to CMS actuaries, or by 2033, according to CBO.

Next, we'll talk about what is and isn't driving Medicare spending growth. Medicare spending growth in recent years has been partly driven by the increasing number of people enrolled in the program, as the baby boom generation has reached Medicare's eligibility age. By 2029, all members of that generation will have reached age 65, and Medicare enrollment will reach 75 million.

The demographic mix of beneficiaries in the program has not been a driver of recent Medicare spending. This is because the share of Medicare beneficiaries who

report being in very good health has been increasing in recent years, as shown here. The Medicare beneficiaries who survived the pandemic are healthier on average than beneficiaries were before the pandemic, and even before the pandemic, the average beneficiary had been getting younger and healthier as the baby boom generation aged into Medicare and increased the share of beneficiaries at the low end of Medicare's senior age distribution.

Finally, a declining share of Medicare beneficiaries have been qualifying for the program due to disability, which has spending implications since beneficiaries who qualify due to disability tend to generate far more spending than those who qualify due to age.

As the circle shows, Medicare prices are not expected to be a major driver of program spending growth in the next decade, because of the statutory formulas used for updating Medicare's payment rates. This differs from the private sector where prices are determined by market forces. The constraint of prices could be one reason why spending per enrollee usually grows more slowly for Medicare beneficiaries than for the privately insured.

Other factors, including growth in the volume and intensity of the services delivered to beneficiaries also contribute to Medicare spending growth. In recent years, the volume of services furnished per beneficiary has grown for some types of Part B items and services, such as clinician services, and declined for some Part A services, such as inpatient hospital stays and skilled nursing facility care afterward.

The intensity of services is harder to measure but generally increases when a more expensive item or service is furnished instead of a less expensive option or when new technology uncovers more potential medical issues that are then worked up clinically.

On net, CMS actuaries project that growth in the volume and intensity of services delivered per beneficiary and other factors will increase by an average of 3 percent per year over the next decade, as shown in the prior slides table.

I next want to talk about Medicare's funding sources. As I just mentioned, the mix of services Medicare beneficiaries receive has been changing in recent years. This, in turn, is affecting the relative role of Medicare's

various funding sources since different types of services are funded with different types of revenue.

As shown at left, we've seen slower growth in spending per beneficiary on items and services covered under Part A, which has reduced the share of Medicare spending funded by the Medicare payroll tax.

Meanwhile, we've seen faster growth in spending per beneficiary on items and services covered under Part B, which has increased the share of Medicare spending funded by general revenues and beneficiary premiums.

Slower growth in spending on Part A means Medicare does not need to rely as much on Medicare payroll tax revenues, which are deposited into Medicare's Hospital Insurance Trust Fund.

As shown here, around the time of Medicare's creation in 1967, there were 4.5 workers paying Medicare payroll taxes for every one Medicare beneficiary. But by 2024, there are only 2.8 workers per Medicare beneficiary, and this number is expected to continue to decline.

Thanks to the slowing in the growth of spending on Part A, CBO now expects Medicare's trust fund to remain solvent until 2052. CMS actuaries also track the status of

the trust fund and estimate it will remain solvent until 2033. The difference between these two projection dates stems from the fact that CMS actuaries assume Medicare spending will be 9 percent higher and Medicare income will be 1 percent lower than CBO does over the next 10 years.

The fast growth we've seen in spending on Part B means there's now greater pressure on the country's general revenues. CMS actuaries report that in 2024, 16 percent of all personal and corporate income taxes collected by the federal government were used to pay for Part B and Part D. By 2035, 25 percent will be used for this purpose.

As the share of general revenues needed to finance Medicare increases, it leaves less revenue for deficit reduction and other national priorities.

We can see the impact that growth in Part B spending is having in this graph as well, which shows all of Medicare's funding sources.

When Medicare was first created in the late '60s, the Medicare payroll tax shown in the bottom layer of this graph was the main funding source for the program. But over time, as spending on Part B has grown, general revenues have become Medicare's largest funding source,

shown in the thick layer near the top of this graph.

DR. HARRIS: As Medicare Part B spending grows, it stretches both the U.S.'s national budget and beneficiaries' household budgets. Medicare beneficiaries typically do not pay premiums for Part A coverage, but the annual cost of Part B premiums is $2,220 in 2025. The average annual cost of standalone Part D drug plan premiums is another $468.

Cost-sharing liabilities for beneficiaries in fee-for-service Medicare averaged $396 for Part A services and $1,621 for Part B services in 2021, which is the most recent year available for this information.

Average cost-sharing in Part D standalone drug plans was $492 in 2023, although this amount is expected to be lower in coming years. This all adds up to about $5,000 in premiums and cost-sharing per year.

The typical Medicare beneficiary has relatively modest resources to draw on when paying for premiums and cost-sharing. In 2024, Medicare beneficiaries' median annual income was estimated to be $43,000, and their median life savings was estimated to be around $110,000.

Only about 6 percent of Medicare beneficiaries

report problems paying a medical bill, but some groups shown on this slide report this at higher rates. Specifically, we see more problems with medical bills among partial-benefit dual-eligibles, who are beneficiaries who don't have low enough incomes to qualify for full Medicaid benefits. We also see more issues among beneficiaries under the age of 65, who tend to be unable to work due to disability, and we see issues among beneficiaries who have low enough incomes to qualify for the Part D low-income subsidy and beneficiaries with fee-for-service and no supplemental coverage.

When Medicare payment rates for providers increase, so do beneficiaries' premiums and cost sharing, which can make it harder for certain groups of beneficiaries to afford their care.

I'm now going to pass it back to myself.

[Laughter.]

DR. HARRIS: In response to continued Commissioner interest, we're now going to discuss the effect of provider consolidation on costs, quality, and access. Notably, we categorize this material into three groups based on emerging research: consolidation between

providers, payer-provider consolidation, and consolidation between private equity firms and providers.

Over the last few decades, health care markets have become increasingly consolidated. Historically, provider consolidation has involved horizontal mergers with like types of providers, such as hospitals merging with other hospitals, or vertical acquisitions of providers with referral relationships, such as hospitals acquiring physician practices or post-acute care providers.

Consolidation between providers does remain a dominant trend. As of 2024, the majority of hospital markets, about 63 percent, have become what we call "super concentrated," where a small number of hospitals control the provision of the majority of hospital-based services in a geographic market.

On the physician side, we see that a minority of physician practices, about 42 percent, are now solely owned by physicians.

However, consolidation between providers and non-provider organizations, such as commercial payers and private equity firms, is now garnering more attention. For example, payers are acquiring primary care practices,

ambulatory surgical centers, data analytics firms, and pharmacies.

We are also observing growth of private equity investment in provider organizations. Though PE investment is not a dominant trend in health care, at this time, the rate of growth, particularly in consolidated high-revenue specialty practices, like dermatology and gastroenterology, is notable.

From 2022 to 2024, there was a 44 percent increase in the number of PE-owned physician practices.

So we know that provider consolidation continues to grow across care settings, but it's important to understand some of the economic and operational motivations for consolidation.

Consolidated providers gain market share and subsequent bargaining power with commercial payers.

For Medicare, where prices are generally administratively set, vertical acquisitions of physician practices by hospitals allows for leveraging of site-based payment differentials to maximize payments. More specifically, when a hospital acquires a physician practice and provides certain services to Medicare beneficiaries,

the hospital can sometimes bill a facility fee in addition to the physician's fee.

When payers acquire providers, they may be better able to generate more intense diagnosis coding, yielding higher payments to both payers and providers in capitated models.

Research also suggests that provider consolidation may encourage patient referrals within that integrated system, which may make it more difficult for new or competing providers to retain enough patient volume to be financially stable.

Conceptually, provider consolidation may also improve care coordination and the efficiency of care delivery through economies of scale, electronic health record interoperability, improved adherence to clinical guidelines, and alignment with value-based payment program incentives.

Okay. So I just told you that consolidation is happening and why it might be happening, but we also want to evaluate the ways in which consolidation is actually affecting payment rates and spending.

So across both commercial and Medicare markets,

we do see considerable evidence that horizontal mergers and vertical acquisitions between providers leads to higher payment rates. For example, hospital physician vertical integration has been shown to increase Part B drug spending through shifted billing from offices to hospital outpatient departments and the use of more expensive treatments.

With respect to payer-provider consolidation, there is limited evidence of the effect of consolidation on spending. However, provider-owned MA plans do appear to be associated with more intense diagnosis coding which, as I said, may lead to higher payment rates to the payer and provider.

Finally, PE provider consolidation does appear to be associated with higher commercial prices in the range of 4 to 8 percent across studies.

Research generally finds evidence of higher payment rates and spending, as I just said. However, the story is much less clear when evaluating the effect of consolidation on access to care. There is mixed, albeit limited, evidence of how consolidation impacts access to care. For example, hospital physician integration may improve access for medically complex and socioeconomically

disadvantaged patients, but other studies have found no change.

There is currently no evidence found of how payer-provider consolidation affects access, and with respect to PE provider consolidation, we do see an increase in some service lines, such as robotic surgery, hemodialysis, and physician-administered drugs, and reductions in other service lines, such as outpatient psychiatric care and retinal detachment surgery.

And finally, as you might expect, we also want to look at quality. So when we assess the effect of provider consolidation on quality, the results are also ambiguous. For example, hospital mergers are generally associated with little to no effect on mortality, but across other outcomes, such as patient experience and readmissions, the findings are inconsistent.

Hospital physician and hospital post-acute care consolidation are generally associated with modest improvements in certain conditions-specific process measures, but have little to no effect on mortality, readmissions, or ED visit rates.

Provider-owned MA plans are generally associated

with modest improvements in patient experience, and PE provider consolidation seems to be associated with lower patient experience and no obvious change in post-operative complication rates.

I'm now going to pass things back to Rachel.

MS. BURTON: A priority of the Commission is ensuring beneficiaries have access to high-quality care. Since numerous studies have found a clear relationship between care quality and having a sufficient supply of nurses and other health care staff, we close this presentation with an exploration of that workforce.

Nearly, two million physicians and other types of practitioners bill payers directly for the health care services they provide. Working alongside them are over 14 million health care staff, including pharmacists, certain types of therapists, including physical therapists, occupational therapists and speech-language pathologists, nurses without graduate degrees, numerous types of health technicians and technologists, and direct care workers, which refers to nursing assistants and home health aides. Training requirements for these occupations range from a few weeks of on-the-job training to graduate degrees after

college.

The composition of the health care staff workforce changes over time. In recent years, a growing share of the workforce is comprised of home health aides and personal care aides, which was nearly four million people's occupation in 2024. This occupation requires the least amount of training of the health care staff occupations, with some positions not requiring a high school diploma and relying on on-the-job training.

The next two most common and fastest growing occupations were registered nurse, which was 3.3 million people's occupation, and health technologist or technician, which was 3.1 million people's occupation.

In recent years, we've seen employers increasingly hiring health care staff who have more training. For example, as shown here, over the past two decades, the number of physical therapist assistants who usually have an associate's degree and a license or certification grew rapidly, while the number of physical therapist aides who usually have only a high school diploma and on-the-job training remained flat and then began to decline. Similar shifts have occurred among occupational

therapist assistants and aides, pharmacy technicians and aides, and RNs and LPNs.

Health care staff wages are generally higher for occupations that require more training, such as pharmacists. In addition, wages for particular occupations tend to be higher in some clinical settings than others.

According to BLS data, hospitals tend to pay more than other settings for pharmacists, RNs, social workers, and direct care workers. Skilled nursing facilities and home health agencies tend to pay more for the various types of therapists who work in those settings and for LPNs. Wages for health care staff also tend to be higher in areas with higher costs of living, such as California.

In the literature on the health care staff workforce, direct care workers are a focus of a lot of articles due to high turnover and a link between turnover and care quality. Medicare's Care Compare website finds that 47 percent of nursing homes' nursing staff, which mainly consists of nursing assistants, leave their jobs in a given year. A number of studies have tried to understand why turnover rates are so high among nursing assistants. One factor that emerges is on-the-job injuries, since

nursing assistants experience musculoskeletal disorders, which can be caused by physical strain at one of the highest rates in the U.S. A national survey found that more than half of nursing assistants in nursing homes reported having at least one work-related injury in the past year.

To try to make this job more appealing, many states have passed laws in recent decades intended to raise wages for direct care workers. A recent analysis of these policies found that after implementation, in many states, the wages of direct care workers did go up more quickly than the wages of other entry-level workers. But in most states, the hourly wages of direct care workers were still several dollars below those of other entry-level workers, such as those in retail. So this remains an ongoing issue.

Turning to Medicare, a key thing to know is that Medicare pays for the labor of health care staff in a different way than it pays for the labor of physicians and other billable practitioners. Fee-for-service Medicare pays physicians and most other clinicians with graduate degrees through the physician fee schedule and generally pays more if a practitioner spends more time delivering a

service or provides more services during an encounter.

In contrast, health care staff labor is generally paid for through prospective payment systems. These payments are set to reflect the typical types and amounts of health care staff labor and other expenses used to treat a given type of patient in a given type of facility. The packaged nature of these payments incentivize providers to use an efficient mix of health care staff. Providers also have an incentive to provide adequate staffing since Medicare operates various pay-for-performance programs, and health care-associated infections caused by understaffing can lengthen a beneficiary's stay and a facility's costs without increasing the size of a Medicare payment.

Medicare layers on some more direct staffing incentives for nursing homes. It publicly reports detailed staffing and turnover statistics for each nursing home in the U.S. on its website, and in 2026, Medicare's Pay-for-Performance program for nursing homes, which is funded by a 2 percent withhold, will begin tying payments to staffing-related measures shown here.

Okay. We've made it to the end. In your discussion, we'd like to know if you have any questions

about the material or any other comments or guidance as we finalize the chapter. The draft chapter you received for today's meeting will be updated in the winter when some newer data come out. Commissioners will have an opportunity to review the revised version in January.

I'll now turn things back to Mike.

DR. CHERNEW: Thank you, both. That was terrific. I both appreciate the comprehensiveness in each of the sections and the ability to focus on specific sections. So that was wonderful.

We're going to go through our regular Rounds 1 and 2, and I think Stacie is first in Round 1.

DR. DUSETZINA: Thank you very much. I always enjoy reading this chapter even though it's kind of like a depressing mood-setter for the session, because you're like, "Oh, my God, we're going towards a disaster." Okay.

My first round question, I just was curious about, you mention the disability population. And I think I figured it out when you were talking, that they're shrinking as a proportion of the Medicare beneficiaries but they're not necessarily shrinking as like a number of people who are entering the program as disabled. We're

just like counting people. Because when I read it in the chapter I thought, oh, is there something that's limiting people's access through disability that has changed.

And I think what could clarify this is if in the Figure 1.3 that has the baby boomers kind of like grayed out and shows the number, do you have a line that showed the people qualifying by disability, just the number of people over that time span? I think it would make it more clear that it's not necessarily a change in who's eligible for disability, it's just the denominator is getting much larger with those baby boomers aging in.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you for an excellent report. We do use the word "intensity" a lot in the pre-read materials, but there's no data definition for it. I was just wondering for this, and also for any other future materials we might have, to put the data definition around intensity. And also, you're probably not surprised I would ask this. Also, how does CMO define intensity and how does CMS define intensity. Because it would be nice to compare and contrast. But right now we're using the term but we're not really defining it.

MS. BURTON: Okay.

DR. CHERRY: Otherwise, great report.

MS. KELLEY: Tamara.

DR. KONETZKA: Yeah. Thanks for this excellent work. Very quick clarifications about the spending estimates at the beginning of the chapter. In the text it wasn't always clear, but I assume all of these estimates include both MA and fee-for-service spending, right?

MS. BURTON: Probably. I'm not sure exactly what number you're referencing.

DR. KONETZKA: Okay, yeah. There were just a bunch of times in the beginning where you were referencing lower hospital spending and lower SNF spending, but higher --

MS. BURTON: Oh, that's fee-for-service in terms of like changes in utilization. I don't know about MA.

DR. KONETZKA: Okay. So it might be helpful to just clarify that in the text every time you mention those numbers, that it's only based on fee-for-service. And then the related question is, on page 22, in Figure 1.6, there it explicitly says "This includes both MA and fee-for-service spending." How do you get the Part A and Part B

spending for the MA part? I'm just not sure of the source. I assume the fee-for-service part is all just all from claims.

MR. MASI: Yeah, and Tamara, are you wondering how is the decomposition of Medicare Advantage spending into Parts A and B done?

DR. KONETZKA: Yeah, exactly.

MR. MASI: Yeah. So when the Medicare program makes monthly capitated payments to MA plans, there are specific draws on the two Part A and Part B trust funds. And so that's kind of mechanical information that's reported out. I think it's part of the Trustees Report, but that's data that we have. But we can clarify that in the paper.

MS. BURTON: So it's just --

DR. KONETZKA: I'm sorry.

MS. BURTON: I've familiarized myself with the graph now so I can answer your question. So in the Medicare Trustees Report they identified total amount of Part A spending and then they also separately identified the total number of Part A enrollees. So I've just divided that by that in order to get spending per bene for Part A,

and in each year, so we can see how it's growing. So that's how it's including MA.

DR. KONETZKA: Okay. So we can know that, on an aggregate level. But does the MA part then actually corresponding to aggregated individual spending?

MR. MASI: Yeah, good question. So my understanding is that the A and B split that's used for purposes of making the monthly capitated payment to an MA plan, that's informed by the fee-for-service split. And so it may be that when the MA plans are actually paying for benefits with the contracts providers, that there's actually a very different mix of A and B services. And I think of the A/B spending split as really just an accounting mechanism based on program rules.

MS. KELLEY: Gina.

MS. UPCHURCH: I agree with Stacie. This is sobering reading, but I think you did a great job, and I like some of the concentration, particularly on the workforce issues, so thank you for that.

Just two sort of questions here. On page 38, we talk about the lesser-of state. So when somebody is dually eligible for Medicare and Medicaid, the state can make, and

many states do, make the decisions just to pay the Medicaid amount, not the 100 percent of the Medicare amount. Why is that allowed, I guess is the question. I mean, it seems kind of shocking. Yeah, that is a Round 3 question, but -- okay, we'll save that for Round 3.

And somewhat related, I think, given that we're going to have, you know, more uninsured people, we're going to have cost-sharing reductions, we're going to have this that may disappear, a lot of states, like North Carolina in particular, had state-directed funds that paid providers a commercial rate instead of an old Medicaid rate. So it's putting pressure on providers. All of these things are conspiring to put pressure on providers. And I'm just curious, and it goes back to, you know, why this is even allowed. Has it been something that's been in Medicare and Medicaid for dual eligible for a long time, or is it a relatively new thing that states can make this decision? Do you know?

MS. BURTON: That they can do lesser-of?

MS. UPCHURCH: Yes.

MS. BURTON: Yeah, I don't know.

MS. UPCHURCH: Okay. I think with the pressure

on providers now --

MR. MASI: Eric is coming to the table to provide a brief history lesson.

MR. ROLLINS: A lesser-of policy was put into law in the Balanced Budget Act of 1997, so it's been around for a very long time. My understanding is the backstory for the legislation was that leading up to that, different states were doing different things.

MS. UPCHURCH: Right.

MR. ROLLINS: There was litigation over it, and the federal courts had reached conflicting decisions about whether it was allowed or not. And so the BBA of '97 kind of settled the question, and said yes, you can do this.

MS. UPCHURCH: Okay. Thank you. So related to that then, and this is something I've recently learned in North Carolina, so partially dual eligible, so somebody who has QMBs, SLMBs, MQB, partial Medicaid -- okay, partial, not full benefits but partial Medicaid -- there could be incredible variance by states. So if we could just add that to this. Because like, for example, in North Carolina, the assets and the income test are much stricter than other states. So if we could just put that in there,

because that does limit access for some patients.

MR. ROLLINS: There are federal standards for those programs, and states have latitude to have sort of a -- they can drop the asset requirement entirely. And I want to say, off the top of my head, somewhere between like 12 and 15 states do that.

MS. UPCHURCH: That's right.

MR. ROLLINS: But most states follow the federal standards.

MS. UPCHURCH: Maybe just add that in as context. That would be great. Because it's the context chapter. Thank you.

MS. BURTON: Thank you.

MS. KELLEY: Brian.

DR. MILLER: Thanks. I really loved the worker section in this chapter. It's really refreshing to see that. So a couple of sort of nitpicky points meant to be helpful, not mean.

One is I know Rob mentioned the CT scan example, and I think I mentioned this last years, it's really not a clinically accurate example. And then the drug one is also probably not so great for intensity of care, on page 12. I

would use an example of how you can work up a patient with chest pain and how you can -- I mean, obviously, depending upon clinical appropriateness, you can do lots of things. Like if it sounds like reflux you could prescribe, or tell them to buy over-the-counter reflux med. Or you could order EKG, treadmill stress test, and echo. I think make the intensity example a little more extreme so it's clear to readers, because most readers probably want to understand that concept.

On page 27, I noted that we noted that Medicare -- and this is a good point that I think frankly many of us really forget, which is when Medicare costs increase, beneficiary costs increase, which seems obvious but, like I think all of, frankly, just forget that.

One of the things that we should mention in there, I think for the point of completeness, is sort of the induced demand impact from Medigap. Because in Plan G and Plan F, in Plan F you have no cost-sharing, and in Plan G you have almost no cost sharing. This is not to disparage Plan G or Plan F, but that's 10 million people who, you know, don't really have any cost sharing, which drives induced demand, which then raises expenditures,

which then raises expenditures for the entire program, both in fee-for-service and then also it spills over into the MA benchmarks. So it's on page 27.

