

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, October 8, 2026
11:00 a.m.

COMMISSIONERS PRESENT:

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AGENDA

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P R O C E E D I N G S

[11:00 a.m.]

1
2
3 DR. NAVATHE: Welcome, everyone, to our October
4 public meeting. And we have an exciting agenda over the
5 course of today and tomorrow. We'll be starting with a
6 session on physician participation in Medicare Advantage
7 provider networks, and I will hand it over to Katelyn.

8 DR. SMALLEY: Thanks, Amol. I'd like to start by
9 reminding the virtual audience that you can download the
10 slides from the control panel on the right-hand side of
11 your screen.

12 Commissioners have expressed interest in
13 understanding more about provider networks in Medicare
14 Advantage. This morning, we will be discussing the
15 participation of physicians in MA networks.

16 First, we'll go over some background concepts and
17 review the Commission's discussion of clinician
18 participation at the March 2026 public meeting. We'll then
19 discuss evidence of physician participation in MA by
20 comparing two key sources: provider directory data and
21 encounter data. We'll first look at participation in
22 aggregate, whether a physician participates in the MA

1 program at all. Then, we will consider the extent to which
2 providers who have rendered services to MA enrollees show
3 up in their plan's provider directory.

4 Finally, we will discuss a qualitative project
5 that we did to understand the participation of cancer
6 centers in MA provider networks.

7 Provider networks are a tool that MA plans can
8 use to manage care quality and cost for enrollees. While
9 Medicare beneficiaries report that the choice of providers
10 is an important factor in their health care coverage, we
11 have consistently heard in our focus groups that many are
12 willing to trade some degree of choice in exchange for
13 benefits, such as lower premiums and out-of-pocket costs,
14 or other additional benefits that MA plans can provide.

15 Assessing MA provider networks is important to
16 ensure that plans provide beneficiaries with adequate
17 access to the full range of statutorily defined Medicare
18 benefits.

19 CMS maintains network adequacy standards to
20 support access to the full Medicare benefit for MA
21 enrollees. Network adequacy is currently monitored for 29
22 specialty types and 14 facility types, based on county-

1 level provider to potential enrollee ratios, and average
2 time and distance from providers to potential enrollees.

3 More information about the MA network adequacy
4 standards can be found in your mailing materials and the
5 June 2024 Report to the Congress.

6 MA plans are also required to maintain provider
7 directories, and make them available online for enrollees
8 and potential enrollees. As of plan year 2026, some MA
9 provider network information is available through the
10 Medicare Plan Finder.

11 Beneficiaries rely on directories when choosing
12 coverage and when selecting a provider to address a health
13 need. MA plans are responsible for maintaining provider
14 directories, but the current system is complex, and has led
15 to documented inaccuracies.

16 Providers must submit updates to every plan they
17 contract with, but some may have little incentive to do so.
18 Plans and providers can contract at will (and clinicians
19 move, retire, and change jobs), so networks can change
20 throughout the plan year.

21 Errors or inconsistencies in participation data
22 diminish enrollees' ability to make informed decisions

1 about their care and coverage. For this reason, we want to
2 compare the information that enrollees get about the
3 providers available to them from directories, to the
4 physicians they actually see based on encounter data.

5 Before we get to that comparison, though, I want
6 to briefly remind you of what the Commission discussed in
7 March of this year. We presented findings on participation
8 of primary care providers and specialists in at least one
9 MA plan, and in multiple MA organizations. We also looked
10 at changes in network size and clinician entry/exit during
11 the year. We generally found that participation rates were
12 high and net increases to networks mid-year were small, but
13 with wide variation.

14 We identified MA participation of clinicians for
15 this analysis using a database of provider directories
16 compiled by a third-party vendor called Ideon.

17 We want to note that we included primary care NPs
18 and PAs in the March 2026 analysis because, (1) they are
19 important providers of care to Medicare beneficiaries, and
20 (2) CMS considers them PCPs when assessing network
21 adequacy.

22 This time, we compared MA provider participation

1 using two sources: provider directories and MA encounter
2 data. Provider directories are an (imperfect) source of MA
3 participation data, but are meant to reflect the providers
4 who are contracted to be in a plan's network. Encounter
5 data provides information about the clinicians who have
6 delivered care to MA enrollees. By looking at the overlap
7 in these sources, we can have more confidence that they
8 faithfully represent the providers who participate in MA.

9 It is important to note that the analysis we
10 present today is descriptive; we do not opine on the
11 "right" level of participation in MA.

12 In looking at these data sources, we've made the
13 decision to exclude NPs and PAs from further analysis,
14 because of variation in how these providers are recorded in
15 directories and other data sources, because of things like
16 incident-to billing, variation in state scope of practice
17 laws, and plans' internal policies. We believe that
18 including these non-physician clinician types would likely
19 skew our understanding of PCP participation more than it
20 would clarify.

21 For this analysis, we looked at physicians
22 actively billing Medicare, and focused on local HMO and PPO

1 plans. We used 2023 data, the most recent year for which
2 encounter data is available.

3 More information about our methods are in your
4 mailing materials, and we are happy to answer any
5 questions.

6 This figure shows participation rates by two
7 different metrics: directory-based, shown in blue, and
8 encounter-based, shown in orange. Rates for primary care
9 physicians are found on the left, and specialists are on
10 the right.

11 The blue bars are similar to what we presented in
12 March, which we are calling directory-based participation.
13 We define this as a physician's NPI appearing in at least
14 one provider directory. We found high directory-based
15 participation rates for both primary care physicians and
16 specialists, at 93 percent and 88 percent, respectively.

17 When we look at encounter-based participation,
18 though, the rates are even higher, at 97 and 98 percent,
19 respectively.

20 To avoid including physicians who do not
21 meaningfully provide care to MA enrollees, we considered a
22 physician to be an MA-participant based on encounters if 5

1 percent or more of their Medicare claims volume came from
2 MA encounters.

3 For simplicity's sake, in the rest of this
4 presentation, we will say that a provider is "in encounter
5 data" if MA encounters are 5 percent or more of their
6 Medicare claims volume, and "not in encounter data" if
7 their MA share is less than 5 percent.

8 We next looked at the overlap of physicians who
9 appear in directory data, compared to those who appear in
10 encounter data. In the schematic on the slide, the blue
11 boxes indicate that the directory data and encounter data
12 agree, and the orange boxes indicate that the directory
13 data and encounter data conflict.

14 Most physicians participate in MA by both
15 definitions, with about 88 percent of physicians appearing
16 in at least one provider directory, and also appearing on
17 encounter records, represented in the top-left blue box.

18 Yet, moving down to the bottom-left orange box,
19 about 9 percent of physicians are in encounter data but not
20 found in the provider directory of any MA plan. If we
21 looked only at provider directories, these physicians would
22 appear to not participate in MA.

1 A very small share of physicians is not in MA
2 encounter data; about one and a half percent are in
3 provider directories but not encounters, and only about
4 half a percent of physicians have no evidence of
5 participation in MA.

6 Some specialists may be less likely to appear in
7 provider directories than others. For example, behavioral
8 health providers are less likely to participate in networks
9 across all payers.

10 Some physicians are generally not selected by
11 patients, such as emergency medicine, radiology,
12 anesthesiology, hospitalists, pathology, nuclear medicine,
13 and critical care medicine. These specialists may be less
14 likely to appear in directories because, for example they
15 may be less likely to contract with MA plans, or because
16 plans and providers may have less of an incentive to keep
17 directories up to date for provider types that
18 beneficiaries do not choose.

19 If we decompose the comparison of participation
20 rates by specialty, we see substantial variation. A full
21 table of participation estimates by specialty can be found
22 in your mailing materials. Here, we focus just on the

1 providers who are found in MA encounter data.

2 The blue bars on the screen represent physicians
3 who are in both encounter data and provider directory data.
4 The orange bars represent physicians who were in encounter
5 data, but not directory data. Ninety-one percent of PCPs
6 were in both encounter data and directory data, as shown in
7 the left-most set of bars, and 6 percent were in encounter
8 data but not directory data.

9 We see that those specialists generally not
10 selected by patients, like emergency medicine, radiology,
11 and anesthesiology, are much less likely to appear in both
12 encounter data and directory data than other physicians, at
13 about 73 percent, and more likely to appear in encounter
14 data only, at 26 percent.

15 On the righthand side of the screen, we find that
16 other specialists are even more likely to be found in both
17 encounter data and directories than PCPs, at a rate of
18 about 94 percent.

19 At this point, I'm going to turn it over to
20 Krista, who will discuss our analysis of MA enrollees' use
21 of services from physicians not listed in provider
22 directories.

1 MS. CHERRY: Thank you, Katelyn. On the previous
2 slide, we showed program-level participation in MA, where
3 we discussed the share of Medicare physicians that were
4 listed in a directory for any MA plan and/or providing care
5 to MA enrollees. More salient for beneficiaries is
6 whether the physicians providing care to MA enrollees are
7 in their own plan's directory.

8 We analyzed MA encounter data for February 2023.
9 We identified the rendering physician and plan associated
10 with each encounter, searched for that physician NPI in the
11 plan's provider directory, and then analyzed encounters
12 with in-directory physicians compared with non-directory
13 physicians.

14 More detail on these steps can be found in your
15 mailing materials.

16 We found that 32 percent of encounters in
17 February 2023 were rendered by a physician that was not in
18 the enrollee's plan directory. These encounters could
19 reflect that the physician was in-network, but the
20 directory was incomplete, lagged in updates, or was
21 otherwise inaccurate. Or, it could be that the physician
22 was out-of-network for the beneficiary at the time of

1 service.

2 Evidence on the prevalence of out-of-network care
3 in MA is limited. We are only aware of one study that
4 estimated this. That study found that between 15 and 22
5 percent of MA claims were out of network. The author in
6 that study used data directly from plan contracts with
7 providers, rather than publicly listed provider
8 directories.

9 The share of MA encounters with a non-directory
10 physician also varied by specialty. In this figure, we
11 decompose encounters into encounters with primary care
12 physicians, specialists generally not selected by patients,
13 and other specialists. Looking at the dark blue bar, we
14 find that about 18 percent of the encounters with a primary
15 care physician were rendered by PCPs who were not in the
16 beneficiary's plan directory.