And on page 28, I really -- and we also discuss this on page 35 -- this sort of demographic discussion around Medigap, which I thought was particularly helpful, we noted it as a share of the overall Medicare population. I was reading about Medigap a few months ago. I think we should also note the demographics for the share of traditional Medicare and then the share of traditional Medicare benes who have purchased Medigap. Because when you look at those numbers, they're even, frankly, more disparate.

I looked at the Kaiser Family Foundation, which is one of my favorite sources, and they were saying 94 percent of traditional Medicare enrollees who purchased Medigap are Caucasian versus 86 percent overall. And I'm not saying the number that we have are wrong, because they are correct as the share of overall program, but we should also include the share for traditional Medicare and then the demographics for traditional Medicare enrollees who have separately purchased Medigap, to provide that full

context. Because then it makes it clear, you know, when you make decisions that favor one program or another, which ideally, we should be treating programs more equally, you might be favoring one demographic group over another, and we don't want to do that. Thanks.

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

DR. CHERNEW: That is also all I had for Round 1. So let's go to Round 2, and again I think Stacie is first again.

MS. KELLEY: I have Stacie, yes.

DR. DUSETZINA: Okay. I'm going to apologize in advance because it's going to feel a little chaotic, but I'm going to jump around a little bit.

I had a couple of responses to some of the clarification points Brian had. One is the CT scan example. I know where you're going with that. You're talking about care cascades as a result of getting like a scan that shows something that then you need a bunch of other workups. So I wanted to just mention Ishani Ganguli has some good work on care cascades that you could cite there potentially to help reinforce that point.

I totally agree with Brian's point about Figure 1.10. One of my points there was going to be that often people get really confused about like what percent of people don't have supplements. That comes up just a lot. I always go to the KFF site for this.

So even in the text it's saying potentially, you know, it's 6 percent of fee-for-service but about 12 percent of all Medicare beneficiaries, given the split, I think that would be helpful for people trying to understand the scope of this problem within fee-for-service.

I wanted to just applaud you especially on the breakdown of people who were having trouble paying for their medical bills. I think that is incredibly important to look at that by the different groups of beneficiaries and the types of subsidies they receive. So I really appreciated that specific look.

And I also have one minor wish list item, and it's tiny so I think it's doable. On page 31, you mentioned the penalties associated with late enrollment, and you mentioned Part D, give one example of one late penalty, but I wanted the other one. So if you could incorporate what the Part D penalty is, because I think it

actually ends up adding up to be a lot if you delay.

Totally small thing. Page 30, you say individuals can choose to enroll in Part A, but some people automatically get enrolled, right. It's kind of like a mix of automatically getting in Part A versus needing to enroll, I think. Like so if you have Social Security and you're overage, you automatically get it. So it might just be worth a slight tweak to the language.

The last big picture one is the private equity piece and the growth in that I find to be fascinating and also very concerning, just having been reading a little bit too much lately about private equity and some of the interesting, you know, financing and the ways that that works. So I think it is something to really closely monitor, so I really appreciate the inclusion of that and showing the growth of that in this work.

As always, thank you for the exceptional work.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I'm very appreciative of this chapter. Really great work. And I just wanted to underscore a few things.

For those of you that are new to MedPAC, you

might not realize how different this chapter looks. I'm really excited to see the information on consolidation, Medicare Advantage, and the workforce, and I think this is very much part of the modernization of Medicare. These things were not issues in 1965, and throughout the years there has just been a momentum that has carried it forward.

And it has traditionally been very focused on MDs. And obviously we know that that has left a lot of others out, and that has not been good for physicians. I recall when I was a young nurse there was discussion of nurse burnout. That was a long time ago. Only relatively recently are we hearing about physician burnout, and there are more and more studies that talk about the context of care, the staffing, the experience of the staff. So I think it's really important.

More recently we added PAs and nurse practitioners, and I think that's great. But to draw this distinction between providers who are reimbursed and all these other people who provide care is really important. We have focused, as a nation, really on the providers who bill rather than everybody else who helps deliver care.

So I just wanted to make a couple of points --

3.3 million nurses are working, but there are 5.9 million nurses registered in the United States, new data from the National Council of State Boards of Nursing. So that's a lot of people who are not working, not willing to work. And there are also another shadow workforce of people who have inactive licenses. Turnover last year among new folks in the environments nationwide was 23 percent. So obviously something is not right.

And I'm not surprised at the data on the nursing assistants. It's really, really hard work, and they can do better financially elsewhere. And I think we also forget that nursing, in particular, is recognized as one of the most dangerous occupations in the United States, in some cases more so than police officers, security, and that workplace violence is increasingly an issue for physicians, everybody, as well.

So the burnout issues are real, and that's not directly in our lane, but certainly how we think about finances is in our lane. And I do hope, over time, we think about moving to a recommendation of some sort, and I know that's, you know, down the line, hopefully not a decade down the line.

In a chapter that we have on MA's effects on hospitals, we see the interaction with GME, which is $20 billion a year, right, that disproportionately supports the growth of specialists.

So in summary, the incentives are on the line to create the conditions that patients really want, but physicians, nurses, pharmacists, others really want and our patients need. So I really commend you for taking this, because I know this was really sort of new ground, and I think it's really an important contribution.

I just want to close by saying on payment we talked about creating an efficient mix. It's actually the payment model creates the least expensive mix, which may not be the most effective in the long run, efficient, when you look at turnover.

But thank you so much for this great work.

MS. KELLEY: Gina.

MS. UPCHURCH: I think this is Round 2. So I really appreciate you all mentioning what I consider the elephant in the room, in terms of some of the workforce issues around nursing, but certainly in terms of the direct care workforce. I'm looking at a graph here from a

presentation talking about a survey the National Indicators of Aging and Disabilities did for 2024 and it says this: "Almost one-third of all responding agencies," you know, supporting direct care workers, "28.8 percent reported having turned away or stopped accepting new service referrals in 2023, due to their staffing shortages." So it has huge implications for who can get services, so I just think we need to hammer that point, and hopefully you all have seen that report, and I'll make sure that you do.

The other thing I would just say is on page 45 in your report, it says this: "In 2024, an estimated 15 percent of direct care workers in the U.S. were naturalized citizens, and another 9 percent were immigrants who did not have U.S. citizenship." I think that's an underestimate of like what's happening in the community. So that's the skilled nursing.

And I know from lots of experience, personal experience and that we hear from other folks, so it's anecdotal and it's a lot of it happening, is that it's hard to do the right thing and hire people. You pay a lot of money to an agency, maybe, to hire some help, but the workers don't necessarily get it. And if you make them

household employees you have to file quarterly unemployment with the state. You've got to do federal work. We make it difficult to hire people.

And my main concern is those workers, many of them are being paid under the table and not contributing to their own future in terms of paying into Social Security and Medicare. So we're missing those tax dollars. So any sort of solutions, looking at, like, maybe waive the first $20,000 in income tax. How do you keep direct care workers? We've got to have some incentive. We talked about incentives. What are the incentives that would make direct care workers want to stay? Maybe they don't have to pay taxes on their first $20,000 if they're doing direct care work. Because we've got a shortage and there's a huge problem, not only in facilities but in homes. And so I'm just really appreciative that you brought it up, and I'll make sure that you get that report.

The last thing, you mentioned pharmacists and potentially a shortage of pharmacists coming. Many pharmacists -- and by the way, you mentioned that people get to grad school maybe up to three years. Pharmacists go to grad school four years, plus 20 percent of them do

residencies now. You could finish med school by them, by the time you come out of pharmacy school. There's going to be a shortage, because many feel like they're glorified claims adjudicators, and they're not getting to do the things that they're skilled to do. And I can pull some data for you, but I think that's one of the things with pharmacy that's a real hold-up. So thanks again for the work.

MS. KELLEY: Cheryl.

DR. DAMBERG: Great chapter. I really appreciate all the work that went into it. You know, the numbers you show are sobering, and I think it's a good reminder as we do our work every year of keeping in mind sort of the issues of fiscal restraint in terms of increasing spending, because that has consequences for taxpayers but also beneficiaries who have skin in the game.

And also the importance of aligning incentives. You know, I was interested, or I saw that there's been this pivot away from Part A into Part B services. And I wondered to what extent that's been through all these various efforts to tamp down on spending, whether it's through ACOs or other types of value-based payment models.

So I think, again, keeping our attention on where the incentives are misaligned and what we can do to improve incentives is really top of mind for me.

The other thing I would note is that I like the emphasis on workforce and how you unpacked it, but I was really very appreciative of all the work that you did to really unpack the consolidation space. You know, I think, overall, the purported benefits of how consolidation is being sold to regulators really, you know, those benefits haven't really materialized. We've seen increased spending. It's not clear that we've seen increased coordination that's leading to better outcomes. And I don't think we've seen evidence that it's improved efficiency in a meaningful way, such that it's driving down spend.

And I think there are opportunities here for CMS to collect better data on ownership and affiliation relationship, to allow us all to better understand what's happening in this space, including private equity. So I would like to see us make some reference to the need for better data in this space.

I also would hope that maybe we could continue to

play out some of the underlying problems associated with consolidation, whether it's these arbitrage opportunities that exist that aren't leading to better value and are driving up spending. I know you highlighted the workaround to the medical loss ratio. I think that's important. But also the conflicts of interest. And as I look at, say, the plans that own providers and charging higher prices, the cost of delivering care in those models is potentially higher. I think that is problematic.

I'm going to touch on a couple of other items. One of the things that was noted on page 22 is that Part B has grown as a share of program spending. And I wondered if you might be able to decompose that into how much of that is physician services versus the drug component within Part B.

And then on page 12, as providers furnish more complex, higher-priced services, I mean, I don't expect you to have the answer to this, but to me it raised the question of is this actually translating into better outcomes? Are we getting better value for that spend? So again, trying to understand what types of outcomes we can measure or that the research community could measure to try

to help us understand whether we are getting better value for that spend. Thank you.

MS. KELLEY: Greg.

MR. POULSEN: Thank you. This is -- this is a great chapter. I loved it, and I'm going to have a few suggestions but don't in any way want to have that detract from the admiration I have for all the really good stuff that's there.

The first one is we talk about the 1.9 percent enrollment growth that's leading to bigger impact. So the people coming in through the tail end of the baby boomers. I think that that's really important, but it probably is -- and I think the actuarial assumptions are built into this, but we should recognize in this group that it's probably the leading end of the baby boomers that are leading to the biggest cost increases, not the tail end, because those are the ones that are now moving into the high-use years.

There's nothing more wonderful for an MA plan than a 65-year-old or 66-year-old, right? It's when a decade later they start to really become high utilizers.

So again, nothing I think we should change there, I don't think, but we ought to just keep in mind that as

the pig moves through the python, it's going to take longer than we think, because the people that are now just entering Medicare in the next few years are going to be really starting to increase the cost a decade from now. So thanks for that.

The second point -- and this is kind of related to that -- we talked about the beneficiaries appearing healthier. I think, again, at least part of that is the fact that we're getting this bolus of people moving into the early years and that they tend to look healthier. While I don't think anybody here has said, well, this is a rosy picture, that that part may make us think more rosily than we should, because that group is going to enter the less healthy years over time.

The third area, great job highlighting the fact that the trust fund solvency is not the key issue. So many people talk about, wow, the Part A trust fund -- they don't say Part A. They talk about the Medicare trust fund -- looks like it's in pretty good shape. And whether it's 2033 or 2052, boy, that looks better than it used to. We used to think we were already going to go bankrupt.

What I think is not widely appreciated -- and I

guess I would even suggest we might want to highlight this in the executive summary -- is the fact that Part A is the slowest growing part of the Medicare program. And the other parts are being funded not by money that's sitting around in a bank account somewhere, but by tax revenues that we don't have, that we aren't collecting, so again, just a thought in terms of the way that we tone that. The content is exactly right. I think I just maybe moved the emphasis into the executive summary just a little bit more intensively, so good for that.

Good job on the consolidation discussions, and that's where I wanted to spend the remainder of my concerns. I appreciated that we mentioned that there are some good things that can come through consolidation, and that sometimes doesn't get identified. And while I recognize that the majority of both the content and the concerns are in the negative as opposed to the positives, I'm glad we do mention some of the positives.

The issue, though, that I think we may want to put some more work on -- and it may be too late for this year, but I think we need to look at it in the future -- is I believe the single biggest challenge related to

consolidation is in the area of PBMs.

We mentioned that on page 16, I think it was, but it's just in passing. And I think if we look at the PBMs, the last time I looked, there were 66 PBMs in the country, but three of them are more than 80 percent of the total volumes. And it's not just that they're large. It's that the impact is really significant.

All three of those large PBMs are incorporated into large insurers, and they contribute to an almost complete opacity to the underlying drug expenses. And in some cases, drug funds through rebates are being used or provided in mechanisms that nobody knows what's happening with them. And it's, I think, probably -- and somebody may disagree with me on this, but I think it's probably the most opaque passage of enormous amounts of money that we have in the Medicare program, where we have the least insight into the biggest numbers.

Stacie, I think, did a tremendous bit of work in something that she published that showed that not only is the drug spend for Medicare really, really high, 27.2 percent, I think, in 2019, but that it was growing at about a 5 percent clip per year as a percentage of Medicare

spend. So if we fast forward that, we're looking at a third of total Medicare spending being on something that is becoming increasingly opaque, and that's not a path to success.

So I would definitely think that that's an area where, in our consolidation area, we'd like to put some real emphasis, so thanks for that.

And I think that's probably where I'll leave it. So thanks very much for great work.

MS. KELLEY: Brian.

DR. MILLER: Thank you.

So I have some questions in a couple areas. Excited to see the consolidation workforce and other issues in here, and I'm a big fan of antitrust enforcement. I love the FTC and DOJ antitrust division across administrations. They have been very assertive, which I think is very healthy.

I do think, you know, horizontal integration, the evidence is pretty clear, but for vertical, in particular, payer-provider integration, it's how we discussed on page 4, do we think that there are any benefits to payer-provider integration?

DR. HARRIS: That's a great question. I would have to look at some of the theoretical literature around that --

DR. MILLER: So --

DR. HARRIS: -- and what folks have been saying, but not anything, to my knowledge, that we've seen actual results of.

DR. MILLER: So I can send you the payer-provider vertical merger review framework that I wrote with the former head of the FTC hospital merger section. A couple things -- and there are definitely problems with vertical mergers. I'm 100 percent on board with that.

But for payer-provider integration, despite problems, there's anti-competitive harms and there's pro-competitive efficiencies, and on the program -- and I think we have a pretty good grasp on the anti-competitive harms. On the pro-competitive efficiencies, I'd put elimination of double marginalization, a traditional vertical merger, simplification of consumer choice and streamlining of the care experience, a la Geisinger, you know, UPMC, Highmark, Kaiser. Again, not saying the organizations are perfect. Decreased coordination costs and facilitation of

implementation of new technologies, because you're vertically integrated, you can finance it and require operational execution. Improvement of overall care through integration of claims and clinical data, and those are just a couple.

You also mentioned empirical evidence. There's actually -- and I realize it's not perfect, but McKinsey has looked at star ratings and vertical integration for quite a while. I think going back 15 years. It's been a little bit since I dug throughout literature, but they found a pretty clear relationship between vertical integration or provider-sponsored health plans and MA star ratings. I realized McKinsey is perhaps not always the preferred source, but it's still data. It's still valid, and we should look at that.

Another area, on page 6, we mentioned the workforce, and there was a broader section, of course, in this chapter about that, which was new. I know that's a lot of work. Thank you for doing that. It was very thorough.

One thing that I would add is Baumol's cost disease and the lack of labor productivity growth in the

hospital industry for 30 plus years. That's straight in the BLS data. You can look at the labor productivity for private community hospitals. Again, measurement's not perfect, but it's pretty consistent. Number of hours -- you know, output goes up, number of workers, number of hours, whatever it is, goes up. Productivity is flat or declining in some years, which is depressing. That's why everyone, all of us in D.C., wear black or dark colors to meetings where we discuss health policy, because it's bleak and getting worse.

On page 16, we mentioned private equity. Again, agree that there are lots of challenges, even in financing of a sector that is 4 percent to 6 percent of the marketplace. I guess my question is, do we think that there are economies of scale to be achieved by integrating similar clinical operations?

DR. HARRIS: Economies of scale for who?

DR. MILLER: For the operating system, like whether if you have on -- is there economies of scale if you have one orthopedic surgery clinic versus 10?

DR. HARRIS: I think theoretically, there may be a basis for that. I think empirically, in this space,

particularly for private equity, I am not aware of any evidence.

DR. MILLER: I mean, I think some of the evidence that's been published that shows that there are increased prices also shows that there's a change in the workforce composition and a change in sort of operational efficiency. So I think it's important that we acknowledge that. Again, I agree that there are lots of problems, but we should acknowledge that operational efficiency and economies of scale.

The other thing I think we should also mention, because we talked about the decline of independent physician practices, there's also the decline of independent community pharmacists, and there's good research on that.

Part of the reason that we've gotten here is because of Stark Law, and I think we should mention that because it prevents physician self-referral. Hospitals can self-refer. Integrated health systems can self-refer. A payer provider can self-refer. This is not to say that Kaiser is doing something malicious or bad. Self-referral can have a valid clinical reason. Whether it's

Intermountain, whether it's Kaiser, whether it's Geisinger, there's a lot of reasons why you want integrated care delivery and self-referral that's beneficial to the patient, beneficial to clinical operations, better efficiency, quality, et cetera.

At the micro level and potentially at the macro level, realize easy to say, hard to measure, But we should note that self-referral has benefits and that because we have preferenced one model of self-referral, namely taxpaying and tax-exempt hospitals, we have functionally prohibited physicians from owning and operating integrated care delivery. As you have more consolidation towards integrated care delivery, you have a loss and destruction of small business enterprise, and I think that's an important thing, whether it's physician-owned hospitals, whether it's Stark Law writ large. And we can say that while acknowledging the problems in a fee-for-service setting for self-referral, which apply not just to physicians but also apply to taxpaying and tax-exempt hospitals too, which have the same sorts of problems.

And then we can also note -- and this again makes my physician colleagues grumpy when I say this, but in a

managed care setting -- here we're in Medicare but applies to Medicaid too. In a managed care setting where you have utilization review and prior authorization, which none of us particularly enjoy, that polices and has the potential to police a lot of induced demand. So I think it's important that we mention that.

Just a couple other handful things. On page 18, we noted that payers acquire providers purposely for the reason of improving MA star ratings. Do we have any evidence of that?

DR. HARRIS: There is one paper cited that is a theoretical paper.

DR. MILLER: Right.

DR. HARRIS: But no.

DR. MILLER: So we should probably note that that's a theoretical paper, and it's not empirical evidence, which is okay. And then --

DR. HARRIS: Just to clarify, it is under the motivation section as a theoretical basis --

DR. MILLER: Yeah. And I --

DR. HARRIS: -- but we can add some language there to make it more clear.

DR. MILLER: Yeah. And I would add language that it's potentially good and potentially bad, right? Because if you acquire providers to improve your star ratings, that could be you're manipulating the metric, which is not good, or it could be you're actually improving quality, which would be a good thing.

DR. HARRIS: Yeah. And I think in that case, our intention was not to make a value judgment about that.

DR. MILLER: Yeah, I would mention both of them. I would mention both cases like that it could be good and it could be bad because, you know, a lot of things I think with payer-provider vertical integration can go either way, right? We've all seen multi-billion-dollar examples in various news outlets where this has not gone well, but then there are lots of -- you know, there's selection bias, obviously, in what gets reported in the media.

There are lots of examples where payer-provider vertical integration has gone well. We just don't talk about it because it doesn't generate news.

Two other small things. One, on page 31, when we talk about standalone Part D, we should probably note the pressure that the Inflation Reduction Act created. And,

you know, obviously, it's good to redesign the Part D benefit and sort of eliminate that donut hole, which is not nice to older folks, to put it mildly. But that we unintentionally then juiced the MAPD market and sort of crushed the standalone PDP market by having that really aggressive change in physical responsibility on the back end of the Part D benefit that got, you know, implemented very quickly. And so then drug costs, you know, actually got transferred to the beneficiaries in the form of higher premiums, and then we had the demo to subsidize that.

And then the last thing, I really appreciate on page 36, that description of MA, and I would actually make it even more explicit. And I say this because a lot of people I talk to fundamentally don't understand the differences in benefit design across the programs, and so I would just explicitly say, you know, fee-for-service is A plus B benefits. You buy Medicare supplemental coverage, usually in the form of Medigap, or you get it, you know, through Tricare, VA, Medicaid. Then you buy Part D, and then MA for the super majority of beneficiaries includes A, B, D, and MA's own version of Medigap plus supplemental benefits, because when we say supplemental coverage -- and

I realize like reduced A and B cost sharing, we're all nerdy, and we all know what that means, like the people sitting around the table. But most of the people reading that chapter don't realize that MA functionally includes Medigap as a benefit.

And I realize "Medigap" is a term of art with a very specific meaning, but we should probably functionally say that MA includes that, because then when you tell people that, they're like, oh, and they understand how that benefits package is very different from the fee-for-service one, because at the end of the day, you know, the beneficiary needs the entire holistic benefits package. And if it's not clear what's in what program, like, it sort of, you know, muddies the policy conversation. So I guess I'm saying take that discussion on page 36 and even make it more explicit and more obvious.