17 Moving to specialists who are generally not
18 selected by patients, about 72 percent of encounters with
19 one of these specialists were rendered by specialists who
20 were not in the beneficiary's directory. This share might
21 be higher than PCPs because these specialists are less
22 likely to appear in provider directories or because their

1 care is more likely to be out of network.

2 Other specialists who might be selected by
3 patients, such as general surgeons or cardiologists, had
4 similar rates to PCPs, with one exception of psychiatry,
5 where 46 percent of encounters with psychiatrists had a
6 non-directory physician render the service. This is
7 consistent with literature that finds that behavioral
8 health visits are more often out-of-network than other
9 services.

10 To summarize our findings on physician
11 participation in MA, we find that over 95 percent of
12 Medicare-billing physicians provided care to MA enrollees,
13 as evidenced by MA encounter data. However, these
14 physicians often do not appear in provider directories.
15 Nearly 10 percent of physicians were not listed in any MA
16 provider directory, yet the MA share of their Medicare
17 claims volume was greater than 5 percent. Nearly one third
18 of MA encounters had a rendering physician that was not
19 listed in the MA enrollee's plan provider directory.

20 Beneficiaries rely on provider directories both
21 when choosing coverage and when selecting a provider to
22 address a health need, but directories may give a

1 misleading picture of the providers that are available to
2 them.

3 Now, I will turn things to Alice.

4 MS. STRICKER: Thanks, Krista. I will now
5 discuss our interviews with cancer centers and MA plans.

6 As Katelyn mentioned, CMS maintains network
7 adequacy standards to support access to the full Medicare
8 benefit for MA enrollees. As part of these standards, CMS
9 requires MA plans to include medical, surgical, and
10 radiation oncology providers, as well as outpatient
11 infusion and chemotherapy facilities. However, there are no
12 requirements to include cancer centers or subspecialists in
13 their network. Therefore, it is up to the plans and
14 centers to decide whether they should contract with one
15 another.

16 Commissioners have expressed interest in learning
17 about cancer care in MA.

18 The National Cancer Institute, or NCI, has
19 recognized the cancer centers that meet their research
20 standards as NCI-designated cancer centers, or NCI-DCCs. I
21 want to note that in this presentation I will use the terms
22 NCI-DCCs and cancer centers interchangeably. While there

1 are many centers that do not have the NCI designation, we
2 did not speak with them as part of this project.

3 To understand the dynamics driving MA network
4 status of the NCI-DCCs, we conducted qualitative interviews
5 with seven cancer centers and five MA plans. Each
6 interview lasted approximately one hour and covered topics
7 including, but not limited to, contracting decisions, prior
8 authorization, non-network arrangements, and impacts on
9 patient care. In the following slides, we will discuss the
10 themes we identified across the interviews.

11 Plans reported varied experiences with their
12 perceived market power when negotiating contract terms.
13 Centers with greater perceived market power described
14 prioritizing payment rates, timeliness of payment, and
15 administrative burden.

16 Other centers expressed interest in participating
17 in MA but reported that plans were unwilling to contract
18 with them. These centers speculated that this was due to
19 concerns about adverse selection. They explained that
20 plans may worry that including a specialized cancer center
21 in network would attract high-cost patients, thereby
22 increasing expenditures.

1 Commissioners have expressed interest in the
2 potential implications of mid-year contract changes for MA
3 enrollees.

4 Both MA plans and cancer centers reported a range
5 of contract lengths, with most on 2- to 5-year cycles but
6 others being more open-ended or as plans and providers
7 described them, evergreen. These contracts often, but not
8 always, coincide with the plan year, and plan enrollees
9 generally may not switch plans outside of a defined
10 enrollment period.

11 Some cancer centers reported that the termination
12 of contracts only occurs in extreme circumstances, such as
13 plan bankruptcy. Other centers discussed instances where
14 terminations did occur, sometimes driven by the cancer
15 center and sometimes driven by the MA plan. Plans and
16 centers both acknowledged that the potential for contract
17 termination could be stressful for patients.

18 Plans and centers both reported that payment
19 rates were generally aligned with fee-for-service Medicare,
20 but there was some variation. For example, some cancer
21 centers are exempt from the prospective payment system and
22 receive cost-based payments in fee-for-service. This may

1 complicate their negotiations with MA plans.

2 Additionally, some centers with greater market
3 power reported sometimes being able to negotiate higher
4 rates. Meanwhile, other centers cited concerns that the
5 rates offered by plans did not cover their costs. This was
6 particularly salient for the PPS-exempt centers.

7 Nearly all of the centers we interviewed raised
8 concerns about prior authorization requirements in MA
9 plans. Centers reported that these authorizations are
10 almost always approved, but they may delay care.
11 Importantly, centers noted that prior authorization
12 requirements are particularly burdensome for cancer centers
13 given their utilization of experimental or advanced
14 procedures.

15 Plans also recognized these burdens on providers
16 and they cited efforts to streamline prior authorization
17 review processes, such as gold-carding agreements with
18 providers.

19 MA plans and centers reported varied experiences
20 with coverage policies for cancer care. Several of the
21 centers we spoke with described MA plan coverage policies
22 as opaque and sometimes conflicting with accepted standards

1 of care. For example, some centers noted that MA plan
2 guidance sometimes conflicted with the National
3 Comprehensive Cancer Network's treatment guidelines.

4 Centers also explained that plans may require
5 step therapy before allowing an oncologist to prescribe
6 their preferred treatment pathway, or they may mandate care
7 to take place in a particular setting that a clinician did
8 not always agree with.

9 Some centers also noted that many MA plans have
10 unique formularies, prior authorization requirements, and
11 preferred treatment pathways, requiring providers to keep
12 track of many different sets of guidelines. Meanwhile,
13 plans stressed that while there may be differences in how
14 coverage policies are operationalized, they follow Medicare
15 coverage rule.

16 Many centers reported serving MA plan enrollees
17 even when they were out of network, primarily via single-
18 case agreements. These agreements are one-time contracts
19 between a health plan and an out-of-network provider that
20 allow patients to receive care that cannot be obtained from
21 an in-network provider, generally at in-network cost
22 sharing rate. While centers viewed these agreements as an

1 extension of their principle to take all patients, they can
2 also be burdensome on providers. One center reported
3 completing over 10,000 single-case agreements in a single
4 year.

5 Notably, one center explained that single-case
6 agreements for HMO enrollees can be more favorable for
7 patients than relying on PPO out-of-network benefits, as
8 they allow patients to pay in-network cost sharing rates as
9 opposed to the higher out-of-network rates that come with a
10 PPO plan. However, other centers recommended PPO plans to
11 their patients because they may protect them from losing
12 all coverage if their plan goes out of network with a
13 center.

14 Many of the centers also recognized the burden of
15 confusion on MA-enrolled beneficiaries with cancer, and
16 they discussed having a process for educating patients on
17 their network status and coverage choices.

18 I will now turn it over to Katelyn.

19 DR. SMALLEY: Thanks, Alice. We now turn to the
20 Commissioner discussion. We welcome your questions and
21 feedback on the work presented today and our future plans.
22 We plan to return in the spring with additional analysis,

1 including continuing to refine our estimates and understand
2 discrepancies between different sources of provider network
3 data, and conducting similar analyses of MA participation
4 of other provider types. We intend for this work to be
5 included as a chapter in the June 2027 report.

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

7 DR. NAVATHE: Katelyn, Krista, and Alice, thank
8 you so much for a great presentation, very informative and
9 succinct.

10 So, as Katelyn just mentioned, the work,
11 including the March 2026 presentation, will all be part of
12 this upcoming June chapter, and we are coming back with a
13 spring presentation on this work. So this is another
14 installment in a series of installments around MA provider
15 networks.

16 So, with that, I'll turn it over to Dana to run
17 the queue.

18 MS. KELLEY: Okay. I have Stacie first in Round
19 1.

20 DR. DUSETZINA: Great. Thank you so much for
21 this work.

22 A quick question about the cancer center

1 interviews, I just was curious about who you spoke to,
2 somebody in like hospital operations and billing or people
3 involved in patient care, or did it differ by site?

4 MS. CHERRY: Yeah, great question. It ranged a
5 little by site, but it was primarily people working in
6 payer strategies and the finance department of centers.

7 MS. KELLEY: Tamara.

8 DR. KONETZKA: Thank you for this great chapter.
9 A couple of quick questions.

10 The first one, I think you answered in the
11 slides, and I was a little confused when I read the
12 chapter, about the timing of the encounter data versus the
13 provider directories. So it was clear in the chapter that
14 the provider directory was drawn from February 2023. It
15 wasn't clear to me when the encounters were drawn from, but
16 it sounds like you also just did February?

17 MS. CHERRY: Yes, that's a great question. So,
18 for the analysis of MA participation, we used encounters
19 from the entire calendar year of 2023, but for the analysis
20 of non-directory versus directory rates of encounters, we
21 just used February 2023 carrier encounters.

22 DR. KONETZKA: Okay. Yeah, so that sort of

1 raises the question for me in the first part of the
2 analysis. It's, you know, you said there are a couple of
3 potential explanations. One is the directory is wrong.
4 Another is that people are using out-of-network care. Is
5 there a third explanation that the timing is just off, and
6 maybe the provider joined the network or something, and the
7 encounter is late in the year? I don't know if that's a
8 big issue or not, but you might want to sort of tighten
9 that window and see if that's a problem.

10 DR. SMALLEY: Yeah, we can definitely do some
11 more work around that. We did some work on kind of
12 understanding the timing and maybe that there is an
13 explanation.

14 We also thought that, you know, there are new
15 residents, are coming to on July 1st, so there are certain
16 -- there are additional explanations that we did some work
17 to understand. But yeah, we could do a version of this
18 analysis just using February and seeing if that changes.

19 DR. KONETZKA: Yeah, that would be helpful.

20 The other question, also about the analysis,
21 especially in that first part, was there a reason that you
22 didn't try to differentiate sort of HMOs and PPOs? And it

1 seems like the implications for beneficiaries will be very
2 different in that chunk of out-of-network care if it's
3 actually a PPO or if they're having to cover all of it.

4 DR. SMALLEY: Yeah, so stay tuned. We are
5 planning to do plan type -- breaking things out by plan
6 type. Yeah, thanks.