But I really like the chapter. I love the sort of revamp that it got. So thank you.

MS. KELLEY: Lynn.

MS. BARR: Betty, my hat's off to you. We finally got to talk about consolidation. I mean, I don't know how you snuck this in here. But I'm really, really

impressed by your style.

DR. RAMBUR: [Speaking off microphone.]

MS. BARR: So there you go. Larry would be so happy. I hope he's out in the audience today.

But I wanted to -- I've been thinking -- you know, so from a rural perspective on consolidation, I mean, I was looking through databases a lot recently and cost reports and about -- and it's rather quickly about 30 percent of rural hospitals are now part of a system, which is a lot. And, you know, considering they were pretty much all independent 10 years ago, things have changed dramatically.

And when I think about, you know, a potential concern about consolidation that wasn't mentioned in the chapter is really the concerns about treatment choices. And I'm very concerned that, according to NCI, the mortality rate for cancer in rural America is about 10 percent higher than it is in the rest of the country. And when you are -- and most of the systems that acquire these rural hospitals are not academic medical centers. They're community hospitals. They're referral, you know, nice little 300 bed hospitals that are within an hour's drive,

and they do, you know, a really nice job.

But where cancer has such a -- you know, these opposing incentives of can be very, very profitable for a hospital to administer the drugs. Right? And they want to keep -- and I -- like, oh yeah, we can treat that patient, and we can treat that patient, and we can treat that patient. And I've had the experience of trying to help a friend, you know, navigate the cancer systems, and the community hospitals did not offer anywhere near what we see in the academic medical centers.

I just looked. There's probably, you know, a dozen papers that pop up immediately saying that mortality rates in academic medical centers are, you know -- I don't know -- 7 percent lower than they are in community hospitals.

So when -- if there's something to look at or tease out in this data that could relate to a different conversation, you know, because a lot of the conversations we have are really ideological or theoretical, but we're not saying, hey, if you've got cancer, you really need to get yourself to an academic medical center. You know, I mean, not always, but by and large, you need to be

considering and getting those kinds of relationships. And if you're going from one hospital to a community hospital and then maybe getting to another hospital, then I don't know if that's in the best interest of the beneficiary.

So I don't know if there's anything we can tease out in the data that can show anything about outcomes, you know, for these -- you know, particularly in the rural space, outcomes of patients that are in systems, which is in the data versus not in systems on cancer, something like that to kind of start informing. Maybe we should have policies that are just, you know, like everybody should -- you know, if you have cancer, you really should be considering all of your choices more broadly than what's the most local closest or more convenient hospital.

Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yes. Thank you.

I just wanted to add to Betty's comments. It's great to see the interprofessional nature of the report as well. Particularly striking was Slide No. 27, where the pharmacists have been essentially flat for over a decade, and the LPNs have been relatively decreasing. So it's nice

to see that kind of data more holistically when discussing Medicare in a greater context.

My comments are also going to focus on Slide 21, which basically discussed the motivations around consolidation. It's a good list, but I'm not sure it's a complete list. And I think one of the reasons why in the literature there are mixed results around this is because sometimes we're not asking the right questions to really understand why consolidation occurs in different markets.

But a few reasons, that, you know, sometimes in the interest of long-term financial sustainability, hospitals and health systems are consolidating in different markets that may have more favorable commercial mix in order to make sure that they can still take care of populations that may be more vulnerable and on a more governmental payer mix. So sometimes they're looking for balance, and that's why they reach out.

Other issues have to do with network adequacy, but sometimes the network adequacy has to do with their own employees, making sure that they have access to care as well.

Sometimes it's around a clinically integrated

network. Maybe they have an MA plan. Maybe it's about IPAs that they're affiliated with. And so there's lots of reasons why they may be, you know, expanding and consolidating to make sure that they have the appropriate diverse assets as well, including population health. So they may be looking for skilled nursing facilities and rehab facilities and LTCHs and at-home health just to make sure that they can manage the population well.

And then finally, most hospitals and health systems are actually, you know, not-for-profit, and so many of them are not necessarily always chasing the almighty RVU, but they're also constantly doing, you know, a community needs assessment, engage with their communities. And sometimes they're investing in resources that doesn't necessarily help their margin but serves a community need as well.

So I think understanding all of those drivers can help us understand a little bit better how to target our questions to see why we have mixed results, but whether or not these pursuits of consolidation may have some benefit and under what circumstances.

But thank you for a great report.

MS. KELLEY: Okay. I have a comment from Tom next.

He says this is an excellent presentation, and he appreciates the work going into it.

The performance of the health care delivery system likely needs to be looked at from a local and regional level, rather than a national level.

There's incredible variation in performance among providers and cost utilization and quality. Unfortunately, CMS has set up incentives that are not driving improvements in care. Providers win in MA and CMMI programs through two mechanisms. The first is intense work to document and code increased population risk that drives increased payments. The second is by closing a very narrow set of pay-for-performance costs or quality metrics. Thus, the approach to improved care is not comprehensive and not driven by a vision of truly improving the health care delivery system.

He could expound in much more detail on this, but the current approach to cost control and especially quality is inadequate and, in his opinion, actually holding the country back from improving quality and delivering optimal outcomes for all patients.

I have Paul next.

DR. CASALE: Andy, my thanks. Great report, really interesting and cover a lot of territory.

So at the risk of sounding like a broken record, I'll bring up access, which I had before in general. So I appreciate that there is a focus on access within this report and in particular as it relates to consolidation, hyper consolidation. And I know we continue to look for ways to measure this and whether it's the hyper consolidation, again, the lack -- the movement away from independent practice, which you pointed out.

And, you know, when I was in training, which is a long time ago, most physicians were in independent practice, and we were taught to be successful in independent practice, there are three A's, availability, affability, and ability, in that order. So availability was the number one.

And I think we've surveyed, at least in the cardiologists, there's only about 10 percent that are independent. They consistently say they're successful because patients cannot get into the consolidated systems, which provide -- come to them for their care.

Another data point recently published in the Journal of the American College of Cardiology is that 46 percent of the 3,200 counties in the U.S. have no cardiologists. And we don't know exactly why, but understanding how things like consolidation may impact the choice of where cardiologists end up practicing may have some impact on availability of specialists like cardiologists or lack of that in large areas of the country.

And then finally, as it relates to the private equity, which, again, I appreciate the focus on that, there was a recent study, again, in the Journal of the American College of Cardiology looking at Medicare fee-for-service beneficiaries hospitalized with heart failure. And they looked at hospitals that recently were acquired by private equity, compared them to other hospital types, and fortunately, there were no differences in 30-day outcomes on mortality or revisits to the hospital, but they did see the clinical risk scores were lower in the private equity hospitals. And the transfer-out rate was higher for Black heart failure patients. Now, again, we don't know the reasons for all of that but appreciate the continued look

over time as to the potential impacts around access and care in that private equity acquisition area.

DR. HARRIS: And just to be clear, we can add that paper.

DR. CASALE: What's that?

DR. HARRIS: We can add that paper that you mentioned in ACC.

DR. CASALE: Yeah, okay. Great. All right. Thank you.

So thanks again. Again, great chapter.

MS. KELLEY: Scott.

DR. SARRAN: Yeah, thanks. Great work. Very nicely written. It tells a story really well. Two brief comments and an editorial, or two brief suggestions, perhaps, and then an editorial comment. And these suggestions are in the category if we have data available and it's easy. So I'm not trying to create work.

You described a couple of the drivers or associations with high-spending beneficiaries -- disabled status, I know we've referenced dual eligibility status. I might be worthwhile expanding that a bit and talking about the, Greg's comments, the old part of the pig moving

through the python, institutionalized beneficiaries, ESRD, dialysis-dependent beneficiaries, spending the last six months of life. And then, again, this is all if we have some easily available references, associations of higher spend with obesity. That's so much in the public mind now, in terms of how do we treat obesity, so framing that, I think, can be helpful. Cancer. Obviously, the therapies for cancer become both more, on one hand, efficacious, and impactful, which is wonderful, but very, very high cost on the other. And dementia. Again, as we get old, old, that's particularly concerning. So I think those would, if we have some of that data, that would help, I think the public discussion in the framing of that.

And then as Tom mentioned, a little of discussion, if we have some simple references we can pull, on regional variation. I think the original Atul Gawande article in The New Yorker was in 2009 or 2010, and there was this huge national, I recall, energy around variation in health care. And I feel like it went nowhere, or died down.

MS. BURTON: The answer was comparative effect of this research. That was going to solve the problem.

DR. SARRAN: Yeah. But it might be worthwhile, since you're highlighting it, and again, in a lot of ways simplistically, as people understandably look for some big levers to push, if we have parts of the country where Medicare or price variation is not a driver, by definition, we get equal or better clinical results with lower spend, then exploiting those practices, however we incent, cajole, reward, for that, is a great set of solutions.

The one editorial comment, I really am troubled by vertical consolidation among for-profit providers, particularly when that vertical consolidation is multi-provider type with a hospital, doctor, et cetera, and the payer and a PBM. And although I respect the comments made about how vertical consolidation is enabling better results, which is wonderful, it's also, particularly in the for-profit sector, there is a lack of transparency now, because we don't require transparency, on a granular level. There is a lack of transparency around how money is moved between entities, transfer pricing, for example, how physicians and hospitals are paid by the payer, et cetera. And that potentially obfuscates some regulatory review of MLR, specialists, et cetera. I just think it's very

troubling that there's so much taxpayer money moved in ways that we can't see where it's flowing.

So I think just highlighting that, without it sounding too much like my editorial comment, if we can sort of highlight that as these entities form, that involve all those aspects -- payer, provider, PBM -- it's reasonable for us to expect a higher degree of transparency so that we can understand where the money is going and how that might impact regulations that are already in effect, legislational regulations that are already in effect, such as MLR. Thanks.

MS. KELLEY: Greg.

MR. POULSEN: I put down Round 3, so I guess we're technically there. I just wanted to follow up quickly on what Scott just said about the concerns around vertical integration and the opacity of the money flow. I agree with that completely. And I find myself conflicted here, because I think the concerns are very legitimate, and I think the way they play out in the country are frequently legitimate.

But I'm also aware of the successes where vertical integration has been used to do some very, very

good things. Brian talked about that, Cheryl mentioned the concerns associated with that, and I think playing off of those two, it's very difficult to know how to deal with it from a policy perspective.

Because when we look at some the data, provider-sponsored health plans have been shown in a number of studies to be very effective at improving quality metrics, at improving satisfaction metrics, at keeping people engaged to the point where they want to stay inside of the organization that they are providing. They tend to participate for far longer times, 2.4 times longer, than the alternatives, which tends to provide continuity of care, continuity of commitment, and I think an ongoing reward for taking care of people, both clinically and financially.

So I think it's tricky to try and tease those things out, and I'm not sure that there's a really good way. But I think it would be unwise for us to either fully celebrate or vilify vertical integration, because there are examples of it being both good and harmful that we can cite. So being able to understand those, I think we've got more work to do to be able to identify when it can be a

very effective tool and when it can be a challenging or problematic tool.

So thanks very much for the chance to follow up.

DR. CHERNEW: Okay. We're in Round 3 now, so I'm going to speak more than I normally speak. I know, Tamara, you're going to be next, and you haven't spoken yet, so it's kind of Round 2/3, I understand. But I do want to respond to what Greg said and sort of a lot of the themes of what has been said.

I'm thrilled that you guys loved the consolidation and workforce stuff. There were, actually, those sections in the past reports, but this is obviously done in a way that's captured your imagination in ways that I think are terrific.

I do want to manage a little bit of expectations as we go forward. I will emphasize the context chapter, which our goal here is to, broadly speaking, present context. It is very important to be balanced, and I think the comments related to balance are really important. But it's not going to be a body of work where we're going to try and resolve some of the underlying issues that raised. I think analytically it's quite complicated knowing what

the right counterfactuals are, knowing what the heterogeneity is.

So I think what you'll see in this chapter, going forward, is going to be as balanced a lit review as we can do, as sort of thoughtful about the issues that are going on. But we're not going to try and do what we might in another chapter, where we really are going to say, okay, now we want to drive this or that. Now, it might be, over time, we decide to figure out, okay, this is a big issue and we're going to then build out a broader body of work. But that typically isn't what's going to get done in the context chapter.

So that's sort of my managing expectation comment, and maybe I'll say more about the substance later. But I first want Tamara to get her two cents in.

DR. KONETZKA: So a quick comment about the consolidation and then about the workforce, and thank you for a great chapter. Yeah, I was very happy to see the consolidation piece in here -- well, both of them, the workforce and the consolidation.

I won't say a lot more about it except that I will look forward to, to Mike's point, I will look forward

to, even if this is not sort of a separate workstream, of letting these issues sort of seep through the other conversations we have, because I do think it kind of affects almost everything else we discuss. And I think we can see from this literature review how many different sectors and parts of Medicare it has an effect on.

To that end, too, I mean, I think there are some mostly theoretical ways in which there might be benefits to some of this consolidation. When I look at this literature review, mostly I see it's very clear prices and spending go up, and we don't see a lot of the benefits. So I think another thing that will be interesting to do over time is to look for those examples and see if there is empirical evidence, and we can sort of identify areas where this does seem to work and why, relative to the vast majority of empirical evidence we have that it doesn't really improve quality.

So that's all I'll say on consolidation, just really happy it's in here, and that we're going to be thinking about it more. Because I think it's just really fundamental, becoming more fundamental.

The workforce issues, I really appreciated that

you talked a little bit more about SNFs and some of their issues around turnover. Two things about that, and I appreciated that you sort of mentioned the high rates of immigrant workers in the SNF sector. Two things about that. One, I know we probably really don't have data yet on changing immigration, but as we follow context over time, that will be a really critical piece of the context to follow, to see how that affects the ability of SNFs to hire workers.

And the other thing I would say is the parts of the chapter talking about some of those challenges in SNFs, there's really the same counterpart in home health, as well. And I feel like mostly what was in here about home health was how this is a high-growth area and that we're going to need more and more home health workers. But basically, they're finding the same challenges with finding low-skilled workers, and immigration is likely to affect that sector in the same way. So we might just want to balance that out in the chapter. Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Okay. Thanks for Round 3. So, Greg, I take your point about the potential positives of

consolidation. I think we all hope that those positives happen. But I think there are several challenges in this space, and I recognize we're not in the business of only talking about consolidation in MedPAC.

But this issue around transparency of these transactions and the underlying data to be able to assess impacts is really challenging. And I think it would be helpful if we could acknowledge that as we try to paint a balanced picture.

But, you know, we did a lot of work, this project I led for a number of years, around vertical integration. And organizations tend to be able to sort out the financial integration pretty quickly. And what's hard for them, you know, based on hundreds of interview we did with system leaders, is the clinical integration. And they said that's the Holy Grail, and it's kind of a long time in the making.

And I think part of the challenge in terms of trying to identify whether we've seen better quality, better outcomes, is that they're still sorting out this clinical integration part. And the question is sort of how long do we have to wait for that to emerge, and at what cost? Because clearly this consolidation has led to

increased market power, which has led to increased prices. And I really struggle on the efficiency front, and why aren't we seeing some of those efficiencies.

So maybe it's very costly to bring organizations together and get them to function, so organizations are making lots of investments that ultimately will lead to clinical integration. So this is a really complicated story line, and I just want to acknowledge that.

MS. KELLEY: Robert.

DR. CHERRY: Yeah. I think, first of all, this is a very much an academic exercise, not suggesting that we really rework the analytics around it. But the whole idea around the consolidation is an interesting topic. I tend to agree with Greg, and there are some complexities associated with this, which is you may have provider organizations buying an asset, but the reason why sometimes those assets are attractive is because they're underperforming and they see it as an investment, to be able to get it up to par. So they end up investing in environmental services. They end up hiring an additional infection prevention specialist. They end up improving the nursing ratios. Maybe these institutions are capital

starved and they have to now reinvest in CT scans, MRIs, laboratory equipment.

And so what looks like a cost-effective organization is now a high-cost organization. And then because we don't have the ability to measure the quality of care, we are seeing the same outcomes but at higher cost, when in fact that's not actually the narrative on the ground.

So it's very, very difficult to assess all this, but I think we should be just open-minded, that the narrative that we're seeing around consolidation may be incomplete.

DR. CHERNEW: I don't know if there's anyone else in the queue.

MS. KELLEY: I have no one else in the queue.

DR. CHERNEW: Perfect. I'm in the queue. Do I have to put in?

MS. KELLEY: No. I will allow it.

DR. CHERNEW: I'm actually never in the queue. That's the thing about the public meetings. It's the hardest part of my job is not being in the queue.

Anyway, so I will say a few things about all of

this material and sort of where we are context-wise and stuff. Because there's this core question. The context chapter is a place where the health care system issues overall creep into our work in ways that it typically isn't the case in the other work that we do. And a lot of the things that we think about antitrust enforcement, for example, is outside of sort of core what we do. But I do think there are few things to say.

First let me say something about spending. The biggest point that I think is relevant in the spending portion of this chapter, for me, is that Medicare spending growth projections, including some of the variation across different forecasters of that, is in what's happening in volume and intensity. So Robert, you asked what volume and intensity is and what it means. We can talk through that. I think it means different things in certain ways.

But I think the way to think about it easiest is it's a residual, the things that aren't priced, the things that aren't beneficiaries and mix is in volume and intensity. The distinction between volume and intensity I think is a little bit less important for the grand scheme of things, that we could discuss. But they key point is to

meet Medicare's fiscal challenges we're going to have to find some way to manage the growth in volume and intensity, and that includes new products in a whole bunch of ways.

The second thing, which very much relates to that, is as you all know, we are very aware of the fiscal challenges facing Medicare, and that certainly comes up in the context chapter, and it comes in a lot of the rest of our work. But I want to say, for those at home, we don't operate with a sort of fiscal target. We don't come into the meeting, which is it's our job to set the updates or whatever it is, in a way to meet the nation's fiscal challenges. There is a core bunch of other issues -- death, taxes -- a whole bunch of other things that matter. We are trying to figure out how we can efficiently purchase health care services to make sure that Medicare beneficiaries get access to the care that they need, and make recommendations accordingly. So we are certainly aware of the fiscal concerns, but we don't have this sort of overarching budget concern.

With regards to consolidation, and there's a lot of threads that came into consolidation, and we will do a lot of work on the literature, I think one way in which the

consolidation stuff, I think, really -- I was about to say plagues our work, and then I realized I shouldn't say that, and then I said it. Anyway, that's a learning moment.

We are structured, MedPAC is structured in a somewhat siloed way from much of our core work. We do work on fee schedules, and one of the challenges we face is as the system becomes more complicated, and you realize that the organization of MA plans, also in Part D, and that the hospitals, the inpatient services, is also providing outpatient services, and then often own ASCs, some of them own big physician practices. The insurers are now purchasing physician practices and ASCs. Independent of the sort of general economics of the merits of that or not, it challenges how we view the world in what we do. I think that's loosely what you were saying, Tamara, so I'm agreeing with you. Although it's hard to know. We kind of keep that in the back of our mind, and then we soldier on best we can, because sorting out all of those things matter.

I do think we have to think through how Medicare policy might encourage consolidation, and we do think about that. Certainly site neutral is the poster child for that

question.

The other thing I will say, which is relevant to our work that I don't think really came up but is also important, is the impact of consolidation overall and the impact of consolidation on Medicare depends on aspects of other things, like the way we pay. So it is not, in a sense, that consolidation is, say, inherently good or bad, although I do believe the literatures suggests that more often than not it's problematic, if you were to make an average statement. I think some of that reflects aspects of how we pay and how we regulate, and a whole bunch of other things we do.

So if it was the case that there was a lot of efficiency in consolidation, the solution may or may not be preventing consolidation. The solution could ultimately be change some of the ways we pay or how we regulate, to make sure that we can get the best we can from that consolidation.

And the other way that I think about consolidation as a growing challenge is what the right counterfactual is, particularly in smaller markets, where it's hard to bring the capital into the system to have a

fully competitive system. So then you have to think through how do we make sure that the capital and the resources get to those communities that need those resources and that capital. And the counterfactual, in some cases, might not be independence. It might be acquisition by a different type of actor. So acquisition by a hospital, acquisition by an insurance company. Those might be different ways that organizations, acquisition by a PE company, and we have to think through how those play out.

So for the purposes of consolidation here, I think we're going to try -- I appreciate your comments -- to stick to what we can sort of say in terms of the evidence, what we know from the literature, be as balanced as we can about what we think is going on, without trying to do work that we could at some point do or that the academic community writ large can do, to try and bring the best evidence to play. But right now it's hard to think through, really broadly, a trajectory of work that really takes on consolidation per se, except in some particular targeted places.

In regards to the workforce, which is sort of the

last part here, it is true, although we have spoken about workforce a lot -- actually, I should say this. Before I say how wonderful Betty is, Brian and Larry raised the issue of consolidation like, I don't know, in 1983, whenever Brian came, in 1986. I was five in 1986.

DR. MILLER: My first word to my parents was "consolidation," in 1986.

DR. CHERNEW: I imagine that wasn't the last. But anyway, the key thing is, you've been on that, and you were right. We have been thinking about this in a large way and trying to figure out how to deal with it. I say that, in part, because Betty has been raising the workforce issue since she joined MedPAC, and we've been thinking through that. And we have had a lot of workforce stuff we've done, and I think you see that we've been trying to build that out, and that's reflected in this chapter, which I think is wonderful.

One of the things that, honestly, it took me a while to understand, and I'll just emphasize it now, is in some of our other workforce work we tended to focus on different types of professionals that were delivering care to Medicare beneficiaries in ways that would pay in the fee

schedule. Look on our physician fee schedule work. We would talk about different types of providers delivering services.

And what Betty is really emphasizing -- she said it; I'm just reiterating -- is thinking through the vast number of professionals that are delivering services in ways that aren't paid directly. And we use the word "staff," but just to be clear, if you're a physician and you're on salary, and you're working for a large health care system, you might think, well, that's staff.

But in the way the payment system works, that's not the way it's played. There's a separate fee schedule for paying those folks. But there are a whole bunch of other folks that are not paid for their services through a fee schedule mechanism, and that's the distinction that I make. Are you lumped into the fee, so you're being paid that way, and Betty would say, you then become a cost in the way that fee is, or are you reimbursed directly for the service that you deliver. And that's kind of the distinction that we're thinking through, and that varies across all of these different people.

But what is very clear is to the extent that our

goal is to make sure that Medicare beneficiaries have access to high-quality care, that that process involves an increasingly vast arrays of different types of professionals. And the way the system is designed to pay and to organize that care matters. And it is important to think through that we have the workforce to make that all happen. That's kind of the message in some of the messages and the comments that you gave.

But there are a lot of issues about supporting that workforce to sort of transcend what we are at least now contemplating doing. Some of them could be within MedPAC and Medicare, and therefore MedPAC environment. Some of them, frankly, are things that might be happening outside of what Medicare or MedPAC does. But where it does come up a ton is when organizations can't get the right workforce, or more importantly, it becomes more expensive to acquire the right workforce, that influences the cost of delivery of care, and that influences how we have to think about our updates and the things that are kind of bread and butter MedPAC topics. And we certainly struggled with that a lot during the pandemic, when workforce was a particularly salient issue, and we will continue to do

that.

In any case, there are other areas besides consolidation and workforce. We are always going to have the cost part. I think the consolidation and workforce things are really important. There are other areas that matter, as well. These are the ones we focused on in this context chapter. And I think your comments, writ large, about ways to bring in new information, to maintain the balance of how we discuss that, are really appreciated by the staff, I'm sure, and by me, as well.

So, thank you very much for all of your time and all of your comments. I think it was a really good first day of this cycle. We had a real treat this morning. And so we will be back, if there's nothing else, and I'm looking. Paul? There is something.

MR. MASI: Real quick. Mike's a tough act to follow. I just wanted to add my thanks to Rachel and Alexandra for your terrific work here. I really appreciate that. I also wanted to add on to Mike's observations earlier around managing expectations. The great thing about a context chapter is we have the context chapter every year. And so we will take all of your comments. As

you know, we go back to the office and go over the transcript very carefully. We really appreciate all this feedback. We will try to incorporate as much as we can this cycle. But as you know, we'll be back at it again next year, so a lot of the things we're talking about here may be ideas for future work. So I just wanted to be up front about that.

DR. CHERNEW: And so for those of you who joined us at home, thank you very much. Please reach out to us with your comments at meetingcomments@medpac.gov, or through other ways. There are other ways to reach us. We do want to hear all that you have to say. But again, thank you. Alex, I hope you enjoyed that experience. I know Rachel loves it. Thank you both, for what you heard is a terrific chapter.

And we will be back tomorrow morning at 9 a.m. to talk about some other things. So again, thanks.

[Whereupon at 4:07 p.m. the meeting was recessed, to reconvene at 9:00 a.m. on Friday, September 5, 2025.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 5, 2025
8:59 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
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AGENDA PAGE

P R O C E E D I N G S

[8:59 a.m.]

DR. CHERNEW: Good morning, everybody, and welcome to our Friday morning MedPAC session for this cycle.

We are going to start with a topic that I think is really challenging. There are certain things that are really big-picture stuff we discuss, and then there's other really important issues that we hear about but maybe don't get quite the same attention. But this is one of these particularly challenging topics that actually could be quite important.

So it has to do with access to hospice services and the way we pay for hospice and how it influences that, and I will not dwell more on it. I'm going to let Kim start to go through with the actual issue. So, Kim, take it away.

MS. NEUMAN: Good morning.

Today we're going to discuss issues related to hospice and certain services under the hospice benefit for beneficiaries with end-stage renal disease, ESRD, or cancer.

Before we begin, I'd like to remind the audience that they can download a PDF of the slides on the right-hand side of the screen.

Hospice provides beneficiaries with an option for end-of-life care focused on symptom management and quality of life. Roughly half of Medicare decedents choose to enroll in hospice.

CMS has raised questions about access under the hospice benefit to certain high-cost services that may be palliative for some hospice patients, specifically dialysis for beneficiaries with ESRD and radiation, blood transfusions, and chemotherapy for beneficiaries with cancer.

In recent proposed rules, CMS has clarified that such services can be covered under the hospice benefit if the hospice physician determines they are palliative for an individual patient. CMS indicated hospices commented that the cost of these services exceeds Medicare's hospice daily payment rate, and CMS has sought comment on whether hospice payment changes are warranted.

So in light of these questions raised by CMS and others, we have a project under way that has two

objectives.

First, the project seeks to examine access to hospice for beneficiaries with ESRD and cancer and seeks to understand the role of and current experience with services like dialysis, radiation, blood transfusions, and chemotherapy for palliative purposes in hospice care.

Second, the project seeks to examine whether the hospice payment system influences access to high-cost palliative services and whether changes to the hospice payment system to improve payment accuracy are warranted.

This project has involved literature reviews, stakeholder interviews and site visits, and data analysis, and we presented preliminary findings at the April meeting. Based on your April feedback, we have revised the paper and added additional analyses.

So here's a roadmap for today's presentation. First, we'll discuss some background on hospice. Then we'll briefly review our prior data analysis and interview findings presented in April. Then we'll discuss new analysis we've conducted, including an analysis of older data on drugs furnished by hospices to cancer patients, and comparisons of hospice payments to estimated costs for

certain services. We'll conclude with a discussion of potential future policy directions.

So first, background on hospice. Enrollment in hospice is voluntary. It is a personal choice made by a beneficiary and their family. The hospice benefit offers symptom relief, comfort, and emotional support to terminally ill beneficiaries who choose to enroll. To be eligible, a beneficiary must have a life expectancy of six months or less if the disease runs its normal course as determined by their physician.

When a beneficiary chooses to enroll in hospice, they agree to receive palliative care for their terminal illness and related conditions under the hospice benefit and forego care for those conditions outside of hospice.

Services unrelated to the terminal condition continue to be covered outside of hospice, paid for separately by fee-for-service or Part D.

Hospice providers assume financial risk for all services that are reasonable and necessary for palliation of the terminal condition and related conditions. Medicare generally pays the hospice provider a daily payment rate that does not vary based on the number of visits or

services or treatments furnished.

So next, let's discuss the role of specialized services in the hospice benefit. For beneficiaries not enrolled in hospice, services such as dialysis, radiation, blood transfusions, and chemotherapy are often furnished with the goal of extending life.

For some hospice patients, however, these services may be palliative, meaning providing symptom relief. In those circumstances, CMS has stated that the services can be furnished under the hospice benefit.

These kinds of services raise complex issues for hospices. For example, at what point does the purpose of the service become symptom relief and fall within the scope of the hospice benefit? These determinations are likely very individualized, specific to the clinical circumstances of an individual patient at a specific time in their disease progression and the medical judgment of their physician.

A second complexity concerns the potential effect of the provision of these services on a patient's eligibility for hospice. If a service is both palliative and life-extending, a hospice physician would need to

determine the service's expected effect on the patient's life expectancy and whether the patient would meet the hospice eligibility criteria while receiving the service.

A third complexity relates to variation across clinicians and providers and their views about whether services are consistent with the hospice model of care. Hospice is intended to provide comfort and emotional support to patients near the end of life and generally lessen reliance on aggressive and invasive care.

Some clinicians and hospice providers may view treatments such as dialysis, radiation, blood transfusions, and chemotherapy as not palliative or not consistent with the hospice model of care.

Medicare navigates these complex individual circumstances by leaving it to hospices to decide whether they offer specialized services, relying on the medical judgment of the hospice physician and preferences of the patient and family.

So in April, we presented results from analyses of Medicare data and stakeholder interviews. I'll briefly summarize the key points and there are more details in your paper.

We first looked at hospice use patterns among beneficiaries with ESRD and cancer. We found ESRD decedents are substantially less likely to use hospice, and those that do enroll in hospice have much shorter stays than other decedents.

Decedents with cancer are more likely to use hospice but have shorter stays than other decedents. Beneficiaries who have blood cancer and especially those that are transfusion dependent have shorter stays than beneficiaries with other cancers.

Little Medicare data are available on provision of palliative dialysis, radiation, blood transfusions, and chemotherapy by hospices under the hospice benefit. CMS does not collect this information on hospice claims. Medicare cost reports include separate fields for palliative radiation and chemotherapy but not dialysis or blood transfusions, and few hospices report costs for radiation or chemotherapy.

As we discussed in detail at the April meeting, MedPAC staff conducted interviews to learn more about the role of and experience with these services in hospice care. We interviewed 12 clinicians in several specialties and

administrative and clinical staff at nine hospice providers and three ESRD facilities and multiple family caregivers.

Key findings from the interviews include, among clinicians we interviewed, there was general consensus that dialysis, radiation, and blood transfusions may be palliative for some hospice patients with ESRD or cancer. But there was less consensus about a palliative role for chemotherapy in hospice.

Hospice that furnished these services reported doing so for multiple reasons depending on the patient, including symptom relief, easing the decision to transition to hospice, or helping the patient reach such as -- certain goals such as attending a family event like a wedding.

Interviewees viewed these services such as dialysis, radiation, blood transfusions, and some chemotherapy as cost prohibitive for many hospices. Hospices we interviewed also mentioned some other services as high cost.

Interviewees also indicated that some maintenance dialysis patients -- that is, patients who have ESRD and who are already on dialysis -- and some transfusion dependent patients -- That is, patients with cancer who

have become reliant on blood transfusions -- who are nearing the end of life and wish to enroll in hospice may be dissuaded from doing so due to apprehension from -- about withdrawing from these treatments upon hospice enrollment.

So now I'll turn it over to Grace to discuss our new analysis.

DR. OH: As Kim mentioned, Medicare lacks data on the provision of specific services by hospice providers though such data could be useful in informing potential hospice payment policy changes. Hospices were however previously required to report on claims through October 2018, the drugs they furnished during hospice stays.

We examined hospice claims data on drugs furnished to hospice patients in calendar year 2017 with two goals, first, to get a sense of claims reporting compliance and feasibility of service-level claims reporting for hospice providers, and second, to analyze data on hospice provision of chemotherapy to cancer patients, a type of service CMS raised questions about and that we included in our clinician interviews.

We found approximately 90 percent of hospices

reported that drugs were furnished during hospice stays in 2017 and paid for under the hospice benefits.

Among hospices that reported at least one drug claim line, drugs were reported on average for 87 percent of beneficiary stays, and five therapeutic classes of drugs accounted for about 80 percent of drug claim lines reported by hospices. These drug classes included central nervous system agents, analgesic, anti-inflammatory or anti-fever drugs, cardiovascular therapy agents, gastrointestinal therapy agents, and respiratory therapy agents.

Among hospice enrollees with cancer, many therapeutic classes of drugs were reported on claims, but reported use of chemotherapy drugs was less than 1 percent.

Additionally, drugs classified as anti-neoplastic drugs were reported on claims for both enrollees with cancer and non-cancer diagnoses, which may indicate that some of these drugs were used for non-cancer indications such as to manage nausea and vomiting.

These data are consistent with what we heard in MedPAC stakeholder interviews that chemotherapy is generally not palliative for hospice patients and generally not provided in hospice.

Only a few clinicians expressed that chemotherapy may be palliative in circumstances limited to certain products and patients.

Next, we examined the adequacy of payments to hospices for patients receiving certain services. Medicare's hospice payments are intended to cover all services provided by the hospice during the stay.

Under a prospective payment system, it is expected that a provider may earn a profit on some cases and loss on others, but that it balances out over their patient population.

However, a mismatch between payments and costs for patients with certain characteristics can create potential access concerns if it is easy for providers to identify in advance which patients are likely to be costly and avoid those costs by not admitting those patients or by not furnishing costly services.

So we estimated the cost of providing dialysis, blood transfusions, and radiation during a hospice stay and compared these costs to Medicare's payment for the stay. We modeled two hypothetical scenarios for each type of treatment with different assumptions about hospice length

of stay, treatment frequency and costs for each service. Our model assumptions were based on what is available from the literature listed in the slide notes below as well as our stakeholder interviews, analysis of Medicare data, and input from MedPAC's staff physician. These comparisons are meant to be illustrative and to give a rough sense of the orders of magnitude.

Across the scenarios we modeled, we find that over the course of a hospice stay, estimated treatment costs for dialysis amounted to roughly 40 to 50 percent of total hospice payments. For blood transfusions, estimated treatment costs range from roughly 30 to 50 percent of total hospice payments, and for radiation, estimated treatment costs range from less than 10 percent to greater than 30 percent of total payments for the hospice stay.

The estimates across the scenario suggest that the cost of these treatments could constitute a substantial portion of Medicare's hospice payment for a stay in which they are furnished. For some hospice providers seeking to offer palliative dialysis, blood transfusions, or radiation, the hospice payment system may create a disincentive to furnish these services.

In the March 2025 report to the Congress, we concluded that aggregate level of payment for hospice care exceeds the level needed to furnish high-quality care to beneficiaries. The aggregate Medicare margin was nearly 10 percent in 2022 and projected to be 8 percent in 2025. This suggests there may be potential for budget-neutral payment adjustments to address payment adequacy for some hospice stays.

I will now turn it over to Nancy for a discussion of potential policy directions.

MS. RAY: Based on our interviews and data analyses, we have identified issues related to access to certain palliative services under hospice and Medicare's hospice payment policy. I will take you through some potential policy directions that are listed on this slide: enhanced data reporting, policy changes to the hospice payment system, and a voluntary transitional program. These options, which aim to improve the accuracy of the payment system and beneficiary access to hospice could be pursued based on Commissioners' interest.

We could explore the potential for hospices to report the provision of certain specialized palliative

services such as radiation on the claims they submit to CMS for payment. This policy option addresses the issue that Medicare lacks data on the provision of specialized services by hospice providers, including what share of patients receive such services and how many of these services patients receive.

CMS would then have baseline data on utilization that would help it structure and model new payment approaches such as the approaches included in your paper.

Also, as Grace discussed, there is a precedent for such an approach. On the other hand, this option would increase reporting burden for some hospices.

Your paper discusses three separate changes to the hospice payment system that are aimed at improving the payment accuracy of the payment system in a budget-neutral manner. These options are distinct, not intended to necessarily be implemented together.

The first potential change would establish an outlier payment mechanism in which Medicare pays providers who furnish certain high-cost services, an outlier payment for a portion of costs above a fixed loss amount. The advantages of this approach are listed on the slide and

include targeting funds to providers, furnishing specialized services, increasing incentives to furnish certain specialized services, and maintaining the bundled nature of the hospice payment system.

On the other hand, some stakeholders may view outlier payments, which compensates for a portion of higher cost as not sufficiently increasing incentives to furnish high-cost services. In addition, providers would have to report the provision of costly services on the claims they submit to CMS. One complexity concerns the calculation of the fixed loss amount.

The second potential change to the payment system would be to provide an add-on payment to hospices when they furnish certain costly palliative services like dialysis, blood transfusions or radiation, in addition to the daily hospice payment rate. This approach would target funds to providers furnishing the palliative services and would increase incentives to furnish them.

On the other hand, this approach would unbundle some hospice services, potentially undermining the structure of the payment system. In addition, some providers seeking higher payments might offer high-cost

services that are not consistent with the palliative intent of the hospice benefit.

The third potential change to the payment system would be including a case mix adjustment in which providers would be paid a higher bundled daily payment rate for hospice enrollees with certain diagnoses; for example, ESRD or blood cancer who tend to use certain special palliative services such as dialysis or blood transfusions. This option maintains the current structure of the hospice payment system and would target funds to providers who treat beneficiaries with certain diagnoses.

On the other hand, hospice providers who do not offer a specialized service such as dialysis would still be paid for treating patients with the selected diagnosis, ESRD, eligible for a case mix adjustment. In addition, it is unclear whether this option would alter incentives to furnish high-cost services because the magnitude of the increase in the payment rates could be modest.

Let's discuss the final potential policy option. We learned from interviewees and the literature that dialysis and blood transfusions are both palliative and life extending for certain beneficiaries near the end of

life and that the prospect of ceasing these treatments upon hospice enrollment may dissuade some beneficiaries who wish to enroll in hospice from doing so; in part, because ceasing these treatments is likely to result in death in a short period. During our interviews, hospices that did offer these treatments to patients with ESRD already on dialysis or patients dependent on blood transfusions told us that the possibility of receiving the treatments made it easier for the beneficiary to elect hospice, and that once enrolled in hospice, beneficiaries often chose to receive few treatments.

In future work, we could explore the potential to develop a voluntary transitional program that offers hospice enrollees the option to receive services such as palliative dialysis or blood transfusions paid for outside of the hospice benefit for some transitional time period or up to a specified number of treatments. For example, one collaborative program developed by a dialysis and hospice provider furnishes up to 10 palliative dialysis sessions while under hospice care.

Our analysis of this approach would need to consider a number of issues, including how to design the

transitional benefit, how to structure the model to promote close collaboration between the specialist administering the transitional treatments and the hospice physician, and how to design the model to minimize the potential for unintended financial incentives or undermining the hospice benefit criteria. Compared with the other policy directions, a voluntary transitional program would not be budget neutral.

So this concludes our presentation. We are happy to try to answer your questions. We would appreciate feedback on the materials, including the potential policy directions and future analytic work, and we anticipate that this work will be included as a chapter in the June 2026 report.

DR. CHERNEW: Thank you, Nancy. That was great. Kim and Grace, that was terrific. So we're about to go through our set of Round 1 and 2 questions. Cheryl, I think you're going to be first. But just let me say, to sort of level set here, We're very, very early on in this work in terms of where we want to go. There are obviously some policy options that have been just discussed by Nancy. The sort of question is what's your reaction. You know,

are there things you hate or are there things you love? And then we're going to think about how this will play out and the timing. But we're not close to sort of, oh, we're just about to make a recommendation.

So anyway, Cheryl.

DR. DAMBERG: Thanks. Just one quick question. Do you know why CMS stopped collecting data from the hospices? You know, is it a burden issue?

DR. OH: Yes. CMS did receive public comments relating to the administrative burden. So they -- oh, and they also stated that they don't need the information for hospice payment reform, so they stopped the reporting requirement in year 2018.

DR. DAMBERG: Okay. Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: First of all, thank you. Very informative chapter. Two quick questions, and this is probably a no-brainer, but we didn't mention peritoneal dialysis in the home as an option for people on hospice. Is that even an option, or is it always hemodialysis in a facility?

MS. RAY: Peritoneal in the home would be an

option.

MS. UPCHURCH: Okay. So when we price things out, I can't remember if there's a big distinction --

MS. RAY: In our policy estimates, it's the same payment rate for peritoneal or in-center.

MS. UPCHURCH: Okay. Because I'm thinking if you're getting it at home there's obviously less transport, less, you know, all of the things, less hassle. But I didn't know if there could be a transitional time where somebody might go, and I don't know if this happens, from hemodialysis and switches to peritoneal dialysis when they potentially go on hospice as way to sort of -- has anybody talked about that or is that in the literature?

MS. RAY: We didn't really hear that about patients switching from in-center to peritoneal.

MS. UPCHURCH: Okay.

MS. RAY: I think if they were already peritoneal --

MS. UPCHURCH: They stayed there.

MS. RAY: -- they stayed peritoneal. If they're already in-center, they would stay in-center.

MS. UPCHURCH: Okay. Then a second question

about that, or not about that specifically. When a family is making the decision to join hospice, and the beneficiary, do they know ahead of time, say if they're on dialysis, whether this high-cost benefit might be covered by their hospice versus, you know, I've got two hospices to choose from, or if I've got blood cancer then I'm going to be able to get a transfusion with one or the other? Is that known or told up front?

MS. NEUMAN: So the hospice physician, and Brian, do you want to --

DR. MILLER: Yeah. I was just going to say, if you're in like the hospital and you enroll in hospice, the case manager or social worker, depending upon how the unit is structured, reaches out to the local hospices, and they ascertain that, based upon the patient and family wishes. And so then you know, when you go and enroll in that hospice, if they have those services available or if they don't, and if they don't have those services available, you can make that choice.

MS. UPCHURCH: I guess you have to ask that, or is it told to you ahead of time? Because like you might not even think about that.

DR. MILLER: The hospice --

MS. UPCHURCH: It's made clear to people ahead of time.

DR. MILLER: It's made very, very clear.

MS. UPCHURCH: Okay. Great. If there's a choice, right. In a rural area I can see how it wouldn't be. Okay, great. Thank you so much.

MS. KELLEY: Robert.