7 MS. KELLEY: Cheryl?

8 DR. DAMBERG: Thanks for a great chapter.

9 Tamara actually touched on one of my questions
10 about stratifying by HMO and PPO, so glad to hear you're
11 going to do that.

12 I was interested in these single-case agreements
13 and how they work between a cancer center and MA plans. So
14 I wasn't sure that I saw information, and I don't know if
15 you explored this about what allows a given patient to get
16 access to these centers and like what criteria are used,
17 and is it limited to certain types of cancer or stage of
18 disease? So I don't know to what extent you can unpack
19 that anymore.

20 DR. SMALLEY: Yeah, we can definitely do some
21 more digging on that.

22 I think generally speaking, the rule around

1 medical necessity is kind of the guiding principle, but we
2 can look more into the details of how that's actually
3 operationalized.

4 DR. NAVATHE: Gina.

5 MS. UPCHURCH: Thanks so much. I really
6 appreciate this chapter.

7 So I think most of you know we're SHIP counselors
8 and so we deal with consumers, you know, dealing with the
9 directories and understanding HMO, HMO-POS, PPO, and
10 there's a lot of confusion.

11 So one of the things that we find that I'll just
12 start out with is that consumers often just want to look up
13 their clinic or the post-acute care rehab facility, not the
14 individual provider. And I know that in an effort to
15 improve the Plan Finder that, you know, there was a
16 temporary company that was hired, and then it's supposed to
17 be a more permanent company.

18 Do we know the due date -- because I thought it
19 was -- it's already come and gone, I think -- for when we
20 can include clinics and that kind of thing? But,
21 practically, that would be very useful. Do we have a
22 deadline for when that's supposed to be in place with the

1 Plan Finder?

2 DR. SMALLEY: I don't know the answer to that.

3 MS. UPCHURCH: So we can, you know, try to make
4 sure all the providers are there, but a lot of times,
5 people don't know, "Is my clinic there?" you know, so okay.
6 That's one thing.

7 Second thing, I'm just curious. In traditional
8 Medicare, you can be a participating provider, you get
9 reimbursed 100 percent of Medicare. You can be non-
10 participating and get 115 percent potentially, or you can
11 be non -- I mean, you can be opt-out. So there's three
12 options as a provider.

13 Is that true with Medicare Advantage? Can I be a
14 non-participating provider and get -- you all have in the
15 chart that it just goes up to 100 percent, but can I not
16 get 115 percent if I'm a non-participating provider and I
17 see them?

18 DR. SMALLEY: So I think there is kind of an
19 asterisk footnote on the chart that it's generally 100
20 percent. The share of non-participating providers is very,
21 very small.

22 MS. UPCHURCH: Small.

1 DR. SMALLEY: But you're right that those
2 providers can bill up to 115 percent of fee-for-service.

3 Whether someone is participating, it's kind of
4 all or nothing across Medicare. So there's not -- you
5 can't participate in MA but not fee-for-service. Like your
6 kind of participation in Medicare holds across all.

7 MS. UPCHURCH: Okay. That's at least something
8 good that's standardized. That's very good news. Thank
9 you for that.

10 And then the last question, trying to explain HMO
11 versus HMO POS to people, thank you for efforts to do that.

12 I think we've gotten rid of the private fee-for-
13 service Medicare Advantage plans, right? We used to have
14 these private fee-for-service. They could see you for your
15 arm today, but only your leg tomorrow, you but not your
16 spouse. Those are gone. Is that right?

17 MR. MASI: So there are still some private fee-
18 for-service plans. I think there have been some
19 restrictions implemented in terms of what areas they can
20 operate, but there are still some enrollments in private
21 fee-for-service plans, I believe.

22 DR. SMALLEY: That's right. And we excluded

1 those from this analysis.

2 MS. UPCHURCH: Yes. Okay. Yeah. It would be
3 very confusing.

4 So I guess my question is from HMO, the HMO POS.
5 In North Carolina, anyway, the only reason we've seen an
6 advantage of the POS is really for the extra benefits,
7 mainly dental. So I didn't know. Are you seeing primary
8 care specialist visits where an HMO would allow somebody to
9 get in-network, you know, the provider -- the individual
10 will pay in-network rates, the provider get paid as an HMO
11 POS for primary care or specialists that's normally not
12 contracting with that HMO, or is it just the extra
13 benefits?

14 DR. SMALLEY: We didn't look at that
15 specifically. You're right that, generally speaking, the
16 POS benefits are around the extra benefits in MA plans, but
17 it is theoretically possible for them to extend those types
18 of benefits for other providers.

19 MS. UPCHURCH: That's really hard to explain to
20 consumers, right? Because it's like a difference without a
21 distinction, you know, in many ways, unless we know for
22 sure, and it's hard to dig into that for people. So

1 they're looking at HMO versus HMO POS, and we really can't
2 easily explain it to the consumer.

3 Anyway, thank you so much for diving into this.

4 MS. KELLEY: Gokhan.

5 DR. METAN: My question is about the 32 percent
6 number reported on page 17 about rendering physician NPI
7 not being in the provider directory.

8 So the out-of-network use is a covered benefit in
9 PPO plans and mostly not in HMO plans. Did you look at the
10 breakdown of this number across HMO and PPO plans, and
11 could that tell us something around like whether this is
12 more around the out-of-network use or inaccuracy?

13 DR. SMALLEY: So we are looking at that. We are
14 -- because of the kind of challenge of understanding why
15 we're seeing the discrepancies of between whether someone
16 shows up in encounter data versus provider directory data,
17 it's kind of hard to interpret that number. So we're
18 working on teasing out that difference.

19 DR. METAN: Okay.

20 DR. SMALLEY: But you're right. The implications
21 of going out of network are vastly different for
22 beneficiaries in HMOs versus PPOs. So it is an important

1 thing for us to try and understand.

2 DR. METAN: Okay. So we will include that
3 breakdown figure in the next, maybe, update.

4 DR. SMALLEY: Yeah, we're working on that. Yeah.

5 DR. METAN: Okay. And the second question I have
6 is, so if the billing provider or tax ID is in the data,
7 would it be fairly accurate for us to assume that this is
8 more of an in-network claim, even if the rendering provider
9 is not?

10 DR. SMALLEY: Yeah. You're anticipating a lot of
11 the work that we have that's underway right now. We're
12 working on bringing in the billing NPIs and the TINs to try
13 and get, you know, a more accurate picture of what might
14 actually be indicating out-of-network care versus just a
15 difference. Yeah.

16 MS. KELLEY: Josh.

17 DR. LIAO: Thanks again for the presentation.

18 I found it really helpful to go back and look at
19 the March materials in which you presented this time, and
20 on page 10, you mentioned that one of the challenges with
21 accuracy is when plan years and contract years don't align
22 and providers leave.

1 My recollection from the March report is that at
2 median 5 to 6 percent or something like that for PCPs and
3 specialists. But the 95th percentile, north of 20 percent
4 of providers will leave a contract midyear, which creates
5 some challenges for beneficiaries.

6 Just to make sure I'm thinking about this
7 correctly, could you walk me through kind of the special
8 enrollment period and that SEP process? If a provider does
9 leave, what are the mechanics of what happens next for
10 beneficiaries?

11 DR. SMALLEY: Yeah. So the SEP process is only
12 for enrollees who are active patients of providers who
13 leave, and generally what happens, it's not a guaranteed
14 SEP when that happens. So plans are required to reach out
15 to their enrollees who are affected by a provider network
16 change, and then if those beneficiaries are affected in
17 such a way that they can -- they can reach out to CMS and
18 ask for a SEP.

19 CMS evaluates whether that provider network
20 change is significant enough to warrant a SEP that all
21 affected patients would be eligible for, and then the plan
22 is responsible for reaching out again and saying that we

1 are offering a special enrollment period for people
2 affected by this change.

3 We don't at this time know how often this
4 happens, but I would venture to say that that SEP is not
5 used particularly often.

6 DR. LIAO: I see. Okay. Thank you.

7 And I think somewhere between the potential
8 consequential nature of it and north of 20 percent, you're
9 going to add new provider types in, these types of things,
10 just as a suggestion, that may be helpful and think about,
11 just a quick insight about explaining that, given that that
12 is such a dynamic related to directories and enrollment and
13 changes in networks.

14 Thanks.

15 MS. KELLEY: Scott.

16 DR. SARRAN: Yeah. This actually builds off
17 Josh's point in terms of beneficiary protections in the
18 event of a mid-year or mid-course of treatment termination.
19 Can you remind us, are there any beneficiary protections
20 around continuity of care?

21 So separate from -- or potentially additional to
22 the ability, a beneficiary may get the SEP to switch plans.

1 Is the plan -- if that member stays in that plan and his or
2 her care is interrupted by a network termination, does the
3 plan have any obligation, regulatory obligation to allow,
4 at in-network rates, that care to continue?

5 DR. SMALLEY: Yes. There are care continuity
6 protections. We don't know a lot about that transition
7 period, but we can look into that for next time.

8 MS. KELLEY: That's all I have for Round 1, Amol.
9 Should we go to Round 2?

10 Okay. I have Brian first.

11 DR. MILLER: Let me try and do this at Josh's
12 speed. It's my standard of care.

13 So, first of all, this is a great chapter. The
14 NCI response rate, this cancer center response rate of 26
15 percent, probably means we have some selection bias. Not
16 your fault. I would say that I would hope that in the
17 future that when providers hear from MedPAC staff, that
18 they answer at a higher rate, because the work that you all
19 are doing is super important.

20 That being said, also, cancer centers are super
21 important. I was looking at some stats. They care for I
22 think around 400,000 people annually. Might be more; might

1 be less. So that's a minority but still a significant
2 share of the Medicare population.

3 There are 68 NCI cancer centers in 37 states.
4 So, by definition, some people don't have access to them.
5 I think thinking about where we would go with this, like a
6 network adequacy requirement for NCI-designated cancer
7 centers would give them even more market power when they
8 already have a lot of market power, because there are some
9 states where you don't have that.

10 I'd also point out that in that context, we
11 actually don't have a network adequacy standard for IRFs,
12 which there are 1,200 of them. So, if we're going to be
13 adding network adequacy standards, we should probably start
14 with markets where there is a greater supply.