DR. CHERRY: Thank you for this report. It was good looking through it. Just one, I think, minor correction. On one of the slides it was mentioned that there are five therapeutic classes of drugs that you're looking at, but it looks like there are six. I'm not sure if it's five or six, but if you could just take a brief look at that. Thank you.

MR. MASI: I think Kenny is next in the queue.

MR. KAN: Okay, thanks. On page 13, the cost of radiation, that's a wide range in there. If I have to estimate like a median cost, what would that be? It's like less than 10, greater than 30.

MS. NEUMAN: So with the radiation, and with all of our scenarios, we had to make assumptions about the

frequency of treatment. And so in that situation we had two scenarios, one where a person got a single fraction of radiation, and another where they got five in their hospice stay. And so those are just two scenarios, based on assumptions from our interview and from the literature. We don't have data on the actual frequency that it is incurring in hospice currently or that it would incur if payment changes were made. It's just scenarios, two scenarios, to give you a sense.

MR. KAN: Okay. Thank you.

DR. CHERNEW: I think we missed Lynn.

MR. MASI: I apologize, Lynn. You are next.

DR. CHERNEW: But it's okay. Go ahead, Lynn.

MS. BARR: Okay. Thank you. On Option 3 you talk about budget neutrality, and I'm focusing really just on ESRD, particularly. And like that's a hard transition. So I'm wondering as you think about to go from ESRD to hospice and give up your dialysis, so I would understand patients wanting to continue, and they do tend to enroll in hospice much later. So I'm wondering how you're thinking about budget neutrality when really we're just, you know, they're continuing their dialysis without hospice services,

right, but we're not going to do more dialysis, right, because they're in hospice. Hopefully we would end up doing less. And I was wondering, how are you going to think about that?

MS. NEUMAN: So in those payment options or directions, they are sort of conceptualizing making changes within the hospice payment system in a budget neutral way. So the idea is that the Commission has found, in aggregate, that the hospice payment level is sufficient. And so can you possibly make changes for certain kinds of stays, such as a stay where someone might be receiving dialysis, in a way that increases those payments, but then there's an offsetting effect to all hospice payments. So that in aggregate the amount of money that the hospice payment system is paying out isn't changing. It's just that some stays are getting a little bit more, and then other states would be getting less. So if you think about it in other payments, that's how outliers work, right, in the hospital payment system, for example.

MS. BARR: So you're talking about budget neutrality within hospice but not budget neutrality within Medicare. Because you do have evidence that people going

into hospice save money, right? I can't actually remember whether that goes down or not.

MS. NEUMAN: I think that that is a very complicated issue that we're still sort of wading through. And we were sort of setting that aside for the purposes of this analysis and thinking about this in terms of hospice payment accuracy and sort of getting the levels right within the hospice payment system.

DR. CHERNEW: So let me try and jump in for a second. We, as I said, are early on in how we think through this. So we don't have to impose budget neutrality or not. We don't have to think about it within the hospice system with Medicare overall. I think the core problem that we've been sort of focusing on as a starting point, or the core issue, actually we'll see as we go around how big of a problem it is. But the core issue that we've been focusing on is because of the way that the hospice payment system is set up there is a disincentive for some types of patients to get into hospice. And so the question is can we address that issue. Once you address that issue there will be some fiscal consequences to whatever you do. The question is do you just pay it?

I could tell you a story -- I'm not sure it's true -- where you actually save money by getting more people in, overall, and that you don't worry about the budget neutrality. So that's a separate scoring issue.

But I'm not sure we're yet over the hurdle that we should try and make sure that there's an incentive to bring these people into the hospice system, and if so, through which of the mechanisms that the team discussed. So that's kind of where we are. I would think of budget neutrality, at least at this stage, as the secondary question. First figure out if there's a problem. Then what we want to do, and what that's going to cost, and then how we want the burden of that cost to be paid. But that's a multi-chain set of things when we're sort of in the beginning.

MS. KELLEY: Wayne.

DR. RILEY: Yes, thank you for laying out these three options. I had two questions, one of which you addressed with Gina about the whole issue of peritoneal dialysis, because from my experience that has come up when talking with patients or the case workers, about the appropriate place to offer to a patient in terms of hospice

care. So thank you for clearing that up a little bit.

The second question is about the limitation in services in Option 2. What can you tell us about the frequency analysis about what services, you know, tend to cluster with ESRD patients going into hospice care? I think I have a hunch, but I don't want to prejudge it without data. So what can you share about that?

MS. RAY: Okay. So your question is what services would be involved with the Option 2 as an add-on payment.

MS. RAY: Right. And just to be clear, are you on Slide 17 or 18?

DR. RILEY: [Inaudible.]

MR. MASI: Can you put up Slide 17, I think we're talking about?

MS. RAY: Okay. We've listed two complexity disadvantages with respect to the high cost outlier payments. Number one, Medicare uses outliers in many prospective payment systems. However, it pays for a portion of the cost that providers incur. And so some may view that as not being sufficient.

DR. CHERNEW: Let me see if I can interpret your

question. I think you're asking which services. So it says it's going to target the outliers for certain specialized services. And so there's an outlier version of it where you could say, okay, looking at the total spend and pay a portion of the total spend outlier. And the way this is designed, the way it's written, it's saying we're going to look at providers who use certain services and pay a portion of those services. So it's not an aggregate spend outlier model. It's a service-specific outlier model. At least I think that's the way that Wayne is interpreting it. And so I think the question he's asking is, is that the right interpretation, and if so, which services?

MS. RAY: I think at this stage we are still seeking input about that. I mean, we are thinking about it for dialysis, radiation, and blood transfusions as we said. But whether it's like the ESRD-PPS, where the outlier is targeted for certain drugs and services, versus other outliers where it's paid on the patient case, I think that's a road we have not gone down yet.

DR. RILEY: And that's why I probed it, because I think it would be helpful, as you and the staff think about

this, to come up with the top 10 or top whatever, whether it's drugs or procedures, therapeutics, that might fall under this scheme.

DR. CHERNEW: And as an aside, it's probably the case, as we go back and think through this, that you could make the add-on payment option and the outlier payment options reasonably similar by just setting the add-on payment as a portion of the specific service. So we can sort through the nuances of that distinction. I think the bigger one is how service-specific versus how case-specific you want to think through outlier stuff. I think in each case, because the parameters of all this matter, right, I think the add-on and the outlier policy all have the flavor of you're putting more money in for a subset of patients, based on their use, measured in a particular way.

DR. RILEY: Thank you.

MS. KELLEY: Gokhan.

DR. METAN: First of all, thank you very much for this work. This is very great. I have two questions, clarifying questions. The first one is about page 20, Slide 20, the voluntary transitional program. It's essentially recommended as part of this kind of like

transition from some of these services. But then when I kind of like look to Slide 2, these services are part of Medicare and it's covered by CMS, even if it's conflicting that we are proposing something that's already covered.

And the second related question to that is if these services are covered under the current program, why would this voluntary transition program increase the spending? I'm trying to understand that. So that's my first question. I will get to the second question later.

MS. RAY: All right. I will take a stab at it and then look to my colleagues for help. So we put out there the voluntary transitional program as an option, based on what we heard from our interviews of stakeholders and our analysis of the literature and our analysis of data that hospice use rates for certain beneficiaries, and that includes the ESRD patients, is lower. And that the access to dialysis, which you are correct, is covered under the hospice --

DR. CHERNEW: It's covered, but it's not incrementally paid for. So you could deliver the service. The hospice would have to pay essentially out of its current daily rate the cost of dialysis. You could give it

to somebody, but their hospice wouldn't get extra money for that. And that discourages the hospice from accepting patients, and patients from going into hospice, that may want or need those services. And the discussion now is the service is still covered, but now, in some of these policies, there's an added payment for those services that then changes the incentive for both the beneficiary and the hospice for going into hospice and delivering those services.

So I don't think it's an issue of whether the service is covered, in a technical sense. It's a question of how the hospice is or is not getting reimbursed for the added provision of the service.

DR. METAN: Okay. So these could be given outside of hospice and that would create additional --

DR. CHERNEW: No, no. So I think the question he's asking, if you join a hospice and you want to have dialysis, the hospice has to pay.

DR. METAN: This is under the hospice payment, and with the transitional program does that mean that they can get those services outside of hospice, and that would incur additional payment? Is that the reason?

MR. MASI: And I think that would be -- and Kim and Nancy, you can certainly jump in -- I think that's kind of an additional design detail that you all certainly should talk through when you want to. I know you want to get in here, Brian. But I'd emphasize what Mike said, that this was intended to be not a change in coverage or any kind of change in clinical delivery but really just a change in the payment model with an eye on the underlying incentives. Brian, I know you want to get in here.

DR. MILLER: A clinical comment. If you don't enroll in hospice, you can still put together a bunch of other services to get hospice-like care, and like scope things that you want or not want done to yourself. So if you have end-stage cancer and are on dialysis, you can enroll in hospice. Hospice probably won't offer dialysis. You can also get discharged from the hospital to a subacute rehab or a home with additional services like nursing care services, et cetera.

So you can get a lot of those services wrapped around through the other parts of the Medicare benefit, and clinically get a very similar experience to hospice. It's not exactly the same, but it's relatively similar. And a

lot of those beneficiaries, they don't necessarily want to enroll in hospice for specific reasons but to get those services through part of the benefit.

And then sometimes they and their family will make that transition and then transition into hospice, and that's sort of part of that, the stages of end of life, where people have different values and different priorities. And the Medicare benefit is not perfect, but there is actually a lot of flexibility for people to access support and services in different ways, with different degrees of limitations and scoping.

So when we talk about transitional care program, I guess I would say you can already sort of get that through other parts of the Medicare benefits package.

DR. METAN: Okay. Thank you. And my second question is, so to my knowledge, if someone is end stage and moving to hospice service, and if they are enrolled in Medicare Advantage plan, they are moved to fee-for-service, correct, in the current --

MS. NEUMAN: So fee-for-service pays for their hospice care. They can still remain in Medicare Advantage.

DR. METAN: Oh, they can?

MS. NEUMAN: Yes. And so for services, like supplemental benefits, and drugs that are not related to the terminal condition, those continue to be under the MA plan. But it's largely fee-for-service who is paying for their care, even if they remain in MA.

DR. METAN: Okay. So my question is more historical in nature. Were there any pilot programs or experiments where hospice care is kind of like managed by the Medicare Advantage plans, where we kind of like have data to compare how, in those situations, this is managed, or efficiently kind of maybe serviced?

MS. NEUMAN: So CMMI has included in its VBID models for Medicare Advantage plans a hospice benefit component, and that was a four-year effort. And in that, certain Medicare Advantage plans could offer hospice. And the evaluations have found that it didn't generally change hospice utilization. The other thing just to note about that, because it's relevant here today, is that they were allowed to provide transitional concurrent care. It's in the paper. There's more discussion of it on page 44. But there was the possibility that they could provide certain services like dialysis, radiation, other kinds of services

that are more specialized, while someone was in hospice. But there was very low use of that in the demonstration. And there are more details in your paper.

DR. METAN: So when you say little used, like less people utilized? Is that like we don't have data to compare?

MS. NEUMAN: Well, so the evaluators did -- stepping back. In terms of use of hospice, putting aside use of specialized services concurrently, but use of hospice, the evaluators found the demonstration didn't have much effect. There weren't changes in utilization patterns for the folks who got hospice through their MA plan versus those who get it through fee-for-service. So that, at sort of the highest levels, would have found. And then there is this piece where the MA plans could allow patients to receive these specialized services as outside of hospice while they were on hospice, but that was a very small percentage of beneficiaries who got anything like that in the demonstration. And there's some discussion in your paper of like some of the challenges that they encountered in trying to do that.

DR. METAN: Okay. So would it be fair to say

then we don't have much historical experimental pilot programs to learn different models and how they can work in this situation?

MS. NEUMAN: I think so. I think the MA VBID is our main experiment at this time.

DR. METAN: Thank you.

DR. CHERNEW: So there's going to be, I believe, a lot of discussion about some issue about the extent to which non-hospice enrollment, non-enrollment in hospice, what can be cobbled together. So let's just let that discussion roll out through Round 2, so we can just stay on that general point.

Paul wants to say something.

MR. MASI: Just real quick for context, I just wanted to flag that as we're talking about MA relative to the hospice benefit, in 2014, the Commission recommended carving the hospice benefit into Medicare Advantage, and talked about a variety of benefits around improved care coordination and equity across beneficiaries. So that's kind of the historical point on where the Commission has been on that in the past.

DR. CHERNEW: Okay. So we're going to start Round 2, and I think Tamara is going to start. But I think the issue that kind of going around that I think is going to matter is the core issue we're focusing on is that there are disincentives in the hospice payment model for certain patients choosing hospice. Whether or not that is a big problem or a small problem, or one that needs addressed or not, is central to the discussion we're having now. And the team put together a series of ways you could address that, but it is important as we go forward to get a sense of how we think about how big of a problem that is.

So, Tamara.

DR. KONETZKA: Thank you. That's a great lead-in to the beginning of my comments, actually. Thank you for this really exciting work. And I wanted to start by saying I'm very excited that we're going down this road because I think it is a problem when we look at sort of general satisfaction with hospice and some good evidence, at least in some populations, that it can save money overall for Medicare.

I think looking at these populations, ESRD and some of the cancers, as well, the fact that their rates of

use of hospice are so low really indicates to me that there's some kind of structural or payment problem that really should be solved, and that beneficiaries would be better off if we could solve that problem. So I'm really happy that we're exploring these.

I'll start by saying that I think it is just wrong that hospices are allowed to have different philosophies over whether or not to cover these services. I know given Gina's Round 1 question she's probably about to say the same thing. But the example in the text about, well, we do this all the time, like SNFs can decide whether or not to offer event care, to me that's a very different kind of decision, where SNFs decide whether to invest in this capability or not, and whether it's worth it to them. And it's clear to beneficiaries, if they need event care, whether the SNF they're thinking about has event care or not.

And here, I think the philosophy-based decision is just much squishier, and I think it's just very easy for hospices to say, well, our philosophy is basically not to cover this very expensive service, and it really has little to do with the philosophy. I think there is a sort of

basic philosophy of hospice that should remain intact, but I think beneficiaries should sort of be able to go into hospice anywhere in the country and expect that the same set of services are possibly going to be covered, depending on their individual circumstances, not depending on the hospice decision about what's in their philosophy.

And so I think that's just a basic fairness issue. And I would throw in there the same thing about it should be very clear what's inside and outside the bundle. That shouldn't be sort of left to discretion.

So that's one basic thing. I think that this issue of hospices being able to do different things in terms of whether or not they decide to offer palliative dialysis, for example, needs to go.

In terms of -- oh, one other thing I would say that kind of needs to go is, you know, it was mentioned in the chapter that, for example, nephrologists have no incentive to refer people to hospice because it doesn't help them in their quality measures, for example, and I think that's sort of a tangent that's worth exploring. Like if we think hospice is a good benefit and may be beneficial to people, then maybe we should look at

incentives for specialists to offer that option or to discuss that option with their patients.

So that's sort of an aside. In terms of the actual alternatives here, I think I like a few of them. It's hard not to be in favor of collecting more data, but I'd really love to know more about that burden and how much burden really is it? Is it reasonable to expect us to require this data or not, and sort of balance that burden against can we actually do these policy analyses and figure out the best course of action without having more data? I'm in favor of more data, but with the caveat that it needs to seem worth it.

In terms of the other options, I would love to see us explore, with some simulations if we don't have data, but sort of explore the policy options for whether or not these costs are just too much to include in the current bundle and which of these policy options might address that without affecting access or without adversely affecting access, or if it might increase access.

I think, to me, the two that seem very appealing are the outlier approach, because I think that it seems to have the most potential to actually bump up the payment

enough to avoid access problems, for example, for dialysis patients. And the other thing, the other thing I'm still interested in, is some of these transitional programs. I think it's actually pretty hard to sort of piece together palliative care under just the regular fee-for-service benefit, because you sort of need to have the providers on board as well. And if, for example, you go to a SNF, you're like excluded from your quality measures in a SNF if you're on hospice. But if you're not on hospice, they're going to be responsible for quality measures that may not be consistent with a hospice kind of palliative care model. So I think these transitional programs really have potential to sort of ease that transition for beneficiaries.

So I like both of those options, the outliner payments and the transition payments. I would love to see more analyses of both of those, just to see how we can align the incentives better and get more of these patients onto hospice who might benefit from it. Thanks.

MS. KELLEY: Brian.

DR. MILLER: Okay. Lots of thoughts. I'm organized to make it focused.

So, first, a clinical thought. Hospice is fundamentally a trade-off, and it's an unpleasant trade-off that we all have to make at some point, because we're all going to the same place at different speeds for different reasons. And the goal, as I always tell patients who are thinking about this, is it's a change in goals. It's focused on symptoms, not a focus on quantity of life. It's focused on quality.

And so sometimes you do things that you might not do when you're just focusing on quantity versus quality, and you make different sort of risk-benefit trade-offs for drugs and therapies, just totally different framing. And sometimes people actually live longer on hospice or they are happier on hospice, and sometimes people don't want it, which is also fine. And so a lot of this is also about patient autonomy and choice, and I agree with everyone that you should have the choice regardless of where you live. If you want access to that service, you should have access to that service.

I do get a little concerned about some of this conversation that we're having, because I read the letter that we got on June 2025 from the hospice physicians asking

for additional funds, because it's very easy to turn the hospice benefit into the regular medical benefit if we're not careful, and before you know it, you're in hospice. The hospice is functionally functioning as a hospital, a home care agency, a pharmacy, and I don't think we want to transform hospice into the routine medical benefit. And so I actually think some pressure for clinicians to have those tough conversations with beneficiaries or patients is important.

And I'm okay when people -- and my thinking as a clinician has evolved over time. It's totally okay when people don't want to pick hospice and they don't think it's right for them, they're not ready for that, they don't want to make those decisions or accept those trade-offs, and that's fine. And obviously, we want more people to have access to it. We often think for many patients it's often the best choice, not always the best choice, but often we tend to think that. But it's okay when people don't want that.

So I don't think that we should look at trying to transform the hospice benefit into more of the routine Medicare medical benefit in order to increase uptake. I

think leaving it focused as it is on symptomatic treatment, quality, caring, et cetera, is important, and that avoiding those conversations, which are very hard and very emotional, very taxing -- and the hospice physicians, along with my other hospital medicine colleagues and internal medicine colleagues and oncologists and hematologists and cardiologists and people who have those conversations regularly are very good at it. They could be better. We all could be better. But I don't think we want to use additional taxpayer subsidy to avoid having those tough conversations about trade-offs in clinical care.

I agree that -- as some have pointed out, that getting those services cobbled together and the other part of the benefit don't always work as well in all parts of the country. That's something that we should probably have some policy thoughts on as to how do we make that clinical opportunity easier for people. So if you choose not to get hospice, you can get other services, nursing care at home, after-hours care, and other things.

And we need to recognize that if you are severely chronically ill, near the end of life, and you're in hospice at home or you're not in hospice at home -- you

have home care services, nursing care, habilitative services -- it's going to be really burdensome on the family either way, and for many, many people, objectively terrible, right? Because dying is not something that any of us really want to do or is a process that we enjoy.

So that's sort of my clinical thought, which is proceed with caution. Don't turn the hospice benefit into the rest of the Medicare benefit.

Financial comments. Cheryl pointed something out really important yesterday, which prompted me to go look at our prior report, in that she said hospice is highly profitable, and she's correct. So I looked at our March 2025 payment update, and we denoted profit margins in the 10 to 14 percent region.

Could that methodology be improved? Of course, right? Now, could it be -- is the actual number compared to what we are projecting lower or higher? Probably varies, again, different regions, different providers, et cetera.

But I think what we can say is that that probably means we don't need additional overall spending, more spending in hospice. We probably need better targeting

within hospice, maybe adjustment of payments to different types of hospice providers for different types of cases and patients, but not more money into the overall pool.

So those are my financial comments, and I thank Cheryl for encouraging me to look.

I have an auditing and program integrity comment, which I think is really important for all of us to think about. There are challenges with length-of-stay management in hospices where they have some very long length-of-stay patients who probably need lots of services, home care, nursing care, et cetera, but may or may not be appropriate to be enrolled in hospice.

And so I have heard and seen anecdotal stories, and I think it's part of a widespread practice, because I've heard about this from multiple regions of the country, where hospices are approaching hospitals, and there's a percentage of patients who pass away in hospitals. We all have -- many of us who are clinicians have cared for those patients, and you know they're going to pass away, and they'll pass away pretty quickly in a couple of days.

And what has happened is that that patient gets administratively discharged from the hospital. They remain

physically in the bed, physically under the care, in the hospital, like in the physical facility, and then they get enrolled in a hospice under the hospice attending physician, and either the hospice -- either a hospice nurse comes and cares for them or the hospital-employed nurse cares for them, but there's some payment arrangement where they're paid by the hospital.

What this functionally does is it improves hospital mortality statistics, because the patient who you know is going to die and, as part of hospital mortality, is no longer part of your inpatient mortality measurement, and then it massively improves the length of stay for the hospice, because they have a couple patients -- you know, they have -- they're harvesting patients who have a length of stay that's one, two, three, four days, tops, to counterbalance patients who have exceptionally long stays. And so they're juicing their average and distribution, anticipating, of course, that CMS is looking at this.

This practice, I've been hearing about it for years, a variety of regions, West Coast, Midwest, Southeast, et cetera, and so this, again, with the margin issues that we pointed out, suggests that actually CMS has

additional opportunities for oversight, could be executed through the Recovery Audit Contractors, Center for Program Integrity, could update the Fraud Prevention System. We could have UPIC oversight.

So there are lots of opportunities to, I think, look under the hood in fee-for-service hospice, where there's behavior that is perhaps unsavory and not intended -- or what the hospice program is intended to do.

The combination of, you know, significant profitability and, as I said, these gaming of metrics and financing is why I don't support additional funding in the fee-for-service hospice benefit, and why I think if we do do a high-cost outlier payment, an add-on payment for high-cost services, or a CMS adjustment, it absolutely must be budget neutral. And our recommendation must do that because of the high profitability that we've shown for years in the hospice industry, and these emergence and growing, you know, what I would frankly call unsavory practices towards folks who are at a very vulnerable point in their life. And to me, it's disappointing that, you know, as a clinician and as, you know, someone whose parents have passed away, that, you know, the hospice

industry is evolving in this direction.

I think for policy improvements, you know, I really like the list that the staff put together. I really liked this chapter, and the PowerPoint, it was very targeted.

I think we've actually forgotten, collectively, the most important recommendation. It's been mentioned a few times, this old recommendation, oldie but goodie, sort of like the Fonz from "Happy Days," which -- you know, I was looking up in 2014, we made a recommendation that by 2016, hospice should be part of Medicare Advantage. Right? So that's a now 11-year-old recommendation.

So I think we would all benefit from some policy elbow grease, you know, collectively as Commissioners and from the staff about how we can make that happen, because there's this weird, you know, favorable selection at the end of life, where the beneficiary previously in fee for -- previously in Medicare Advantage is now getting a fee-for-service benefit. That doesn't really make sense to me. Maybe it made sense 20 years ago. Definitely doesn't make sense now, because we don't want disenrollment at the end of life.

And what's interesting is that when you look at the sort of concerns about adding hospice into Medicare Advantage, you get concerns from all angles, which actually says it's a good policy recommendation. So you have folks who think that managed care plans are going to save money and push people into hospice, and then you have the hospice docs at the same time saying that, you know, plans aren't going to want people to enroll in hospice, and they're going to use prior auth and make sure that people don't access it or exclude them from the network.

So if all the stakeholders are unhappy, it's probably a good recommendation. So I think we should spend some time looking into that and thinking about how we can operationalize that.

MS. KELLEY: Scott.

DR. SARRAN: Excellent work. You guys did a very nice job of pulling things together and telling a story that leads us to the right kinds of next steps.

So I think a helpful framework is to start, in terms of next steps, thinking about what our goals are, and I would posit that our most important goal should be to enable beneficiaries and hospice enrollees to receive the

full range of clinical services consistent with their continually evolving condition and collaboratively developed care plan -- that should be our north star, if you will -- and that we do not allow features of the benefit structure or the reimbursement mechanisms to present barriers to that. So I think it's helpful to say what's our goal, work backwards from that.

A secondary goal, somewhat aligned to the first, is we want to make sure that potential hospice enrollees are not dissuaded from accessing the full range of hospice services, because oftentimes it is very difficult, truly, to put together in an a la carte kind of fashion, the services that are available to a beneficiary in the fee-for-service system outside hospice. So we don't want to dissuade beneficiaries from enrolling in hospice. And we certainly don't want to do anything or allow anything to continue that basically encourages beneficiaries currently in hospice to disenroll in order to access services that would further their primarily palliative goal.

Lastly, I think -- and I think this next one is truly less important than the first ones -- we don't want to incent medically unnecessary care. So we obviously want

to be fiscally prudent.

As we do that, I do think it's really critical -- and I'm reinforcing other comments, including Tamara -- that we just cannot allow a provider in the Medicare program to, in essence, opt out at their discretion to providing medically necessary care that's defined by the treating clinical team using some pretext that it is inconsistent with their, quote, "philosophy" or, quote, "model of care." That's just absolutely, absolutely wrong, and we should not allow that.

At the same time, I think we have to recognize that if we don't do something to ameliorate the negative financial burden to particularly small nonprofit hospices of providing that expensive care, as you've documented, we run the risk of forcing some of the smaller nonprofit hospices out of business, and that's not helpful.

So I like how you've teed up the policy directions, and my thoughts there are that absolutely a no-brainer to going down the road of enhanced data reporting. I mean, I said that in other contexts as well. It's taxpayer money. I think we need a full understanding of how that's spent. So that, again, I use the phrase "no-

brainer."

In terms of the payment policy, I think it's actually a little bit less critical which one we choose as long as it's done, as Brian and others alluded to, in a budget-neutral fashion, because the sector overall, as well documented, is more than adequately funded.

I do think it's ideal to maintain the overall current bundled nature of the program, and so I like either the outlier or the case mix adjustment. And I think we could explore one or the other. Certainly, CMS has used those in other provider sectors. So there's experience with that. There's nothing new there.

I don't like the add-on, because I think that potentially, potentially incents unnecessary care in a very direct fashion. So I don't like that.

And I don't like the voluntary transitional approach. I think it's clinically confusing who's the captain of that clinical ship then, and it's probably unnecessary if we go via one of the other routes.

Thanks.

MS. KELLEY: Stacie.

DR. DUSETZINA: Like others have said, thank you

very much for this really great work. This is an incredibly important topic for all of us.

I'm not going to repeat all the things I agree with that Tamara and Scott have just said. But I think, again, the emphasis on this should not be based on a philosophy of a hospice. It should be a covered service or not a covered service or something that you have access to, because it is covered as was discussed in that Round 1.

I think that when looking at the options that have been put forward, I agree with others that it's hard as a data person not to say we want more data. It would be helpful. I do worry a little bit about the comment about it was burden and lack of need for the data that was why it was not being collected. So I think there's a little bit of a trade-off on just how burdensome is that, but always worth exploring having better information for making these analyses and trade-offs.

I dislike the case mix adjustment idea. I think that if we do pay more, it should be tied to receipt of services. I am a little bit on the fence about whether that would induce a lot more care. So unlike Scott's comment just now, it did give me pause, because I'm like I

kind of like the outlier payment idea if it's tied to receiving the service. But I think you could maybe structure it in a way so it's not like paying the full amount. It's paying like part of it. So there's not -- there's still a -- you know, not an incentive to go get a lot of extra care, but there's not the burden of, you know, really just decimating the budget for that person or that hospice.

I thought the transitional program was kind of intriguing specifically for these patient populations where we know there is this challenging set of services, and the Medicare Choices Model that you discussed in the chapter -- and I was looking at some of that on the CMMI website, and it looks really promising as a concept for people with these conditions where maybe there needs to be a little bit more time and intentional transition.

And to prior conversations among us, you know, I think it does look pretty promising that people don't use a ton of services. It's almost like you're transitioning into more exposure to hospice and you and your family are starting to reach a point of acceptance about what treatments are necessary. So I kind of like that

conceptually.

I do understand it could maybe make it a little bit more confusing about who's in control and who's making certain decisions. And maybe to Brian's point, like you don't want to have it be something where now everybody just gets like a hospice-plus benefit and we're paying more, but everybody's still using the same services. So I think it has to be well targeted to specific beneficiaries if it's considered.

But I think that these are areas definitely worth exploring. Just as having prior work with looking at quality of hospice care measures for groups like ASCO, this issue, especially for blood cancer, patients with blood cancer, I think is incredibly important and something we need to help to solve, and same for dialysis. They're just not as close to that area clinically.

Thank you again for this outstanding work.

MS. KELLEY: Cheryl.

DR. DAMBERG: So I agree there's a problem. You know, again, getting our hands around how big of a problem this is, it's a little bit hard to gauge given the absence of really great data here. But I do want to commend the

team on doing all these qualitative interviews. I think they were incredibly informative in giving us some sense of what's happening in this space and some of the barriers that people face in making this transition.

You know, this is a super complex space. Patient preferences are paramount here and -- you know, which makes it very hard to come up with sort of a standard approach. So I appreciate sort of the careful thought that's being given to the various options on the table.

I think across the different payment options, I was less interested in add-on payments for some of the reasons other Commissioners have cited. I do think there's this potential for potentially overuse or inappropriate services. That's sort of a hard thing to measure in this space. But that said, I think it could drive overutilization.

Among the three payment options, I was most interested in the outlier payment because I think it preserves incentives for efficiency, given the risk-sharing structure of it, and it seemed -- I mean, they're all sort of complex to design and implement, but it seemed like it sort of had maybe the best properties and would be feasible

to implement.

I agree with the assessment around case mix adjustment. I think it's very hard to design this, absent having the data to design it, and I think at the end of the day, the payment differential is likely going to be insufficient to really motivate providers to deliver this type of care.

I too support a budget-neutral approach, given the profitability in this space. I recognize there's a lot of heterogeneity across hospices in terms of their profitability, but on average, they're very positive margins.

I think I'm going to respectfully disagree with Scott, although I take his point. The transitional program was appealing to me in part, because I think from a patient perspective or a family perspective, it has a clear line of sight. It's like you can see what you're signing up for. And I think this space -- and I was kind of heartened to hear from Brian sort of the conversations that are being had with patients and their families and explaining this space and kind of how to navigate it. But I've been watching my neighbor and others I know go through this

process, and I think they remain confused about what services they're going to have access to versus not. So I think that that transitional program could be important. But obviously, there's complexity in terms of deciding how much you want to put in that package versus how little, but I do think it's worth continuing to explore that space.

MS. KELLEY: Kenny.

MR. KAN: Thank you very much for the insightful chapter on a very complicated topic.

Echoing Comptroller General's remarks yesterday to be more holistic while focused on outcomes, I recommend that we proceed with caution with any future analysis, be crystal clear on what is the real problem we're trying to solve. Is it a payment adequacy issue to overcome the current disincentives of some members that opt out of hospice palliative dialysis? And even if we can propose some rate adequacy scenarios, what are the likely outcomes?

On outcomes, I'd like us as a Commission to be intellectually honest on three things. One, is it an intended outcome that moving these services into the hospice program be budget neutral? How do we define budget neutral? Do we define this to be an average global

additional payment, a one-size-fits-all, or something much more targeted? Two, is care and quality of life much better for palliative dialysis patients in a hospice versus non-hospice setting? And three, even if we achieve the first two, what will be the take-up rate by Medicare beneficiaries?

I worry that if we propose a global additional payment, spend a lot of precious staff bandwidth on this with a very low take-up rate, this would end up adding additional cost to the system.

I mean, let's face it. Behavior change is hard. I would like us to get feedback from member focus groups and docs for those patients who currently continue to want to receive this palliative services in a non-hospice setting. Will they switch to hospice? Is the juice worth the squeeze?

So again, be crystal clear on the problem, assumptions, and intended outcomes. And in terms of direction for future analysis, I would support gathering more data to simulate great adequacy and beneficiary take-up scenarios, provided it's not more burdensome to providers, and I think in terms of what's more burdensome,

probably maybe there may be some questions that may be too difficult to collect, but there may be some other ease -- but perhaps, you know, instead of, like -- I don't know what questions CMS has proposed previously, but let's just say if they're, like, they ask, like, 10 additional questions. Maybe if, like, five to seven of those are a lot easier to collect and maybe the other three or five is not worth the squeeze, that could actually help inform our analysis, that would be very helpful.

Thank you.

MS. KELLEY: Lynn.

MS. BARR: Thank you. Great chapter. I really, really enjoyed it.

I have a quick Round 1 question before I go into my comments. What percentage of hospice patients are Medicare? Do you have a sense of that?

MS. NEUMAN: It's very high. It depends on days or patients. We're in the high 80s to 90s in those two metrics.

MS. BARR: Okay. So I'd like to make a point that 10 to 14 percent margin, when you're the only payer, is actually not a great margin, right? So if we're the

only payer, we're -- you know, we like, you know, budget neutral because we got commercial and everybody else paying for this. So this isn't a high-margin group because we are the payer. So I just want to focus on that a little bit.

I think that I really struggle with the conflicts of interest, that, you know, there's so many conflicts of interest. I'm starting at the case management person that knows that if I put you in a hospice program, you're not going to get the palliative care you're getting today, that you're going to suffer. And I am going to be less inclined to want you to suffer in that way. And so I'm not going to be full-throated. The fact that these people are not getting hospice is a real problem, and it's being -- and we've got these conflicting incentives. And so the hospice program itself, which is running on this margin, is not, you know, wildly wealthy. They've got to make that decision of if I bring that ESRD patient in, what am I going to have to cut? Right? And so they don't have the incentive to have that patient in the program.

The patients, you know, want to let go, but they're afraid of what happens when they give up any piece of the care they're getting. And I believe that if we just

pay fee-for-service on ESRD, transfusions, and -- what's the third one? -- and radiation, I think that that's a very limited set of palliative services that these patients are going to continue to get today, because they're not in hospice. And that if we get them into hospice, they'll get less of those services, and it will not only be budget neutral, but potentially budget positive, but much more important, it'll be patient positive, because our capitalist tendencies are causing undue pain and suffering for these patients, which I don't see any real benefit to the Medicare program or to anyone else.

Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yeah. You know, thank you for this report. It's generating really good discussion here.

And to oversimplify a bit, I think the problem here or at least the current state, anyway, is that basically Medicare does allow for, you know, these services that we're talking about, depending on the medical judgment of the providers and the capabilities of the hospice provider. And that's reasonable. It's not fundamentally broken.

You know, the question is, does the current state disincentivize, you know, the patient and the families in any way? And is this a big problem? I don't really know, because the decision to go into hospice care is very complex, and it's a highly personal one. And so it's hard to kind of superimpose, like, our judgments onto this.

But I do think that the narrow question about whether the model can be improved around a subset of patients that may require end-stage dialysis or blood transfusions or chemo-radiation therapy, it is a good question to ask. There's probably an opportunity here, at least for those patients.

I think that before we start getting into payment issues, it's, first and foremost, a clinical question, and it's a clinical question that does require, I think, some data.

So, for example, you know, what a hospice care provider might be concerned about is that, you know, they would admit a patient who might be there for six months, who might require hemodialysis, and that's 75 treatments. But the data may show really a different story, is that perhaps -- and I'm just being hypothetical here -- is that

most of those patients may only require 10 treatments, and it's occurring in the final four weeks in life, let's say. That changes the perspective a bit, because then CMS may want to convene clinical experts to wrap some guidelines and eligibility criteria around hemodialysis, including options for peritoneal dialysis as well, because right now, you know, hospitals, if they're discharging the hospice, they may be putting in the feeding tube, but they're not thinking about putting in a peritoneal dialysis catheter, because it's not part of the construct or the model or the payment model.

So the same with chemotherapy, but, you know, there are low-cost options for chemotherapy using oral drugs, and it may be that looking at what cancer types and what chemotherapeutic agents are currently recommended, we might be able to better understand what clinical guidelines are better suited for this patient population.

Same is true for blood transfusions. Maybe it's patients who have a hemoglobin of 6 with chest pain that should be getting transfusions. I don't know. But I think it requires some degree of data in combination with a clinical expert panel to really determine who would benefit

the most, you know, from these different services, and what's truly considered palliative care, because right now, there doesn't seem to be consensus -- and this is the second time we've talked about it -- among the different hospice care providers.

So I personally think that that's kind of the way to start to really kind of develop the eligibility criteria, and then the payment model follows. But I doubt it will be overly expensive. There will be incremental costs, but if we're giving the patients what they need and still respecting the concept of, you know, hospice care and palliation, it may not be as huge a cost as we think.

But thank you. I'm looking forward to future discussions on this.

MS. KELLEY: Betty.

DR. RAMBUR: Michael just reminded me to be brief, so I will.

DR. CHERNEW: I remind all of you.

DR. RAMBUR: Yes, that's why I said that.

So, briefly, thank you for this important work. It is really delicate work, and I feel like we're really walking on sacred ground when we're thinking about this,

because people are at their most vulnerable.

I think we need to be very attentive to creating incentives that extend dying. You know, we talk about extending life, but oftentimes we're extending dying. So, from that perspective, it's very easy to reject the unbundling add-on.

I agree with the need for clinical expertise in this. I'm not fully certain that there's a problem that can be solved with throwing money at it, financial incentives, without creating new problems. So I really look forward to the work that you'll be doing to explicate this.

At a broader issue, we're talking about this as changes to the payment system, but death doesn't look like it used to. I mean, hospice was started really looking at people who had relatively short periods of time with cancer, and we see that stage 4 cancer is increasingly, for some, becoming a chronic condition, and the whole issue of cognitive disorders and all of that.

So I know that's not within this particular scope of work, and this is important, but I think we have to look overall at some point down the line how hospice should

look, because it's really important.

And I'll just close by saying nurses feel an enormous amount of moral distress at being part of overtreatment at the end of life but don't know what to do about it, and perhaps physicians do too.

So I think this is really important work, and I thank you for getting us started.

MS. KELLEY: Okay. I have a comment from Tom. He says, first, we are making an assumption that hospice is better for patients, which he generally agrees with. Thus, it is desirable to encourage terminally ill patients to enroll in hospice.

Second, he believes there are substantial numbers of patients who would benefit from hospice that choose not to enroll for a variety of reasons. Some of these reasons include the lack of access to those services. Without the services, especially dialysis and transfusions, certain patients may have a much shorter lifespan with less quality of life than if they continue to receive these palliative services.

His assumption, therefore, is that moving these services into the hospice program is essentially cost

neutral. Specifically, those patients who continue to want to receive the palliative services choose not to enroll in hospice and continue to receive them, but do not receive the perceived benefits of hospice.

Based on the options, he believes number two, add-on payments for specialized palliative services, or option number four, a voluntary transition program, make the most sense. He is interested in why staff believe option four would not be cost neutral to the overall hospice program.

MS. KELLEY: Greg.

MR. POULSEN: Thanks. I was wondering if I could bring this over and you could read it. It sounds better when you say it.

[Laughter.]

MR. POULSEN: I want to begin by saying that I really have seen huge benefits of hospice, both professionally and personally, and so I want that in that context, but I am less persuaded that we should try and make hospice fit the needs of all patients who are in the terminal situation. I think that I see meaningful and significant challenges with each of the potentially

enhanced or ancillary payment mechanisms that we are talking about.

Robert, I think, just talked about some of the complexities that we would need to go through in order to be able to understand how to use those and use them cost effectively, and that troubles me. I think it puts us on a bit of a slippery slope. There are many, many less common or less dramatic differentiators that fit into the category of people that are getting hospice or could potentially get hospice, and if we go down the path of paying in whatever way for an additional service, other things that require additional capabilities -- well, wait a second, why aren't you paying for this, this, this, or this? -- and pretty soon I worry that we could be having an additional fee-for-service -- I think Brian said that we could find ourselves in a situation where we are duplicating the regular payment program within hospice, and that would be a disservice to hospice as well as to the overall Medicare payment program. So I don't like the idea of risk-adjusting hospice patients. I don't like the idea of additional add-on payments.

I do like the idea of creating expectations of

what you should expect when you are in hospice. I think that makes sense.

But I much prefer that people with their care teams determine when hospice is appropriate and when it isn't appropriate. It isn't for everybody, and it shouldn't be for everybody.

The case which people can -- the ease with which people can leave hospice -- and it really is straightforward, and I have seen that multiple times -- and return to the MA program or the fee-for-service program they came from mitigates the concerns that people would become trapped in a program that doesn't meet their needs.

So I see more downsides to structurally modifying the hospice program, at least the payment components of the program, than I see benefits.

MS. KELLEY: Gina.

MS. UPCHURCH: Greg has just attenuated my comments. Okay.

So I guess the main thing that I would just like to point out is that I definitely agree that we need a clearly defined bundle. It's either in or out. It doesn't matter where you live. It doesn't matter anybody's

philosophy. You just know that this is a benefit of your insurance.

And I had some other comments, but I'm going to leave them for now because I'm contemplating these things. If we do go one of these payment routes, I do like Stacie's idea of the partial outlier payment.

Thank you. Thank you for the great work.

MS. KELLEY: Josh.

DR. LIAO: A very important topic.

I think setting aside the technical issues, I think need to be worked out. I appreciate a lot of the other Commissioners' comments.

I want to bright line just that I support collecting more data and solutions within budget neutrality, which others have mentioned.

I think given what's at stake financially and, at least to me, what is at best an incomplete understanding of administrative burden, I think it's more than fair to ask those two things.

When I look at the options that are set before, I'm more generally supportive of a service-based rather than a case-based approach for reasons mentioned before. I

think it's hard to case-adjust. Don't know if we have the data to do so, et cetera.

I think a service-based approach is limited primarily by this idea of when is it appropriate. I think Robert set out a number of those considerations.

Wayne asked a question about what would those services be, how frequent, lots of complications there. But I think there I'm supportive of this idea of an outlier in some form rather than an add-on.

I really like the spirit of a voluntary transition plan, and I take other Commissioners' comments well. I do -- I am cautious, though, about the potential complexity that comes with using a policy tool to address clinical arcs of care. Again, going back to Scott and some of Robert's comments, as a clinician, that worries me quite a bit. I think if we were to make steps in that direction, I'd love to see some measured approaches such as demonstrations and other things, but I just think that's going to be very difficult.

Thank you.

MS. KELLEY: I'm sorry. Paul?

DR. CASALE: That's okay. I was -- yeah.

MS. KELLEY: Go ahead.

DR. CASALE: I'll be very brief, I think really everything's been said that I think is really important.