15 I also was doing some digging, and I saw that
16 there are 11 NCI-designated cancer centers that are exempt
17 from the Medicare Prospective Payment System. And so I
18 went to Northwestern, and Northwestern, which is, you know,
19 a good cancer center, Robert H. Lurie Cancer Center, it's
20 not a PPS-exempt cancer center, but Dana-Farber is. And
21 so, I mean, I think one of the questions I wonder is, why
22 are some of these cancer centers exempt and others aren't?

1 And maybe everybody should sort of be in the PPS, and we
2 should always swing together.

3 I would say, also, if we want to improve network
4 adequacy, we should probably address certificate of need.
5 A couple of ways to think about this, one, you could say if
6 a state has certificate of need, that hospitals should be
7 considered to be in network for services that can only be
8 provided at a hospital. I'll say that again. If a state
9 has certificate of need, we could think and say that
10 hospitals should be considered in network for services that
11 can only be provided at a hospital.

12 Another thing to think about for provider
13 directories, which other folks have mentioned, PPOs pay 100
14 percent on out-of-network care by regulation, and there's
15 no utilization management. So, if you go out of network in
16 a PPO, the provider gets 100 percent, and you, as the bene,
17 gets no utilization management. So that's basically like
18 traditional fee-for-service.

19 We now have 46 percent of MA is now PPO for the
20 Kaiser Family Foundation. So that probably explains some
21 of this discrepancy we're seeing between provider networks
22 and encounter data.

1 In the setting of the NCI-designated cancer
2 centers, when this happens, right -- so if you're in a --
3 46 percent of benes are on a PPO, and the NCI-designated
4 cancer center is not in that MA plan, and you're the bene,
5 and you go to the NCI-designated cancer center, and you
6 can't get care, that actually means that the cancer center
7 is refusing you because they do not want the out-of-network
8 fee-for-service rate. They want a higher rate. So it's
9 just the same as refusing you as a Medicare beneficiary if
10 you're on fee-for-service Medicare.

11 And I suspect that that's probably because the
12 cancer centers are selecting for commercial patients, which
13 are paying at 2 to 3x fee-for-service Medicare rates. And
14 so they're saying, oh, fee-for-service Medicare, I can only
15 take so many of those, and some of these MA plans, you
16 know, I don't want the UM. And then even the out-of-
17 network, which doesn't have UM, which is just like fee-for-
18 service, they're like, well, I'd rather have more
19 commercial patients, because, again, there's limited supply
20 of cancer centers. You know, we mentioned that they're in
21 37 states, and there are 68.

22 So I would say this is probably -- what I would

1 say is that if the NCI-designated cancer center is
2 accepting patients on fee-for-service, they probably should
3 also be equally accepting out-of-network patients on MA,
4 and the reason they're not doing this is because they want
5 commercial-like rates on MA, and they see MA as a pathway
6 to commercial-like rates.

7 So I think one of the things that we should
8 probably do -- and sorry to give you an additional task,
9 because you're already doing a lot -- we want to make sure
10 that Medicare benes aren't discriminated against on the
11 basis of cost controls that we have in fee-for-service
12 Medicare and MA. So can we do like a survey of access and
13 time to appointment at NCI-designated cancer centers for
14 Medicare versus commercial insurance?

15 Thank you.

16 MS. KELLEY: Tom?

17 DR. DILLER: Yes, it was a great chapter. I
18 really enjoyed reading, reading through all this.

19 I've got a couple of comments. The first is
20 around the hospital and facility-based physicians and how
21 commonly they are in the directory. I was actually shocked
22 at how high that rate is because, typically, that's

1 oftentimes not done. And there's some pretty good reasons
2 for that.

3 Basically, as a consumer, if I'm going to go to
4 hospital ABC or facility XYZ, I'm assuming that the
5 physicians that I'm going to see there are in network if
6 I'm going to an in-network hospital. And there's some
7 dilemmas with that.

8 Oftentimes, because those physicians are
9 credentialed by the facility, the plan doesn't feel a need
10 to credential them, and then secondly, especially in
11 emergency medicine, urgent care, and to some degree in
12 hospitals, there's significant turnover. They'll use
13 locums. They'll move from facility to facility very
14 frequently. So trying to keep up with the directory is an
15 almost impossible task.

16 So my suggestion is that, going forward, it's
17 more beneficial to, say, have safeguards in place that
18 those physicians are, in fact, in network if you're going
19 to an in-network facility and not worry so much about who's
20 in the directory.

21 The second comment is around the cancer centers,
22 and one thing that was kind of not really discussed in here

1 is that while the fees for each service are fairly similar
2 within MA plans, what you will see when a patient goes
3 there, even though the quality is higher, is that the cost
4 per episode is substantially higher. And that is because
5 these entities oftentimes are ordering additional tests or
6 things. It's not, for example, an uncommon thing for a
7 patient who goes to one of those, has just had CT or MRI
8 scans, and the center requires that they be repeated in the
9 center. That's an unnecessary test.

10 And so, consequently, the health plans, I think,
11 are probably a little resistant to contracting with them
12 and/or put more stringent prior authorization things in
13 place, so just a quick comment about that.

14 But thanks for a great chapter.

15 MS. KELLEY: Cheryl.

16 DR. DAMBERG: Yeah, I have two comments.

17 So my first comment is -- so the real concern
18 here, potential concern from the beneficiary perspective,
19 is whether their providers are in or out of network so that
20 they can use their plan appropriately and not incur
21 unnecessary costs. And, you know, I was sort of -- when
22 you were presenting the slides, you noted that 18 percent

1 of primary care physician encounters were with non-
2 directory rendering physicians, and I know you're going to
3 do some follow-up work to try to figure out whether those
4 providers are kind of in network or out of network. But
5 the fact that the encounter data doesn't contain a flag
6 that helps you easily identify that, I think, is a problem.

7 And I know you're going to use another sort of
8 indirect approach about whether they're in capitated
9 payment arrangements, and I know we're not sort of at the
10 point of making a recommendation. But it felt to me like
11 we definitely need to, you know, have access to in versus
12 out-of-network flags in the MA encounter data. So I see
13 that as a gap area.

14 My second comment relates to -- so I think
15 there's an opportunity to potentially add a bit more text
16 about some of the efforts that states are trying to make in
17 this space, and the one that I would call to your attention
18 -- so California, the governor just signed California AB-
19 280, and this directs the California Department of Managed
20 Care to designate a statewide central utility for provider
21 directory data, and it's provider source information, which
22 the stakeholders in California have been sort of at this

1 for some time and have identified that as the more accurate
2 source of information.

3 So I would hope that you might be able to add
4 some text to try to spotlight what some of the other states
5 are doing to try to improve what's contained in provider
6 directories to ensure better accuracy.

7 MS. KELLEY: Stacie.

8 DR. DUSETZINA: Okay. Thank you again so much
9 for this really important work. I hope I'm coherent in my
10 comments because I've been thinking about these issues a
11 lot, and they are really hard to parse out with the data
12 that we have available. So this is an incredibly
13 challenging space.

14 Also, with the NCI cancer center space, I mean, I
15 think one of the reasons for being interested in this group
16 of centers is that it's kind of a marker of high quality,
17 sophisticated care. Like where if you really have a
18 complicated cancer you may need the expertise there to help
19 figure out a care plan for you.

20 So I think it also is kind of a flag for, you
21 know, expensive conditions. So if you were having people
22 pick their plans, being able to look at the network

1 directory and see that these big cancer centers in your
2 area are not included in the network, you go and pick a
3 different plan. And I think that's a concern, broadly,
4 about, you know, when people are shopping for plans that's
5 an easy way to signal that you don't want to people who are
6 going to be very sick at some point in your plan

7 So that's one reason I think it's just kind of a
8 marker for these expensive and, you know, kind of high
9 quality places to receive care once things are going not to
10 so well.

11 A couple of things that I was thinking about with
12 the results you got and with the information you got, is
13 the single case agreement was kind of surprising to me.
14 And I agree with the prior comments, like it would be
15 helpful to know a little bit more about that. It feels
16 incredibly unsatisfying to me, as a person who's like,
17 okay, well, who gets that? How much advocating for
18 yourself do you need to be able to do to be able to get
19 into one of those agreements and get care there? So I
20 think it is an inequitable way to have care delivery.

21 I also worry a lot about, you know, I think the
22 content of when that happens, I don't know how much to dig

1 in on this, but I think in general I could see you have a
2 really complicated need for a very specialized treatment,
3 like CAR T or something like that, and then all the rest of
4 your care is somewhere else. So I also worry about do you
5 just a small subset of your care there and then can't
6 really get follow-up care. So I think that is a suboptimal
7 way for people to get care, but I understand why it
8 happens.

9 The midyear contract changes, I know that we've
10 talked about this from time to time, that seems completely
11 unacceptable to me that that could happen. It seems like
12 even if we just got the point of aligning and saying that
13 you develop these networks and everybody has to agree to
14 stay in them until the calendar year, and that's it.
15 Because I know there are some protections built in, but it
16 feels suboptimal. And Gina has pointed out repeatedly that
17 if you have change, your out-of-pocket is reset. So you
18 might be able to get somewhere else for care but it's
19 really unsatisfying, and it seems like a low-hanging fruit
20 thing to fix for beneficiaries.

21 Okay. Switching over to the network directory
22 and alignment with physicians, this one is so hard, and I

1 was working through it, and I was like, okay, I think it's
2 not quite -- one of the question I stew on is I think we
3 see here physicians are in any directory and in MA
4 encounter data is one view, big picture. And then you have
5 patients who have physicians who aren't listed in their
6 directories.

7 But one of the things I kept wondering is like,
8 okay, if you ask it from the perspective of like the plan,
9 like for Plan A's directory what percent of that plan's
10 physicians are in the encounter data? And that's the
11 question that I really am wondering about, because I think
12 there could be a ton of variation where mostly it's fine
13 but sometimes there are plans that really have low
14 percentage of coverage. So that's maybe a longer-term ask,
15 a little different orientation

16 And I want to plus-one. I'm glad you're going to
17 go down the path of HMO versus PPO. I think that's super
18 important, and I kept wondering about that out-of-network
19 question and the clinicians not listed. Is that really
20 showing up more on those bills for people who have out-of-
21 network coverage? So I think stratifying by those will be
22 incredibly helpful for next steps.