From a clinical point of view, again, having had this conversation many times and underscoring Brian's points and Robert, these are incredibly difficult conversations in very vulnerable times for patients and families.

Having said that, I think Josh's point and others about needing more data, I think we really need to start with that in order to understand the way forward.

I think, generally, I'm supportive of thinking more about this transitional program.

And I just want to underscore Betty's comments about treatment has changed. Hospice started for cancer patients when it was very predictable, their trajectory. That's no longer the case, and chemotherapy has evolved tremendously.

So again, a lot of this clinically is nuanced, but we're in a very different place than when the hospice program started. So I think that's where I'm thinking. Again, the transitional program and getting more data may

be very helpful and a kind of very important topic. So thank you.

DR. CHERNEW: Okay. Thank you, everybody. This is a difficult topic. It was a really rich discussion. I very much appreciate it.

We're going to take a four-minute break and come back at 10:40 because we have another important topic, and we are going to end at noon. So thank you all. We'll be back in four minutes, and I'm going to just start talking.

[Recess.]

DR. CHERNEW: Hello, everybody. Welcome back for our final session this month. As I'm sure everybody knows, the Medicare program is increasingly becoming a Medicare Advantage program. Over half the people now are in Medicare Advantage. And that has really shaped a lot of our agenda. And one of the really important questions that comes up all the time is the impact of the Medicare Advantage program on providers.

So to talk about part of our work in that area we're going to have Jeff and Brian, and Brian is starting.

MR. O'DONNELL: Good morning. Last spring, we discussed the effects of MA growth on rural hospitals.

Today, we'll extend that work by discussing how MA has affected IPPS hospitals, including urban hospitals. Before we begin, I'd like to thank Krista Cherry and Betty Fout for their assistance with this work.

The audience can download these slides by clicking on the link in the upper righthand side of your screen.

We'll start today by discussing background on MA enrollment growth, prior research on how MA enrollment changes affect hospitals, and MA plan incentives. We then discuss our research that examines the association between MA enrollment and changes in hospital revenues, costs, and profit margins. We then discuss a topic for further exploration, which is the association between MA enrollment changes and uncompensated care payments per discharge. We'll end with Commissioner discussion.

Just to emphasize, we're at the beginning of our work examining the effects of MA growth on providers, so we're looking forward to your input to shape our future research agenda.

As you know, MA enrollment has grown rapidly in recent years. From 2014 to 2025, the share of Medicare

beneficiaries enrolled in MA has grown from 31 percent to about 55 percent. This increase is driven by multiple factors, such as beneficiaries' preferences for additional benefits not covered by fee-for-service, out-of-pocket spending limits, which is required by statute and not available in fee-for-service Medicare, reduced beneficiary cost-sharing, and integrated Part D benefits.

In addition, employers increasingly offer retiree health benefits through MA, and MA is often the only option employers provide. For example, one survey found that, among large firms offering retiree benefits through MA in 2024, about half offered no choice but to receive their retiree health benefits through an MA plan.

Every year, the Commission conducts hospital site visits. On those site visits, hospital representatives report that MA plans result in higher costs and lower revenues for hospitals. Hospital industry analyses also suggest that MA patients have lower payment-to-cost ratios than fee-for-service patients. However, prior academic research on the effects of MA enrollment changes on hospitals has been limited, mixed, and mostly focused on rural hospitals.

For example, one study found that MA growth was associated with improved financial conditions for rural hospitals. Another found that MA growth reduced inpatient days at rural hospitals and increased inpatient days at urban ones.

In the next few slides, we'll discuss the incentives MA plans have when dealing with providers. These incentives don't directly affect our analyses but rather help establish the context for our analyses.

MA plans have multiple tools to reduce volume and shift care to lower-paid settings. For example, MA plans form provider networks and employ other utilization management tools, such as prior authorization. When used appropriately, utilization management tools have the potential to promote more efficient care and better outcomes. However, when misused, such tools may lead to beneficiaries having difficulty accessing needed care and increasing burdens on providers.

MA plans also often have an incentive to negotiate payment rates below fee-for-service payment rates. Prior research has found that MA payment rates are similar to fee-for-service rates for hospital inpatient

services. But MA payment rates in other sectors may be above or below fee-for-service rates.

MA plans have an incentive to reduce payments to providers in other ways as well. For example, plans can reduce payments to providers by downgrading a hospital admission to an observation stay. Plans may also deny claims for a lack of medical necessity. For example, a recent study found that MA plans denied 17 percent of initial claim submissions and that, while most of these denials were eventually overturned, the denials ultimately resulted in about a 7 percent reduction in provider MA revenue. Therefore, even when MA payment rates are equal to fee-for-service rates, providers' revenues and costs of providing the service may not be equal.

Up to this point, I've discussed MA plan incentives in general, but incentives may differ if plans are financially integrated with providers. And, as we discuss in your paper, many hospitals are financially integrated with an MA plan, that is, they have common ownership. At non-financially integrated hospitals, MA plans may have an incentive to reduce volume, reduce payment rates, and downgrade inpatient admissions to

observations. In contrast, at non-financially integrated hospitals, MA plans have different incentives. In those situations, plans have a weaker incentive to reduce volume, no incentive to reduce payment rates, and, among teaching hospitals, an incentive to code stays as inpatient admissions rather than observation stays. As the Commission expands this body of work, we are aware that incentives associated with financial integration could vary across sectors.

The MA plan incentives that I've discussed on the last few slides may affect providers' finances through many channels. Our approach looks at the aggregate effect of these incentives. Specifically, we look at associations between MA enrollment and changes in all-payer revenue, all-payer costs, and all-payer profit margins.

Some effects that we are interested in measuring may be offsetting in the aggregate. For example, if MA reduces hospitals' patient volume, we would expect to see reductions in both revenues and costs. Given their substantially different incentives, we also test to determine if the effects of MA enrollment changes are different for hospitals that are financially integrated

with an MA plan.

DR. STENSLAND: All right. We're now going to shift from theory to some data on the associations between MA growth, revenue, costs, and profit margins. We used cost report data to ask whether hospitals in counties with faster MA growth have different rates of growth in revenues, costs, and profit margins than hospitals in counties with slower MA growth. We examine all-payer revenue, costs, and profit margins from cost reports rather than looking specifically at MA and fee-for-service revenues, because we do not have MA-specific data on revenues or costs.

Because MA plan incentives can differ with respect to IPPS hospitals and small rural hospitals, known as critical access hospitals, we examine those two type of hospitals separately. We also examine whether the effect is different for hospitals that are financially integrated with an MA plan.

To estimate the association between MA growth and hospital finances, we ran a series of linear regressions. We estimate the association between of county-level MA penetration changes and changes in revenues, costs, and

profit margins. Our models included hospital fixed effects. This means we are looking at changes within an individual hospital. We're asking, essentially, is their margin higher or lower than expected in years after rapid MA growth. We have year fixed effects, meaning we are controlling for national trends.

As a caveat, we are looking at associations. Any association between MA growth and changes in financial condition may not be fully due to the MA growth. There could be other factors that are correlated with both MA growth and the hospital finances that we have not included in our analysis, as we'll discuss more in the limitations section.

The overarching finding is that we do not see a statistically significant association between MA growth and profit margins. That's the top row we show here. However, we do see some effect when looking at revenues and costs. If we look at the average across all IPPS hospitals, a 10-percentage-point increase in MA penetration is associated with about a 1.3 percent decline in revenue. Interestingly, because revenue reductions and cost reductions roughly offset each other, we do not see a

change in profit margins.

Next, we compare hospitals that are unintegrated with an MA plan with hospitals that are financially integrated with an MA plan through common ownership. The first column shows the effects for unintegrated hospitals. We don't see an effect on margins, but MA growth is associated with a material decline in revenue and costs of about 2 percent, which is bigger than the average.

Now contrast this with the financially integrated hospitals. To get the estimated effects for the financially integrated hospitals, you have to add the first column, which is the base effect, and the second column, which is the additional effect you see due to the financial integration. When these two are added together the estimates on margins is still about zero, but the estimated effect on revenue and costs are 0.6 percent and 1.4 percent, respectively. These are not statistically different from zero, but they do materially differ from the unintegrated hospitals.

The fact that we do not see declines in revenue or cost for integrated hospitals may reflect that those hospitals have different incentives that MA plans that

operate independent of the hospital.

Next, I shift to talking about critical access hospitals, which we talked about last spring. As we showed in the spring, there are no material changes for these hospitals in revenue, costs, or profits, on average.

As we discussed in the spring, this could be due to two factors. First, as critical access hospital volume declines, payments per unit of service increase due to the critical access hospitals receiving cost-based reimbursement. Second, MA plans tend to pay those critical access hospitals a per diem payment rather than a payment per stay, and MA patients tend to have longer lengths of stay, which may actually benefit the critical access hospital and offset some of the other effects of MA expansion.

Now, it may appear odd that when we look at the hospital revenues, we see some declines in revenue and costs but not a decline in profits. That would imply that all costs are variable. Except if you go deeper into how Medicare prices are set, you can see a potential explanation for how we could see a decline in revenue but not a decline in profits.

While we provide more details in your mailing materials, the short-cut version of it is this. Medicare prices for inpatient care include a payment for "uncompensated care." Uncompensated care payments are distributed as per-discharge add-on to inpatient payments. Fee-for-service pays this add-on, and because MA prices tend to follow fee-for-service prices, MA plans generally also pay this add-on.

Because individual hospitals' fee-for-service prices tend to increase when MA volume declines rapidly, due to the way this is computed, the price increase could offset some of the lost revenue from declines in fee-for-service admission.

The key point is that uncompensated care payments per discharge increase when there is an above-average shift of discharges from fee-for-service to MA. This is because of how the formula for setting the payments per discharge works when MA plans use the fee-for-service pricer. And all the evidence over the past decade suggests most use the fee-for-service pricer.

The formula for MA uncompensated care payments is shown in orange. The first part of the formula is the

number of MA discharges. The second part of the formula is the payments per discharge, and that is equal to the uncompensated care fee-for-service payments over the average number of fee-for-service discharges.

And so when you look at the second equation, you can see the bottom line is first, that as MA discharges increase at a hospital, MA uncompensated care payments increase. But also, as fee-for-service discharges decrease at a hospital, MA uncompensated care payments per discharge and overall increase. We estimate that for every 10-percentage-point shift from fee-for-service to MA in a county, uncompensated care payments per discharge increased by about 13 percent, relative to the national average change.

Now I'm going to shift to what might be the most important part of the presentation, and that's the limitations.

As you know, as I've been going through this presentation, I've been emphasizing that we have an association between MA expansion and the effects on hospitals, and not a causal conclusion that MA is causing all the association that we see. And I think we can say

we've made some improvements in our model. There are a couple of things we've done, such as we've talked about the uncompensated care effect, we've added the issue of being integrated with the MA plan or not integrated with the MA plan. Those are things that are omitted from many of the other studies that are in the literature.

But we still have some limitations in that there could still be other variables that are missing from our models that could be affecting both MA enrollment and hospitals' revenues, costs, and profits.

For example, there could be a situation where an MA plan enters a market, but they may also enter in that same market with a Medicaid managed care plan. For example, a Centene or a Molina might come into a county and are offering a Medicaid managed care plan, and then they're offering Medicaid managed care and Medicare managed care. And then the question is, well, our model doesn't include anything about Medicaid managed care. So the fact that that's correlated with Medicare managed care means some of the association we're seeing might be picking up something else like that effect of Medicaid managed care growth. So our model still has significant limitations.

In addition, we have an imprecise measure of how integrated a hospital is with an MA plan. We just have a 01 variable. We are not measuring the degree to which their MA patients are coming from their own plan, and therefore, because our measure of integration is imprecise, certainly our estimates of the effective integration are imprecise.

I also want to say there's a lot of heterogeneity amongst hospitals. Some hospitals are going to differ from each other in many ways, including differences between unintegrated and integrated hospitals. And the effect of MA growth may differ amongst these different subgroups of hospitals.

So in summary, I have three main points for you to remember. First on average, above average MA growth is not associated with an increase or decrease in profit margins, but it is associated with a decline in revenue and costs at some hospitals. The effects of MA growth appears to differ by whether the MA plan is associated with the hospital. Possibly because Incentives differ for hospitals financially integrated MA plans than for when MA plans deal with unintegrated hospitals.

Consistent with these incentives, we see MA growth associated with revenue declines at unaffiliated hospitals but not at hospitals affiliated with MA plans. Part of the reason we do not see declines in profit margins overall when MA grows could be that uncompensated care payments per discharge tend to increase when MA payments grow more than average, and more detail on that explanation is in your mailing materials.

We can start out answering question you have about the analysis.

So now we can start answering questions you have about the analysis, and then we'd like to hear your thoughts on additional work in this area, going forward. And I turn it back to Mike.

DR. CHERNEW: So, you know, it's always a challenge to do this type of analytical work, and I think you've done a really good job. This is a sort of fundamental question that we face, and I think there's a level of aspiration to what we'd like to know, and then there's a level of realism about what we actually can know, in a bunch of ways. Hopefully we can pick up, if there's like a serious, serious, huge problem in what's going on.

But this is really a great start, and I think we should jump in to get everybody else's comments right now. We're just trying to get this information out in front of the world.

And if I have this right, Brian is first in the Round 1 queue.

DR. MILLER: I did not actually expect to be first. Very brief comments. So I love reading STAT News. I read their stuff probably every day. I also think there are lots of problems with intercompany transfer pricing and conglomerates, accounting rules, SCC reporting, IRS rules around all those, whether it's United, Kaiser, or UPMC, I'm completely on board with questions about that.

We probably shouldn't cite STAT News as a reference for that, on page 18. Again, love the article. Love Bob Herman's reporting. But if we can find an accounting reference that would probably be better.

Another small nitpick. On page 3, we note that when a system owns both an MA plan and hospitals, there is no incentive to deny claims to the integrated hospital. That's actually not true, because in a vertically integrated system you have incentives to use funds to drive

either margin for the overall business, which would be doing that, customer acquisition, or creating new businesses. So if you owned the hospital and you're an MA plan, if you deny an inappropriate hospitalization, you can use those savings not just for margins but also to offer, say, enriched, functionally Medigap coverage or other supplemental benefits like vision, dental, hearing, and either improve the health of beneficiaries or increase your plan market share. So I would add more color to that.

It's a really well done chapter.

MS. KELLEY: Lynn.

MS. BARR: Thank you so much. This is very complicated. So I have two questions in Round 1. One of them is how do you account for hospitals -- you know, we're in the board room, it's like volume's going down, we're going to bring in a new service to keep everything okay, right. So now we've got excess capacity. So how do you account for new services that are brought in to offset the losses through MA?

DR. STENSLAND: Because we're looking at the net revenue on all payers, it's the net effect. So what effect does MA have in maybe bringing you down, with the volume

going down.

MS. BARR: Right.

DR. STENSLAND: And then maybe you have some recovery of using those resources for something else, and then we're looking at the net difference.

MS. BARR: Okay. So it could be, I mean, they could just be offsetting -- the lack of paying could be because they're just being good business people and they're doing something else, because we don't have this business anymore. Is that correct?

And then the other question I have about prior auths that always bothers me is, I don't know how many people here have ever had a doctor say, oh, you know what? We can't do this. It's not going to get approved. That never went through the prior auth process, right.

And so do you ever do any analysis of all the things that are subject to prior auth and what is the differential in the usage of those things, between MA and non-MA plans, that might be quite a bit more than just what got denied? Because once you've been denied like three times as a physician, you're like, I'm not wasting my time with this, right.

And I also would be really curious if you ever asked in beneficiary surveys how often they've paid cash for a service that their doctor told them they weren't going to get. You know, whether it was denied or even pre-denial, I think a lot of people actually pre-denial, just, you know, I'll just pay for it. I want the answer. I don't want to go through this, and think they're not going to get it.

Thank you very much for the great work.

MS. KELLEY: Gina.

MS. UPCHURCH: Yeah, thank you so much for this work. Three just quick questions. We have, on page 7, that sometimes Medicare Advantage plans have been known to downgrade inpatient stays to observation. I know that happens in fee-for-service Medicare too. Has MedPAC, in the past, made any sort of consultation to how we make that more objective, so that's less likely to happen?

DR. STENSLAND: No. Before there used to be the RAC audits, and the RACs would come through and they would say, "Oh, that really shouldn't have been an admission. We're going to downgrade it," and then then the RAC would get part of the savings from that. So they really have an

incentive to downgrade it. And there was a lot of discussion of, "Oh, well maybe we could come up with a really good rule to know when somebody is admitted or not admitted." And I think the conclusion was, no, we really couldn't. Then they came down with this two-day length of stay, that if they're there two days length of stay, or expected to be there two days length of stay, then we're just going to assume that it's a reasonable judgment.

So essentially after a lot of talking back and forth for a couple of years, the idea is this is too clinically complex and too much of a judgment call for us to regular.

MS. UPCHURCH: I think it's two midnight rule, right?

DR. STENSLAND: Yeah.

MS. UPCHURCH: Okay. And then two other quick questions. Sorry. When we talk about retiree health plans, a lot of them are shifting to Medicare Advantage. The ones that I know that have shifted have open networks. It's like a Medicare Advantage plan administered by United, administered by Humana, but it's really run by that business. I mean, often the decisions. So it's very

different. So are those groups locked into this analysis? Okay. And so they're very different kinds of Medicare Advantage plans, and would be a little bit more lenient, generally, on networks. Okay, I just wanted to make that clear. Okay.

And then the last question, and we did this in the context chapter. We deal with people all the time that want to know, "Oh, I'm in this PPO or HMO, but I'm going to be traveling. Is that going to be in that?" We say if it's urgent or emergent, you're fine. It's going to be covered by Medicare. We mention emergent in this chapter. We don't mention urgent. I just want to make that clear, if we could. Thanks. Thanks for this work.

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

DR. CHERNEW: That's the same for me, and I have, I think, Stacie starting out Round 2.

DR. DUSETZINA: All right. Great. Thank you so much for this work. As Lynn said, it is complicated, so I appreciate very much the efforts here.

The couple of information things that I think would be really helpful when I was reading this are to have

like a graph of some kind to show the integrated payments and -- or use over time. So there are a couple of places in the report where you mention kind of increases in the payments going to integrated, like, hospitals and plans. If that could be shown graphically, I think it would help a ton for just kind of getting a sense of has that grown a lot over time and then what it looks like at general breakdown.

I also wanted to say there was a point on page 8 in the chapter about looking at the prices per discharge and the payments for integrated and non-integrated hospitals, and I think that would be a really fantastic bit of information to have. I would like a lot to know, you know, how different those payments might be.

And then this is kind of minor, but on page 9, you also mentioned that there was not as much information about giving, like, a leverage for IRFs, for example, for price differentials for IRFs. It would be nice if we could know a little bit more about that. I feel like we know quite a bit more about -- or more about, you know, dialysis providers and things like that, and I feel like this falls into the same sort of place where the leverage kind of

flips over the way we normally would think about it.

But overall, really love this chapter and really appreciate the work.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you.

I really appreciated this chapter. I thought it was really a lot of new ground, and I thought the inclusion of integrated versus non-integrated was really fascinating. I was really interested in the impact on GME because, as you heard me say, I've been concerned about whether taxpayers and beneficiaries are getting the money's worth for the $20 billion a year we spend.

I do have a question and a comment. My question relates to recent reports that major MA plans are shifting from broker incentives that were PPO and HMO to just HMO. That's been reported in the past month or so, and that seems to have huge implications because, at least I see in our area, people choose the PPO HMOs with the idea that when they want to go to Boston, they just pay the $10,000, whatever the MOOP is. And I don't think people really know what they're getting.

So I'm curious if we would have the capacity or

the time to separate out those two populations within MA or if it's just impossible, too much of a lift.

DR. STENSLAND: We'll get back to you on that. I'm not sure.

DR. RAMBUR: Yeah. it would be really interesting.

And then I had a comment. Where was my comment? My comment was that I think the ideas about cost are really important, but when we look at cost, it's hard to know if some of the reductions in cost can be related to care coordination, avoiding unnecessary services or denial of services that are valuable. And I know that's really important, difficult to tease out. We don't always have the quality metrics that enable us to do that. But I just really want to have that out there. That's really important.

And as a wild extreme, when people are dead, they're really inexpensive, right? So somewhere in between here, there's a line between appropriate use of limiting services and inappropriate.

One last very quick question. I can never think about prior auth without remembering that it was really

caused by all of us providers that were ordering things without restraint, right? And in an all-inclusive total cost of care model, you wouldn't even need to have pre-auth, right? So I think we have to take some -- you know, everybody hates it. Patients hate it. Providers hate it. But it's really been shaped by how we've practiced.

So thank you very much. Really appreciated the chapter.

MS. KELLEY: Brian.

DR. MILLER: I really appreciated this chapter. It's hard because plans will say no hospitals are hurt, and hospitals will -- or I'm sorry. Plans will say no hospitals are hurt, and hospitals will say all hospitals are hurt. And neither of those is true.

I think that the summary you had where you said on page 3, we estimate no statistically significant association on average, important, between hospitals, profit margins and the share of Medicare beneficiaries in the county that are enrolled in MA is an important one, because it also leaves open the idea that we're a big country and there's lots of variation around geographies.

I think anything that we can do to sort of parse

out specific segments of the hospital industry that may be affected by MA positively or negatively and sort of what that looks like, I also recognize from a technocratic perspective extremely hard because there are lots of overlapping hospital categories and classifications. And then also when we go and ask the hospital industry about classifications, you can get different answers. It's not always clear how to define, say, a primary or secondary teaching hospital as an example.

I think that there are definitely post-acute care access challenges, which you alluded to in here. I think there's probably more challenges with IRFs or inpatient rehab facilities than subacute rehab. So parsing the IRF to subacute rehab and the subacute rehab to home health pushes, anything we can do to do that, I think would be good for us to know, because some of that's probably clinically appropriate, and some of it is probably not.

And then the discussion, I think, around observation stays and short-stay hospitalizations is important. I'd note that the observation stays just for the rest of us is a regulatory and payment artificial category. The patient still gets the same care whether

they're in observation stay or an inpatient acute care hospital admission. So if you could add that information in and then add some historical context of why CMS created the observation stay category, which was concerns about abusive short-stay hospitalizations for profitability, that will probably help our readers.

But I really like this chapter. I know it's a politically fraught topic, and I think you guys did a really good job of showing the sort of gray area in between and know that also technically it's hard to do this analysis. So just wanted to say thank you.

MS. KELLEY: Scott.

DR. SARRAN: Very nice work, guys.

Two brief comments. First, although this is a chapter about the financial implications for hospitals, it may well be worth just a quick aside to note that although many hospitals may be able to maintain their profit margins while MA penetration increases, they're still doing that via pulling resources away from other services that might have benefitted their patients and devoting now those resources to managing prior auths, denials, et cetera, again, because hospitals will work hard to maintain their

tight profit margins.

Secondly -- and this builds off Brian's comments -- I'm reminded of the old saying about the patient with their head in the oven and their foot in the refrigerator has a normal core temperature, right? And so what my sense is, how that plays out, it might be worth either -- if we're going to do any additional interviews or just referencing, emphasizing heterogeneity, my sense is that we have haves and have-not hospitals with respect to how they're impacted by MA. So the have hospitals are either they're huge standalone hospitals or they're part of large systems, the must-haves, meaning the MA plan has to have them for network adequacy or effectively, has to have them to maintain a viable product in the market from an attractiveness point of view. Or as you mentioned, they're part -- they're already integrated with the plan.

And those hospitals in the have categories, they have mechanisms to deal with both the operational and financial implications of MA. They deal with it on the front end. They get higher rates and maybe 2 percent or so higher, but that's significant, actually, or they get contractual clauses that limit the MA plan's ability to do

retro denials or things like that. The point is they can put on the front end; they can force into the contract some protections and/or they have resources available on the back end to manage denials, fire offs, et cetera. So they do fine.

And then we've got -- in contrast, we've got the have-not hospitals, unaffiliated hospitals, smaller systems, et cetera, and they are really -- my sense is that a lot of them are really hurting, that they were tenuous operations at best and now higher MA penetration, particularly if it's via some of the MA plans that are more difficult from a hospital relationship point of view and operational point of view. They can be pushed over the edge.

So it's probably worth highlighting that on the average things look okay, but there's probably a wide range in how it actually plays out depending on the hospital's market position.

Thanks.

MS. KELLEY: Tamara.

DR. KONETZKA: Thank you for this great work.

I have a couple of comments that seem -- that are

very different from one another. So I'll start by geeking out a little bit on you.

I really love that that you sort of pushed forward the fixed effects analysis. I think that's the way to go. I think it's a much more defensible model than the IB.

And I also love that you did these robustness checks and were very transparent about the limitations of the model. I have a few suggestions about that.

But first, just in terms of presentations, you put the coefficients in, which are mostly in percentage terms. It'd be really great to see the dollar amounts too, because there's often a situation where you don't get statistical significance, but the amounts might actually be practically meaningful to a small hospital, for example, if the change, a small percentage change results in millions of dollars' difference. So we might want to just take a step and look at those actual magnitudes.

I think your robustness checks, which again, I appreciate very much, basically show what I think is very plausible to all of us, which is that Medicare Advantage doesn't grow randomly. Companies don't -- beneficiaries

don't sign up, and companies don't enter these markets completely randomly.

I think there are a couple of things you could try, and some of this also builds on some of the heterogeneity discussion we've had here, which I think is really important. But you mentioned a few of the sort of time-varying confounders, which is the main threat to this kind of model, right? I don't know -- I don't think there was a whole list in here, right? You said you used some county-level variables, population characteristics. You could certainly try to find any other kind of time-varying confounder that you could include in the analysis and that is not along the causal pathway between MA penetration and your outcomes.

And even if there might be some sort of causal mechanism there, like the Medicaid thing you were talking about, you know, you can do it sort of with and without controlling for those and get some balance on what these effects might be if you could really control precisely for all of those confounders. So that's one suggestion, just control for more stuff that could confound this.

Another thing along the heterogeneity lines is MA

here is continuous, and you might actually see some thresholds, right? It might make a difference to a hospital if you're going from 10 percent MA to 20 percent versus 70 to 80. And so you might want to either do some stratifications or just some interactions or splines or something to see if you see some thresholds in that MA penetration.

And then similarly, yeah, you might want to, like, stratify by initial MA penetration or stratify by some of these other hospital characteristics. You could even do some matching, but maybe stratification is the easiest. But I like, let's say, the level of competition in the market or rurality or some of those population characteristics.

So I think there are ways you could push this model. I think it's already sort of plausible but, you know, with the caveat of these limitations. And so those are just, if your time allows, ways you could tweak the model a little bit more.

And then a little bit more on interpretation. I think I find it very interesting in the integrated versus non-integrated hospitals that basically you get not much of

an effect, but one is because both the revenues and costs decreased, and that I think it's worth noting that that might not be a static concept, right, that as MA penetration grows, there may be different floors for the revenues and the costs. And so it would be interesting to sort of follow that over time or, again, see if that sort of changes with the level of MA penetration, because we may see that hospitals have hit a floor in how much they can reduce their costs, and then we'll see more effects in the future.

The uncompensated care effect seems really quirky to me, and I'm glad you're going to investigate that, because it seems like it must be sort of historical accident in the way that's calculated, and maybe it's not a -- maybe that needs to be revisited.

Finally, I'm really excited to read that you will start looking at this issue in other sectors, especially in the post-acute care sectors, because they're -- I think it's plausible that there's not that much of an effect in hospitals for many of the reasons you mentioned. I think we may see a very different case in SNFs and IRFs, for example.

And then one more thing about the post-acute sort of following on something Brian said about the length of stay. You know, we're looking here at profit margins in hospitals. There is this issue that length of stay for MA patients is longer in hospitals. That may actually be a more important issue than the profit margins and in ways that we haven't even really discussed, and that when length of stay is longer for patients trying to wait for a post-acute care prior auth or a bed, it not only -- I mean, I have a doctoral student who's preliminarily investigating some of this, but -- so my thoughts are based on those preliminary analyses.

But it's not just that the hospital is losing money by having the patient there longer, but it kind of creates a bottleneck for everything else, right? Like, the hospital is waiting for a bed for somebody in the ER, and that bed is still filled with that post-acute care patient. So it actually sort of indirectly also affects maybe access to people who need hospital care as well when a hospital is full.

And so that seems to be a very complicated issue, and I don't know if we're going to go down that road, but

that also makes it perhaps more plausible that, like, the main effect might not be just in the profit margins.

Overall, really excited about this and really excited to see it in other sectors. Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Really great work. Thank you so much.

I think that this work that, you know, is continuing to build on the work that you previously did in the rural space is important, and I support continuing to expand this to other sectors.

I'm going to plus-one on all of Tamara's great comments about methodologic issues and sort of the complications of showing causal effects, but I think you did great work with what you had available.

I guess one thing that occurred to me -- and again, it's contingent on how much time and resources you want to devote to this space, but I think at the state level and in California, the hospitals have to report in their financial reports, their revenues and costs broken out by different payers. So there may be an opportunity to leverage some state databases, you know, where state

financial reporting is required, maybe to, you know, provide more evidence in the space. So that might be something you could explore.

I also found myself, as I read this, say, in terms of the differential effects for affiliated versus unaffiliated, even though I know it was a statistically insignificant increase in all-payer revenue and costs at the integrated hospitals, but it made me wonder what is happening in the care process that's different between integrated and non-integrated facilities. So are there more observational stays in non-integrated and more hospital admissions in the fully integrated? So I was just, like, how do I unpack this story? What's the narrative?

The other thing -- and I was glad Tamara raised the issue around the length of stay. One of the things that I think is also potentially in play, but it's, I think, unobservable -- and I've seen this happen -- which is the hospital will hold on to a patient longer while they're waiting for the approval from the health plan to transfer. But at some point, they want the patient out of the hospital, and then they may move them to another

facility, or they're absorbing the cost of that care through their charity care. So there's still a cost to the hospital in terms of continuing to provide services until that approval process fully plays out, and I think that's something that's not discussed or fully captured.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks again for this great work, and to the fellow Commissioners who know how to analyze information, thank you for your insightful comments.

Mine's a little bit different. So one of the things that we deal with as a SHIP coordinating site is network breakups between hospitals and Medicare Advantage plans.

So, first of all, how often do they -- I think it's every two to three years they create contracts with Medicare Advantage plans. So they don't review them every year. Is that about right? Do you know?

UNIDENTIFIED SPEAKER: [Speaking off microphone.]

MS. UPCHURCH: Okay. So, I think it's not every year, and we allow them to do it mid-year, which I really hope will stop, or we have a policy to stop that, but we're seeing one in Durham, North Carolina, that would break up

huge insurance companies, huge health system, October 20th, in the middle of the month. They create these incredible campaigns. The hospital creates a campaign, all this money and energy, "We care about you." They don't care about you. The insurance company does the same thing, "We care about you." They don't care about you. And the patients get fed all this information. We may end this contract at this time. Stay alert. It's a real problem.

And so, I'm just wondering, related to this work, do we know how much money goes into these mid-year network breakups, and is that included in this analysis? The hospital, what it costs the hospital to say, you know, we care, they don't, or vice versa. Thanks.

DR. STENSLAND: The money, all the money is in there, so any effect that those mid-month breakups have that's correlated with the expansion of MA is going to be in there, but it's kind of a tenuous tracking of that through.

MS. UPCHURCH: Okay. Because, I mean, there are letters that go out. You have to train your staff how to deal with it. It's very expensive. So the fact that we allow it and we add that expense is tough, I think.

DR. CHERNEW: The only thing I'll say is, this is focused on the impact of the expense on the hospitals. It does not take into account the impact of the expenses on anyone outside of what's happening in the hospitals. So it's just not -- so if there's expenses because of all of that that's being incurred by your pharmacist or whoever it is -- or enrollees --

MS. UPCHURCH: Or the Medicare Advantage plans, right?

DR. CHERNEW: Right.

So it's just, this is a limited question. I think you guys are trying to do a very good job of it. So let's just keep going around, but yes, I agree with that completely.

MS. UPCHURCH: Thanks.

MR. MASI: Can I just add one other quick thing? And, Gina, hear you that this is a really important issue, and we have separate work we're trying to pursue this fall, specifically looking at provider networks and what we can learn about them, changes over time, things like that. So, as always, stay tuned.

MS. KELLEY: Greg.

MR. POULSEN: Yeah. Thanks very much. I live a lot of my life at the confluence of MA and providers, and in spite of that, I learned a lot from this paper, and I'm grateful for the good work. So thanks.

I'm grateful, obviously, that you looked at the integrated MA plans differently and separated that and teased it out.

I do note, as Scott did, that maybe taking this a slightly different direction than Scott did, the hospitals that have MA plans don't look like other hospitals, generally. I mean, you're not going to find a 200-bed community hospital that has an MA plan, and so sort of almost by definition, the hospitals that have MA plans are kind of different than a lot of the others or than that mass, and so that's -- you guys clearly know that, but we need to just remind ourselves of that.

I'm grateful that you underlined the point that the relationships that we identified are not always causal, because I think that simply the capability and size of the hospitals that would have plans make them almost by definition more sophisticated, and so they're different in some other meaningful ways.

The point, though, that I think that I really wanted to make -- and by the way, Jeff, I really appreciated also your point of the binary nature of the "do they have plans" or the "do they not," and that can range from a Kaiser hospital who is essentially 100 percent associated with the plan members to some other where it may be a small percentage of their total patients and even a small percentage of their MA patients may be coming from their own plans. So I think that's really good too.

Again, I'll identify the causality issue. This is one area where I think -- and it probably doesn't belong here in this section. In fact, I know it doesn't -- that there may be some additional clarity as we look at plans as opposed to hospitals and look from, if you will, the other end of the street, where we're looking at it from a plan perspective and then comparing the plans that are related to hospitals or other health system components versus those that aren't, because there the strength is much, much higher.

I'm not aware of any plan that is owned by a health system that doesn't have a very, very significant impact in their relationship with the health system. You

know, they're not owned by a health system, but they interact with all the hospitals in the world and all the doctors in the world and so forth. Those relationships tend to be tight. So we may be able to tease out higher degrees of correlation, and we may even be able to identify some degrees of causation that we simply can't get from looking at it from the provider side of the perspective. So appreciate all that great work.

The only other thing that I would just say is, as we look at all of the things that frustrate Medicare beneficiaries, things like claims denials and the potentially unduly onerous prior authorization capabilities, right now the plans have very little disincentive for doing that. If they deny care and then it gets overturned, all they end up doing is paying for it. They don't end up with any kind of penalty.

The providers, including the hospitals, if care is denied or if payment is denied, they can potentially have provided the service and not get paid anything for it. So the downside for them is very high.

And candidly, I think -- and this may or may not be the right place to bring it up, but there probably

should be a penalty on the side of plans who conscientiously and without conscientiousness deny care as a financial mechanism, because right now the worst they do is end up paying what they would have paid anyway. And so were we to consider as a recommendation at some point that there be a penalty when there are constant denials that are constantly overturned -- you know, for example, a penalty on top of the payment rate for an overturned denial, and of course, we all know there are multiple layers of denial recovery. And the further down the path may be the more, but that may be a topic for a different day.

But in the meantime, I just wanted to say thanks so much for the great chapter. Really, really good stuff.

MS. KELLEY: Robert.

DR. CHERRY: Yeah. I also want to thank you for a well-written chapter as well.

I want to dovetail a little bit on one of Greg's comments that specifically hospitals that integrate with MA programs are not the same, but I also want to focus very specifically on teaching hospitals, because it did stand out in that slide where teaching hospitals are incentivized to admit patients rather than put patients in an

observation status.

First and foremost, not all teaching hospitals are the same. So if you look at the American Hospital Association, they'll quote about a thousand teaching hospitals. If you look at the Council of Teaching Hospitals, where they have more robust educational programs, there's about 400 of those, and of those 400, roughly around 226 are academic medical centers where they're the primary teaching hospital for their medical schools.

It's probably within that 226 that represents kind of a special category of facilities that are integrating with MA plans. Many of those hospitals are not, but it may be worthwhile looking at them as sort of a special category that may be thinking about MA plans a bit differently.

So they aren't necessarily incentivized to admit for a number of reasons. They are incentivized to admit for quaternary care services because that's what they're built for. That also means their cost structure is pretty high, too, and they're motivated to put patients in lower-cost settings within their network.

They also don't want to admit patients unnecessarily, because they tend to have capacity challenges and patient flow-related issues and, also, just like yesterday's conversation, subject to the same RAC audits that every other facility has.

They also tend to have a population health culture about them, and so they're less likely to admit for unnecessary reasons.

And the clinical acuity of the patients that they admit may be a bit underappreciated, relative to just looking at a CMI, an administrative billing database.

So I would argue that they're a bit different, and they're incentivized differently. And it would be interesting to know, out of the 226, how many have integrated with MA programs, but also, how many of those have divested from MA programs because of some of the reasons that I mentioned? The high-cost structure may not lend itself to, over the long term, having a financially sustainable model with these programs, and is there lessons learned around those that are integrating with MA programs, as well as those that have disinvested since that time period?

So I just wanted to put a finer point around that generalized statement, because it's a group worth looking at, but I also think it may be a misunderstood group for the reasons that I mentioned. But thank you.

MS. KELLEY: Gokhan.

DR. METAN: Thank you very much for this work. I really like the data-driven nature of the recommendations. I really appreciate it.

I have two comments. In general, I'm less concerned about regions or markets where there is healthy competition happening, both from the presence of multiple providers in the market and multiple MA carriers representing total market share. I'm generally more concerned when that is skewing one way or another. I have been both on the insurance side and the provider side, seen how some of these contracts are negotiated. There are one or two carriers who represent that market penetration of the MA plans more. That's typically like when you see they have a lot of negotiation power.

So it might be helpful to actually look at those regions where some of these dynamics are skewed one way or another, if there is one big MA player or two big MA

players, for example, in that market, or vice versa, like if that region is represented by one hospital system. So competition skew one way or another, might be interesting to look at, and how MA penetration plays in that market.

And then the second comment I have is more on the timing effect. Some of these things are delayed effects. Like when a market penetration of MA plans increases, it may have some 1-, 2-, 3-year delayed effects of how those contracts are renegotiated and some of those things change. So it might be worthwhile to look at how market penetration changes and how those effects later on kind of like come to play. Without the timing dimension, the regression model may not pick that up.

It might be also worthwhile to look into that timing effect of how those dynamics are shifting. And within that framework, looking at some of the extreme regions, markets, where market penetration is even more pronounced might also help, because some of those timing effects may not be a strong innovator, but by looking into some of those concentrated markets may help you isolate those effects.

So those are my two comments. Thank you.

MS. KELLEY: Kenny.

MR. KAN: Thank you for this excellent chapter. I am enthusiastic about future analysis on this.

As noted on page 10, the current preliminary research uses retrospective data from 2013 to 2023, and it suggests no impact on hospital inpatient profit margins from higher MA penetration.

In terms of more concurrent data, I am wondering, can we actually be intellectually honest and that the following non-intuitive hypothesis. Could higher MA penetration be resulting in higher margins, and yes, two vantage points. Number one, instead of retrospective data, can we look at more concurrent data? I struggle to reconcile why it would not result in higher margins, and here's why.

In July, for Strada, acute industry growth operating revenue grew 10.6 percent, year over year, or 5.6 percent, month over month, underlying 12 percent outpatient and 7.2 percent inpatient annualized revenue growth. Net patient service revenue was up 3.1 percent, year over year, and an adjusted discharge basis. Outpatient visits grew 6.6 percent, year over year, outpacing inpatient admission

growth, not decline, are 3.6 percent, year over year.

I'm struggling and would love to better understand this. Can we explore the interplay between inpatient admissions and outpatient visits on future hospital payment recommendations and impact to margins? Thank you.

MS. KELLEY: I think that's all we have for Round 2, Mike.

DR. CHERNEW: Great. So, as always, you guys are wonderful, so I really, genuinely thank you.

Let me just make a few comments about where this is and where I think it's going. The first thing is this was motivated by a general concern about the impact of Medicare Advantage growth on providers. That's a very important and a very real concern and a very salient concern. We hear it all along, and we hear it from both sides in different ways, as has been pointed out.

What we're measuring, in many ways, is net of adaptation, per what Lynn said at the very beginning. So there are a lot of things that can be going on in this, and as I think Scott and Brian emphasized earlier on, there's a lot of heterogeneity. So we're not answering the question,

what's happening to this one particular facility with MA growth, but to be totally honest, policymakers, in general, also are often working in an average world. So we're just trying to get an average sense of what's happening, and there are a lot of very strong stories there.

On the plus side, it seems to be the case that the biggest fears that MA is making hospitals dramatically unprofitable, on average, does not actually seem to be true, perhaps because of adaptation. And I take the cost results that you showed, in some sense, that there is, in fact, adaptation, in a bunch of ways that other people mentioned. Revenue goes down but their costs go down.

What is unclear is what we make normatively of that. Are we okay, we believe that somehow MA is making the system more efficient, and that is generally good, or are we worried that, no, the reduction in cost is having real deleterious consequences? We are not making a statement on that right now, and I'm not sure where we will go. That is a longer, more complicated analytic question, and frankly, it's a question that couldn't be addressed by us, and can be addressed in the rest of the sort of analytic community.

And the last thing I'll just say, this is, I actually think, an incredibly well-done piece of work, and in particular, incredibly transparent in terms of what the strengths, the weaknesses are, what you can do, what you can't do. And kudos for that.

But the one thing that really I want to emphasize for those at home is we don't have a particular plan about how to react. We aren't thinking, oh, if we would've found this, we would've done this, or we would've done that, or what's good or bad. We are not looking for a policy or reaction. We are right now just trying to understand how to respond to a question that is percolating around in the world. I think we will continue to do this. I think your comments have been very helpful. So just at least for now, take it for what it is, and I think that is quite useful, and I appreciate it, Jeff and Brian, for your comments.

So with that said, let me thank Jeff, Brian, and the staff who presented here, and all the staff who did, as well. There is a lot of stuff that goes on. I want to thank all the Commissioners for your time. It's really good to see you, and kick off another year of MedPAC work. There's a lot of good stuff we did today and a lot of good

stuff to come. It's obviously a bunch of very complicated and important issues.

For those of you at home, we really would like to hear your feedback, so please reach out to us at meetingcomments@medpac.gov. That's meetingcomments@medpac.gov, or any other way, to let us know what you think. We do want to hear, analytic or otherwise.

But with that we will be back again in October, and looking forward to all the topics we have then. So again, thank you very much.

[Whereupon, at 11:48 a.m., the meeting was adjourned.]