1 MS. KELLEY: Tamara.

2 DR. KONETZKA: I agree with a lot of what was
3 just said. I have just a couple of main points. The first
4 one is about the exclusion of the NPs and the PAs. I
5 imagine that was a somewhat difficult decision because
6 there is so much interest in the primary care especially
7 that those clinicians provide.

8 In the chapter there were a couple of
9 explanations for excluding them. One was around the data
10 issues, because some states have incident-to billing. Some
11 states let nurse practitioners and PAs bill on their own.
12 But then even in the states that do let them apparently
13 it's not always done, and there's still incident-to
14 billing, right. And I think what you also said in the
15 chapter was that MA plans used incident-to billing more, it
16 seems, than under fee-for-service.

17 And so there is a set of data issues that make
18 analyzing these data hard. And then there was the issue
19 brought up with the robustness check in the back which I
20 was very happy to see included, that either because this is
21 the way they practice or because of the data issues, this
22 wasn't clear, that they tend to bill at lower volumes but

1 we're going to be excluding them more often when we set a
2 minimum threshold for the number of encounters.

3 So to me those are very separate. I mean, the
4 data quality issues may be one of the causes of the second
5 issues. But those are very separate, and when I think
6 about the overall goal of this analysis, it's really about
7 beneficiary access to care. I mean, sort of an overriding
8 theme here is beneficiary access to care.

9 And so I think I didn't love the argument that if
10 nurse practitioners and PAs just bill at lower volume we
11 should exclude them because it's distorting the physician
12 analysis. Like we just should be looking at primary care
13 physicians.

14 So I'm not actually questioning the rationale for
15 excluding them, but I think maybe there's going to be so
16 much interest in this piece, I think, I would love to see
17 that robustness check brought up farther and maybe have
18 like a text box in the main chapter that sort of goes over
19 this nurse practitioner and PA issue and why the data
20 quality issues are so difficult. And if time allows, you
21 did a robustness check where you showed the volume effect,
22 but if time allows it would be nice to have a robustness

1 check showing, well, what if we actually included them?
2 Would our conclusions about this or consistency across
3 directories and encounter claims, would those change?

4 So that's my main point. The other one really
5 echoes something that Brian said, which was, you know,
6 there was some talk in the qualitative interviews about
7 maybe cancer centers should be a mandatory part of network
8 inclusion. And that, to me, seems very sort of -- I'm not
9 clear that that's a good idea. If we went down that road
10 the questions I would have, again, similar to Brian, would
11 be, well, how different is this from other things?

12 There are heart centers too, right. Should
13 everybody be able to go to a heart center if they have a
14 cardiology problem? And I'm not sure. Maybe cancer is so
15 unique in its bundle of services that we could treat it
16 differently, but I'm not sure we want to go down that road
17 without a lot more thought and analysis.

18 I look forward to your analysis of the post-acute
19 and hospital facility inclusion. Thank you.

20 DR. SMALLEY: Thanks, Tamara. I didn't mean to
21 cut you off. I just wanted to be clear that we were
22 reporting what cancer centers and plans told us. We're not

1 advocating for that necessarily. We're just kind of
2 offering what people told us. I just wanted to be clear on
3 that point.

4 DR. NAVATHE: Yeah, thanks Katelyn. And I'll
5 just jump in also and just echo that point. The scope of
6 this work is not related to network adequacy of cancer
7 centers, cardiac centers, IRFs, any other sector. This is
8 about the MA network, just descriptive. I just wanted to
9 make sure that we're clear about that. Thanks, Katelyn,
10 for pointing that out, as well.

11 MS. KELLEY: Scott.

12 DR. SARRAN: Excellent work, and I think looking
13 at it through the lens of beneficiary protection, very
14 important work.

15 A brief comment on network accuracy and
16 timeliness and then a slightly longer comment on the cancer
17 issues.

18 Historically, plans had always been, I think,
19 appropriately defensive about their ability to maintain
20 timeliness and accuracy of their data, because they said we
21 live downstream from providers who don't keep us informed,
22 et cetera. I don't think that's any longer so much the

1 case. I think there are probably AI enablement approaches
2 that would help plans do a much better job should they
3 choose to or be regulated to do that. So I think that's
4 important to keep in mind.

5 On the cancer, just a reminder of a lot of what
6 modern state-of-the-art oncology care has become, and this
7 is vis-à-vis the issue of cancer centers. It's become
8 largely a subspecialty disease. If you talk to general
9 oncologists, they will admit no general oncologist, however
10 well trained and well-motivated, can keep up with the
11 relevant literature across multiple different types and
12 provide state-of-the-art care. It's frequently multi-
13 modality, meaning the care really needs to be provided by a
14 team within one center.

15 The care requires frequent adjustments, and it
16 also requires tight coordination done by the provider. And
17 if think about all that, so think about that sort of on the
18 lefthand side of your screen of what cancer care requires,
19 and then on the righthand side think about typical MA plans
20 and their approach to issues like prior authorization in
21 site of service. It's a huge disconnect.

22 The whole prior auth, we're going to prior auth

1 one service, one drug, one diagnostic at a time, it's
2 incompatible, just incompatible with modern cancer care. A
3 plan requiring that somebody gets their diagnostic tests
4 somewhere else and then it gets somehow transported
5 electronically, presumably to the treating center who has
6 to rely on it, it's also incompatible with modern cancer
7 care.

8 So what I think we might consider in further work
9 in this space is to surface, if we need to, surface some
10 actual cases of beneficiary harm or potential harm that
11 occurred as a result of plan policies, stringent prior
12 auths, stringent site of service policies. And then, maybe
13 even more importantly, surface some potential solutions.
14 Maybe an interview perhaps would be with the American
15 Cancer Society or other advocacy groups who have thought,
16 I'm sure, quite a bit about what might be solutions to
17 these problems. And I think there are some -- we're not
18 trying to jump to solutions -- but I think, again, the work
19 has teed up some real issue, and I think further work is
20 appropriate. Thanks.

21 MS. KELLEY: Gina.

22 MS. UPCHURCH: Yeah, thanks again for this work.

1 Just a couple of comments. First of all, I agree with
2 Tom's comment that having the facility listed because of
3 the rotations of residents, and that might help with the
4 NP/PA situation too. But if we don't get to that, or if it
5 takes too long, and this is not for the analysis purposes
6 but practically for the beneficiary, we need to the NP and
7 the PA listed on the Plan Finder tool so people can
8 understand whether their providers are going to be in
9 network with them. And I understand that some plans do
10 that and some plans don't do that, and there are different
11 requirements by state, but to me that should be a
12 requirement that they be listed, because the consumer is
13 left wondering.

14 The second thing, and this goes to a question
15 Josh was asking in Round 1 and that Stacie alluded to, so
16 if you're in a Medicare Advantage plan, in network, max out
17 of pocket for this coming year, for 2027, is \$9,850. So
18 again, midyear breakups, you've got to start paying that
19 thing again. That seems very inappropriate.

20 If you're in a PPO and you do some in and out of
21 network, the combined is \$14,800. And that is just a lot
22 of money and breaks the bank for a lot of people. So I

1 think we just need to make sure these in-network breakups
2 are monitored.

3 And that continuity of care, CMS gets to decide
4 case at a time, happens after the termination, not before.
5 So here's Ms. Jones dealing with her cancer, she's got to
6 wait until the deadline, midnight of that night, to decide,
7 oh, I'm out of network. Now let me deal with the insurance
8 company, or SHIP, or a broker. That's inappropriate. It's
9 not protective enough.

10 So we need at least two special enrollment
11 periods for people in that situation, termination, middle
12 of the year. One, at the threat, when you start getting a
13 letter from the hospital saying "evil insurance company"
14 and the from the insurance company saying "evil hospital
15 health system," when those threats start coming you get a
16 special enrollment period, and after the fact, if they
17 stayed together or if they broke up, you get another
18 choice. It really should be the beneficiary's opportunity
19 and their max out of pocket travels with them, just like it
20 does with Part D.

21 And the last thing, I just want to read this
22 paragraph. If we don't think choosing Medicare is

1 complicated enough, because when you're helping people you
2 decide, traditional Medicare or Medicare Advantage. Then
3 in the Medicare Advantage, okay, do you want an HMO or a
4 PPO, okay, trying to explain all this.

5 But here's the paragraph. "One center, this time
6 a cancer center, noted that single case agreements for HMO
7 enrollees can, in some cases, be more favorable than
8 relying on the PPO out-of-network benefits, as they allow
9 patients to pay in network cost sharing rates." So that's
10 that \$9,000 versus the \$14,000. "Whereas in PPOs,
11 enrollees are entitled to go out of the network for care,
12 but generally are expected to pay higher liability.

13 "Meanwhile, other centers report recommending
14 patients to select PPO plans, explaining that the HMO plans
15 could be more challenging to work with at time.
16 Additionally, obtaining a PPO plan protects patients from
17 losing all coverage if their plan goes out of network with
18 the center and single case agreements are not an option."

19 Trying to explain that to someone who is making a
20 decision in the middle of cancer treatment, to choose a PPO
21 or an HMO, and you may have the single case but it's case-
22 by-case, is too much. So we need a little more

1 standardization of this to support our beneficiaries.

2 Thanks.

3 MS. KELLEY: Danielle.

4 DR. PIEROTTI: So a little bit of recency effect
5 here that particular paragraph makes me want to quote from
6 the Jabberwocky poem of nonsense words, because to most
7 beneficiaries all of that is just nonsense words. We just
8 made it all up.

9 I have a couple of comments on this section. The
10 first one is that at a root the point of this section was
11 to evaluate network adequacy, and I have an old adage from
12 clinical care, if it's not documented it wasn't done.
13 Network adequacy is, as many of us have said, a beneficiary
14 issue. Can they pick accurately? Do they have the
15 information they need to make an informed choice? If the
16 provider isn't in the directory, it doesn't count.

17 So these other investments in amazing analytical
18 time are phenomenal and are an error rate. The data in
19 here that talks about 30 percent of MA enrollee encounters
20 were with unlisted MDs followed by 9 percent of MDs not
21 listed in any directory but were named as the rendering MD
22 on MA enrollee plans, for which there was a directory,

1 that's an error rate. And all of the explanations about
2 why the poor MA plans can't keep up their directories are
3 weak tea excuses. Do better. To say that it's too hard to
4 keep track of who your employee is, is the stuff of
5 nonsense.

6 And I need to advocate very clearly that our
7 language has to stay. We can demonstrate this error rate
8 by looking at these other sources of data, and it is an
9 error rate, with the core legal requirement for network
10 adequacy. Beneficiaries can only look at that directory.

11 There are lots of ways, several of which have
12 been already suggested here. Another is requiring that
13 information in the contract. They get contracts. What
14 information is it that they can't possibly find to keep up
15 their directory? And one of the root causes of this is
16 that people are having midyear changes and they're suddenly
17 in and out, well then follow a colleague's suggestion of
18 creating standard times when these things change.

19 There are solutions to every single explanation
20 in here, and I just really need to advocate that these are
21 explanations and points for the plans to correct as
22 performance improvement. They are not reasonable excuses

1 that we should be accepting and normalizing. It's an error
2 rate.

3 If Amazon had a 9 percent error rate in your
4 deliveries, you wouldn't be ordering from Amazon anymore.
5 I think that this is a little bit more impactful.

6 Following on that, the carveout of providers, the
7 emergency department, anesthesia, radiology, and pathology
8 as the biggest providers that are not listed in these
9 directories, could make sense. As it was pointed out,
10 patients don't typically choose those providers. They
11 don't stop on their way to the radiology into CT scan and
12 go, "Who's going to be reading my scan to decide if it's in
13 network or not?"

14 To me, this comes back to earlier comments about
15 if these providers are part and parcel of the setting they
16 are in, and the setting, whether it's a hospital or
17 freestanding clinic, whatever it is, is in network, then
18 the question has to be how much difference is there between
19 the provider and the building? Because we make decisions
20 based on, okay, I think this hospital, per se, is in my
21 network, and since I don't get to choose who is on call in
22 the emergency department when I show up there, I have a

1 base assumption, as a provider, that they are also in
2 network.

3 If that is accurate, then they don't need to be
4 listed individually, to the earlier point, and the patient,
5 the beneficiary, needs to be able to rely on, I chose an
6 in-network clinic office, surgery center, hospital, and I
7 don't need to worry about this next level.

8 I think that we've all heard stories, seen
9 stories, of someone who made that assumption and got caught
10 in a bait-and-switch. But when you get a bill because your
11 radiologist or the pathologist was not in network, even
12 after you've paid the bill for the building, that feels
13 like a bait-and-switch, and we can fix that because that's
14 really, really inappropriate. And if we can establish that
15 these two things need to go together, the same could be
16 said of a hospitalist, although they did not come up in the
17 data. I don't pick which hospitalist sees me or which
18 intensivist sees me. I'm picking a hospital that I got
19 admitted to, sometimes.

20 Regarding the cancer centers, I think this is a
21 fascinating conversation, and everyone who has spoken about
22 it so far has brought up another issue I hadn't considered,

1 so thank you so much.

2 The piece that keeps resonating for me about
3 cancer centers is differentiating what they're doing and
4 when it has to be there versus when it doesn't. And I keep
5 coming back to this fabulous statistic. One center
6 reported making 10,000 single contracts in a year. If
7 you're making 27 unique contracts every day, 365 days a
8 year, you are in network. These are not single contracts.
9 They are not sitting down with a host of lawyers on either
10 side of the table and negotiating for this particular
11 patient. They have a template. That's the only way they
12 could possibly do that volume.

13 So they've figured out some way to work together,
14 and somehow both sides of the table have negotiated a way
15 to say "we can do this." The fact that they're making it
16 as an individual contract every time a single case comes up
17 is only adding significant administrative burden, which is
18 significant cost to the organizations, and creating undue,
19 unnecessary, unvalued time and stress for the patient.
20 Make the standing contract. That's just silliness to me.
21 10,000? It's literally 27 contracts a day if you work 365
22 days.

1 The last comment I want to make is to loop back
2 on this discussion about the APRNs and the PAs and really
3 reiterate the earlier comment from my colleague about the
4 critical need to keep looking at that group and keep
5 solving that problem. Increasingly, the proportion of
6 primary care provided in rural, geriatric, and other safety
7 net environments is being provided by nurse practitioners
8 and physician assistants. This has to be something that we
9 keep pushing on to understand the data from lots of ways,
10 and so without looking at the current issues, I need to
11 echo the request to keep bring it up and keep challenging
12 this space. If our beneficiaries are going to continue to
13 seek care from that level of practitioner we have to
14 understand that level of practitioner in the same way do
15 the providers. Thank you.

16 MS. KELLEY: Robert.

17 DR. CHERRY: Yes. Thank you for this report. I
18 agree with a lot of the comments that the Commissioners
19 have already made. There are a lot of different issues
20 here so I'll just touch on a several of them.

21 One has to do with the encounter data. It's not
22 uncommon for physicians to see someone that's out of

1 network, and there could be two reasons for that. One,
2 it's not necessarily always around surprise billing and
3 that kind of thing, but the main fact that the physician
4 and the plan may both find that acceptable, if that's the
5 only physician that's available to actually see the
6 patient, and therefore the plan will treat that particular
7 physician as in network for that purpose.

8 But I think there are concerns, and I agree with
9 Danielle around out-of-network patients that are seen and
10 then the patient gets a surprise bill. Those things need
11 to be reconciled and it needs to be legislative and other
12 types of solutions by the plans.

13 The other thing is that although the provider
14 directories are not necessarily up to date, certainly many
15 physician websites are up to date, and many established
16 Medicare patients know when their physicians are retiring
17 or have moved away. So that degree of knowledge needs to
18 translate into the provider directory, and there also needs
19 to be probably state solutions for that, similar to
20 California.

21 I will say that there is a strong participation
22 rate that's in the chapter, but I would use some caution in

1 saying that, well, because the participation rate is high
2 it doesn't mean in that local catchment area that there is
3 network adequacy. If you have five MA plans but you have a
4 lot of physicians signing up for one that has better
5 reimbursement rates and other area not signed for it as
6 sufficiently then I doubt that's necessarily network
7 adequacy.

8 So the participation rate, it's nice to know, but
9 it may not be sufficient say if there's adequacy within a
10 network.

11 Just regarding behavioral health specialists,
12 unfortunately, many of them just don't take any insurance
13 at all -- commercial, Medicare, Medicaid -- because they
14 find it more of an advantage to directly bill a patient.
15 You know, hourly rates, I know in California could be
16 anywhere from \$250 to \$350 per hour. And the patient could
17 certainly take their bill and send it to their health plan,
18 but that doesn't necessarily mean they're going to get
19 reimbursed for it, or if they do, it will just be a
20 fraction of what they spent.

21 I don't have an easy solution around that, but
22 just acknowledging that many behavioral health specialists

1 are just not taking insurance anymore.

2 Just regarding the NCI cancer centers, their
3 designation is largely based on their research and
4 innovation pursuits and their alignment with their
5 respective medical schools. The cancer centers, though,
6 that might have market power are probably the ones where
7 there is an intentional alignment and integration with the
8 service line business model within the hospital.

9 So there's a disconnect, I think, between some of
10 these cancer centers. So you have cancer centers that do
11 very well, they get their NCI designation, they're doing
12 great research, but that doesn't mean that they have a
13 service line model that necessarily is well-coordinated and
14 works with the patient. And sometimes the plans know that
15 too, and are not going to necessarily reimburse for cancer
16 care that's not well-coordinated.

17 It's good to look at those cancer centers,
18 because they provide some insight in terms of what cancer
19 care should look like and how we can incentivize them on
20 the clinical side to make sure that they're optimally
21 functioning.

22 Otherwise, the other thing that I would mention,

1 too, is around these single case agreements or one-term
2 agreements. I think a lot of hospitals are shying away
3 from those because they're often insufficient, and, you
4 know, cancer care is one example of that. So if somebody
5 needs pancreatic surgery, for example, there might be a
6 one-time agreement for that. But the reason why some
7 hospitals are shying away from those one-time agreements is
8 that there's still a need for ongoing care.

9 So even though they've got an agreement to do the
10 surgery, what about any type of postoperative chemotherapy
11 or radiation therapy that might be needed, further imaging,
12 and surveillance for the patient over the next five-plus
13 years. And that's not covered in a one-time agreement. So
14 those OTAs tend to be fairly insufficient and a reason why
15 a lot of hospitals aren't sort of gravitating towards that.

16 So I just wanted to mention those comments. A
17 lot to think about, and I'm glad we packaged all these
18 different items together for discussion.

19 MS. KELLEY: Paul.

20 DR. CASALE: Yeah, thanks for a great report.

21 Just a couple of comments, and there's been so
22 many terrific comments. So some of this will just be

1 underscoring what others have said.

2 So starting with the NP/PA, in particular -- and
3 I know that's particularly challenging -- Tamara brought up
4 the idea of having -- highlighting that in a text box,
5 somehow bringing it to the forefront.

6 And again, I know this is really challenging. I
7 understand, as you pointed out, CMS considers them to be
8 primary care, but there's a growing number of NP and PAs
9 who are working in specialty care, and that continues to
10 increase.

11 Again, these are very hard things to tease out.
12 If there are data sources, whether at a state level
13 somehow, to even just get a subset of data around some of
14 this NP/PA activity, as you're looking at the directories
15 and encounter data, may be helpful. It's not going to get
16 a complete picture, but if there are, again, certain states
17 where you can get access to that direct billing and not
18 dealing with the incident-to, I think that would be
19 particularly helpful, as, in general, they're providing an
20 increasing volume of care across the spectrum.

21 On the cancer center interviews, they were quite
22 interesting. I don't know if there's time or bandwidth to

1 do additional interviews. There was obviously -- had a
2 subset, and you mentioned that on the cancer center side,
3 there were many around that you interviewed with a payer
4 strategy. If there's any way, if it's possible, to do some
5 additional interviews and include those on the operation
6 side of the cancer centers.

7 And then additional interviews on the MA side as
8 well, I just think the things you've highlighted are really
9 important and particularly challenging around the prior
10 authorization, even on routine care, the comments about MA
11 not following sort of standard of care guidance, which
12 certainly there's plenty of that within cancer care, if,
13 again, there's time and bandwidth to do more of that work.

14 And then to Robert's point, including some of the
15 sort of more community-based cancer centers, you know, sort
16 of high-level cancer centers, but not necessarily the NCI-
17 designated ones.

18 And then the single case, again, that's such an
19 outlier, 10,000 single cases. And I know others have said,
20 if there's anything where you can tease out about that
21 process of how that single-case agreements work, and is
22 there presumably some payment advantage around that? It's

1 very interesting in the interviews, the cancer centers --
2 or the MA plans are saying, well, the cancer centers, they
3 just negotiate around payment. And then the cancer centers
4 say, well, MA plans don't want to include us, because we
5 may have high-risk patients that are more costly. So,
6 again, I think trying to learn more around this with
7 additional interviews, I think, would be particularly
8 interesting and helpful.

9 So, again, thank you for a great report.

10 MR. MASI: Thanks very much for the suggestions
11 in this conversation.

12 Just because it's come up a couple of times, I
13 did want to flag for Commissioners that the Commission did
14 recommend in 2019 to require direct billing for APRNs and
15 PAs to get a better line of sight on all of the important
16 ways that they are serving Medicare beneficiaries.

17 And as part of that, the Commission did some
18 novel work trying to estimate the share of care that those
19 health care professionals provide that's billed incident-
20 to, and our best estimate at that time was roughly a third.
21 And so this incident-to issue is really quite important in
22 terms of, you know, there's Medicare payments, and that's a

1 separate issue, but just looking at the care that these
2 individuals are providing to Medicare beneficiaries.

3 We do track in our March report -- and so this
4 will come up in December and January -- encounters that
5 Medicare beneficiaries have with physicians but also APRNs
6 and PAs. And so I just wanted to flag that for folks that
7 this is a very important thing that we do track.

8 In this particular line of work, we'll explore
9 how we can highlight some of the unique challenges with
10 bringing that volume into this work.

11 And, Tamara, you made some suggestions that we'll
12 follow up on.

13 MS. KELLEY: Gokhan.

14 DR. METAN: I have a couple of comments.

15 The first one is around, again, provider
16 directories accuracies. I understand within the work; the
17 data has some confounding effects that it's hard to isolate
18 whether it's coming from inaccuracies or the out-of-
19 network.

20 But several years back, I have actually done a
21 similar analysis for one of the national Medicare Advantage
22 carriers, and at the time, we were concerned about, you

1 know, the inaccuracies in, you know, provider directories,
2 and there was a substantial kind of, like, inaccuracy
3 within the data.

4 So, since then, I'm pretty sure, you know, these
5 provider directories improved, but still, at the current,
6 you know -- you know, provider directory accuracies is
7 still, like, way inaccurate than where it should be.

8 And I think I agree with Danielle in the sense
9 that we need to really hold ourselves to a higher bar in
10 terms of the accuracy of these directories.

11 Like, it's mind-blowing to me that in the age of
12 this data and artificial intelligence -- and, like, if
13 you're not talking about, like, 99.9 percent accuracy,
14 like, that's totally unacceptable to me. And I think
15 maintaining these directories are not that hard. Like, you
16 can take your contract database, just run it through
17 artificial intelligence, and it would create you all the,
18 you know, missing information that exists in your current
19 provider directory.

20 So I think we really need to kind of, like, push
21 the industry towards a higher bar in this, and I think you
22 did a phenomenal job on page 9 and 10 articulating the root

1 causes of what's driving these inaccuracies in the provider
2 directory. So I really appreciate that articulation.

3 And I think my suggestion along those lines is --
4 as we kind of improve on and build upon this work is, can
5 we actually explore some practical policy recommendations
6 along with this body of work? I'm going to list a few
7 examples here.

8 For instance, requiring alignment of contract
9 cycles with plan year, I think a few Commissioners also
10 called it out. What would be the implications of carriers
11 actually doing that? That would be really informative.

12 Centralized provider directories, rather than
13 leaving it to the individual plans to maintain their own
14 directories. Could that be a smart policy recommendation?
15 What would be the effect of that?

16 Building the right incentives, such as, like, the
17 provider directory accuracy, you know, being used in the
18 Star or quality-metric calculations for the carriers, MA
19 plans.

20 And leveraging AI in, again, maintaining higher
21 accuracy level in these provider directories. What could
22 be really practical and easy for the industry to actually

1 kind of, like, adapt and close that inaccuracy gap?

2 And then the second comment and question I would
3 like to understand better is, how painful is this
4 inaccuracy on the enrollees? Can we look at CTMs,
5 grievances and appeals, disenrollment information, some
6 other data points to triangulate the pain it actually
7 inflicts on the membership base? I think it would be a
8 really informative thing to learn as we develop further on
9 this body of work.

10 Thank you.

11 MS. KELLEY: Josh.

12 DR. LIAO: Nicely done and thoughtfully caveated
13 work.

14 Recognize this is one of just a few installments,
15 I have just kind of three comments.

16 First, very quickly, I appreciated, you know, you
17 brought the participation data in March. You matched that
18 to service delivery, setting aside normative statements
19 about high or low, given you have to work out a number of
20 things, mismatches, reasons for that, structure,
21 composition, et cetera. I did think that 68 percent was
22 helpful. It helped kind of show alignment to me and

1 demonstrate the value of looking at these two together. So
2 thank you for that.

3 My second and more substantive comment is really
4 about kind of the work that I think needs to be done still,
5 particularly in some pockets and some specialties when the
6 measures disagree. So here I'm looking at that 32 percent.

7 Other Commissioners have mentioned kind of the
8 variation by specialty, you know, anesthesia, radiology,
9 emergency medicine being 60 percent to 80 percent. But I
10 want to -- and I think the materials do a good job of
11 talking about how patients have beneficiaries pick certain
12 providers and don't pick others. But I wanted to push in
13 on the PCP example because I think it puts a fine point on
14 it, which is not only that patients pick the PCP as a
15 primary care trained nurse. They always pick their PCP.
16 But that PCP then plays a key role in coordinating care for
17 so much more. So, even if you rank the mismatch rates, 18
18 percent is not near the top. But to me, it's a very
19 consequential for that reason.

20 And I know we can't say if it's a plain old
21 admission, admission if it's a data timing thing, like
22 Tamara mentioned, if it's out-of-network care. But,

1 actually, if you turn the prism any which way, it matters
2 anyway. It matters to know that patients can't find their
3 PCPs on the directory or it matters to know why are 18
4 percent of cases encounters happening outside of network,
5 however you think about it.

6 So I say this just to kind of raise the -- what I
7 think is kind of an interpretive consequence, which is that
8 I would want to guard against the idea that higher numbers,
9 higher mismatch equals a bigger problem finding positions.
10 I don't think that's true. I think the material does a
11 good job of that. I just wanted to state that plainly.

12 And then I think the second is, you know, once
13 you're done doing the thing you're going to do with TINs
14 and rendering providers and billing providers, if there are
15 key areas, in my opinion, like primary care, where you
16 still see a gap, I think it makes sense to push into that.

17 I imagine a future policy world where you said
18 you can't fix every directory for every plan; I think
19 things like PCPs matter a great deal for the reasons I've
20 mentioned. And so I advocate for that kind of emphasis.

21 My third comment is just to quickly acknowledge
22 all the things that sit outside these two measures. I

1 think we all acknowledge that. But, you know, I
2 appreciated where the materials talked about how direct
3 inclusion does not equal availability.

4 I would just extend that across the whole
5 beneficiary experience, right? So, even if we have perfect
6 directories, great encounter records, I think that wouldn't
7 tell us how many offices a beneficiary called, whether
8 those offices are taking new patients, how long the wait
9 was, broken or kind of like searches that are delayed or
10 foregone, that type of thing. I'm not necessarily saying
11 that fits within the context here, but it's just worth
12 noting that of all the kind of the space that lives between
13 care delivery and what people see in a directory.

14 So, in conclusion, really excited about what's
15 next. I think it's kind of land a plane here. Really
16 looking forward to seeing the NPI, TIN kind of work that
17 you've talked about.

18 I think in addition, as you work that out, again,
19 if there are gaps, I really appreciate maybe like a
20 beneficiary- level analysis, so not just encounters. But a
21 beneficiary level in areas like primary care, you might
22 think about beneficiary position relationships. What that

1 would tell us would be, if there are mismatches, are they
2 concentrated among certain plans and beneficiaries
3 repeatedly seeing the same PCP, or just scattered across
4 different encounters with different PCPs? I think that's
5 consequential.

6 The other idea, which I like that Tamara
7 mentioned, was just to look at different timing snapshots
8 to see if that lag in publication timing and data cuts
9 would be part of it.

10 Finally, this point about everything else that's
11 outside these two measures, I realize the next steps here
12 are to move on to other provider types, and so maybe not
13 for this chapter, but maybe just to put a pin in it, I do
14 think work when we can through referral tracking, surveys,
15 interviews about delays, unsuccessful searches, all the
16 things that create friction between what I see and getting
17 that care, super important, even if not in this chapter.
18 But thanks again.

19 MS. KELLEY: Kenny.

20 MR. KAN: Outstanding chapter. I commend the
21 staff for going beyond provider directories accuracy to
22 examine actual patterns of care.

1 MA plans must be accountable for ensuring timely
2 access, but we should be careful not to equate directory
3 inaccuracies with barriers to care. Equally important, we
4 should preserve the value of managed care in coordinating
5 care, improving quality, and maintaining affordability.
6 The chapter finds that 97 to 98 percent of active Medicare
7 physicians provide services to MA beneficiaries, yet 32
8 percent of encounters involve physicians not listed in the
9 beneficiary's plan directory.

10 I acknowledge the descriptive nature of the work
11 with no current intent for network adequacy solutioning in
12 this cycle.

13 That said, I suggest that we explore the
14 following two questions for future cycle analysis, sort of
15 like similar to what Josh and Gokhan have actually
16 indicated.

17 Number one, we should distinguish administrative
18 gaps from actual access barriers. Of the 32 percent of
19 encounters involving non-directory physicians, how much
20 truly reflects genuine network inadequacy? Was this
21 directory inaccuracies or legitimate out-of-network
22 arrangements?

1 Number two, we should measure what matters to
2 beneficiaries. Rather than focusing primarily on directory
3 completeness, should our central measure of network
4 adequacy be whether beneficiaries can obtain clinically
5 appropriate care without unreasonable delays, travel
6 burdens, or out-of-pocket costs?

7 I'm very excited about this body of work, and I
8 look forward to future analysis on this. Thank you.

9 MS. KELLEY: Ben.

10 DR. IPPOLITO: Thanks. I guess I'll just ask one
11 question, since most of my comments have already been made.

12 As I read this, it struck me that there's just
13 this inextricable problem of we cannot tell what these
14 numbers reflect, right? Are these networks that are -- you
15 know, is this out-of-network care, or is this the networks
16 being inaccurate and other potential timing issues and so
17 on?

18 Could you synthesize -- you've mentioned various
19 different ideas. Could you synthesize what your sort of
20 empirical plan is to try to distinguish these different
21 explanations before moving on to extending to other
22 specialties and other groups and so on, just so we sort of

1 have a clear understanding?

2 DR. SMALLEY: Sure, and thanks for the question.
3 You kind of have distilled the issue that we have here is
4 that we have kind of two general theories of the case, that
5 the care is either truly out-of-network -- and as we've
6 learned in the cancer center interview, sometimes it's out-
7 of-network, but there is an arrangement between the
8 provider and the plan in place. And then the other kind of
9 theory is that it's an inaccuracy in the directory, and we
10 think that there are lots of reasons that that can be, some
11 of which make total sense.

12 I think we have some strategies in mind to try
13 and bring in other information from the encounter data, so
14 different NPI fields, bringing in TINs, other provider IDs,
15 so TINs, CCNs, to try and triangulate, bring in multiple
16 sources of data to try and tease out, you know, if we are
17 able to identify an inaccuracy or if we're able to identify
18 that, you know, for instance, a provider, a physician works
19 for an in-network facility, we might be able to impute or
20 assume that that is, in fact, an in-network physician. I
21 think the short answer is that it's still really tricky,
22 and so we have some strategies that we're going to try.

1 But I think we will still have this. There will be a gap
2 in our understanding. There will be a certain number of
3 these things that we're not going to be able to explain the
4 source of the discrepancy.

5 I also want to clarify, because it's come up a
6 few times, about the kind of timing, and I think I did a
7 poor job responding to Tamara's original question about
8 this. So I think one thing I want to be really clear about
9 is that the two different analyses that we did, first of
10 all, when we looked across program-wide, that was really
11 about is a -- do we see a provider in a directory or in
12 encounter data at all, not for a particular -- not in a
13 particular plan directory or a particular -- an encounter
14 for a particular beneficiary, an enrollee of a particular
15 plan? And that was the one in which we looked at the full
16 year of encounter data and compared it to a single snapshot
17 of directory data.

18 In the second analysis, where we were looking at
19 actual encounters with actual MA enrollees, that was why we
20 thought it was important for that particular analysis to
21 narrow it down to a single month so that we didn't have
22 those kind of lagged directory issues.

1 So the first one was kind of, are you in any MA
2 directory versus not, and the second one was, you know, for
3 a particular month, are you out of network or in network?

4 So, yeah, just wanted to make that clarification
5 that we were sensitive to those lags in the directories and
6 that they're consequential when we're looking at actual
7 enrollees and actual encounters. I'll stop there.

8 DR. IPPOLITO: Thanks. That's helpful.

9 The only other thing that I'll -- I think it's
10 genuinely helpful just to set expectations that there's
11 likely to still be a substantial gray area. That was my
12 expectation based on reading this, but I think that's just
13 useful as like a level-setting thing.

14 The only other thing I want to mention -- it's
15 come up a couple times -- this idea of aligning networks of
16 facilities and physicians that work in facilities, and I
17 agree that's a very natural-sounding idea and that may or
18 may not come out of this workstream.

19 I just want to flag that that has come up
20 recently in federal policy discussions related to out-of-
21 network billing or surprise billing in most of the
22 commercial market. I think that might sound natural to a

1 lot of people. It is a very contentious idea in certain
2 circles, and so I just want to propose that that is not
3 like a -- or just highlight that's not a sort of a light
4 lift idea.

5 It might be a little different in the Medicare
6 setting because of all the out-of-network rules and
7 everything, but you may want to revisit that experience if
8 you're interested in that idea.

9 DR. NAVATHE: All right. Thanks, folks, for a
10 robust discussion. I think very thoughtful from all of you
11 all.

12 So I wanted to just highlight and underscore a
13 couple of things. So our goal in this work was descriptive
14 in nature, as we've talked about, in understanding what the
15 networks and the directories look like, what participation
16 and then use looks like via the encounter data, and the
17 spirit of this is to support and sort of make sure that
18 beneficiaries are supported in having informed choice and
19 then protected in that choice kind of going forward.

20 And I want to separate that from things like
21 network adequacy and prior authorization, and I think we
22 had some comments on that, which is great. You should all

1 obviously opine as you would like, but I just wanted to
2 separate that in terms of kind of the direction that we're
3 going versus some of the Commissioner comments.

4 And you gave us several suggestions, and I think
5 we have a nice long list of things to sift through around
6 to-dos. I think a lot of those are generally thematically
7 aligned around some aspect of access in some way, I think,
8 and access kind of in relation to networks and contracts.
9 And so I can highlight a couple there.

10 So we heard -- I think Josh had asked a question
11 about the special enrollment periods, and Gina brought that
12 up as well. So I think there's some work to do there, care
13 continuity. The single-case arrangements I think have come
14 up a few times. So I think that those are important.

15 We also had a discussion -- Ben kind of
16 transitioned us right there towards the end around the
17 data, the data limitations that we have, and so I would
18 highlight two things there.

19 So, certainly, we're not going to get to perfect
20 data and perfect analysis, and I think that is part of the
21 reason that we're pointing out to you all that this is
22 descriptive work, and we should be careful from thinking

1 about kind of normative types of implications that we might
2 pursue from this, but sometimes for us it's also important
3 to identify where we have those data gaps from being able
4 to inform that. So there's sort of double -- you know,
5 that piece of it does double duty a little bit. On one
6 hand, it's informing how we should be contextually, you
7 know, cautious about the implications that we take away,
8 but also we can flag the areas where we don't have the data
9 that we may need to be able to look more deeply at things.
10 So that itself can also be helpful to Congress and the
11 policymakers that we're trying to inform.

12 And some of the issues we'll be revisiting this
13 afternoon, we talked a little bit about NP/PAs and
14 incident-to, so we're going to talk a little bit about
15 that. Paul, thank you for giving some greater context
16 there. And it is obviously an ongoing challenge, relates
17 to the data limitations, data issue as well, and so we have
18 some recommendations there, specifically on incident-to,
19 and we can talk a little bit more about that.

20 In the future, certainly heard a lot of thematic
21 questions around the HMO and PPO work, which is planned, as
22 well as the work around looking at TINs and trying to dive

1 a little bit more deeply, again, keeping in mind that we
2 have some data challenges and limitations.

3 And, broadly speaking, I appreciate the comments
4 also about some of the challenges here. I think it can
5 feel -- the sort of temptation is there to say, hey, it's
6 easy to just flip a switch and we can figure, you know, fix
7 things, but this is a multi-stakeholder issue, obviously,
8 the venues at the center, but there's plans and providers,
9 and there's data dependencies and sharing between these
10 organizations. And so we're going to try to do the best
11 that we can to bring that information as much as we can,
12 and then we can think through in the future kind of what
13 that might imply in terms of how we might be able to make
14 data-informed recommendations going forward. Although I
15 will say, coming out of the next meeting, the goal is not
16 to make any recommendation per se. This is still kind of a
17 fact-finding mission workstream for us.

18 So I think with that said, that will bring this
19 session and discussion to a wrap. I wanted to invite
20 anybody from the public forward if they would like to make
21 -- if anybody would like to make any in-person comments
22 here at the microphone. We'll pause a moment for our team

1 to step away.

2 [Pause.]

3 DR. NAVATHE: It doesn't seem like we have any
4 in-person comments.

5 So, for those who are listening at home or at
6 work through the webcast, we want to hear from you.
7 Please, you can send your comments at
8 meetingcomments@medpac.gov.

9 We will close this session, and we will be
10 restarting at 2:00 p.m. Thank you.

11 [Whereupon, at 12:41 p.m., the meeting was
12 recessed, to reconvene at 2:00 p.m. this same day.]

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1 AFTERNOON SESSION

2 [2:00 p.m.]

3 DR. NAVATHE: Welcome, everyone. We're going to
4 go ahead and get started with our afternoon session, and
5 this session is entitled "Issues affecting the payment
6 accuracy of the physician fee schedule and the clinical
7 laboratory fee schedule." And I will turn it over to
8 Brian.

9 MR. O'DONNELL: Good afternoon. In this session,
10 we'll discuss several issues affecting the payment accuracy
11 of the physician fee schedule and the clinical laboratory
12 fee schedule. The audience can download these slides by
13 clicking on the document icon in the upper righthand corner
14 of the screen.

15 Before I start I'd like to thank Ledia Tabor,
16 Evan Christman, Rachel Burton, and Allison Kim for their
17 assistance with this work.

18 We'll start the presentation with some
19 background. We'll then discuss three physician fee
20 schedule topics: global surgical services, incident-to
21 billing, and telehealth. We'll then discuss recent data
22 collection under the clinical laboratory fee schedule. And

1 we'll wrap up with Commissioner discussion.

2 First for some background on the motivation for
3 this presentation and update on recent physician fee
4 schedule changes. The Commission believes that payment
5 rates should be set high enough to ensure beneficiary
6 access to high-quality care, and minimize financial burdens
7 on beneficiaries and taxpayers. Payment accuracy is also
8 important to reduce inappropriate incentives to furnish, or
9 not to furnish, certain services

10 CMS has already taken multiple steps to improve
11 payment accuracy, but opportunities for improvement remain.
12 The materials presented today are for Commissioner
13 information only and are not intended for published
14 chapter.

15 Before we get into our three physician fee
16 schedule topics, we wanted to acknowledge that CMS has
17 taken several steps in the last few years to improve the
18 accuracy of physician fee schedule valuations. This slide
19 lists several such policies. I won't walk through all
20 these policies, but I will note that several of the policies
21 are directly related to work the Commission has done,
22 including revaluing E&M office visits, implementing an

1 efficiency adjustment, and redistributing PE RVUs from
2 facility to non-facility settings.

3 All of the policies listed on this slide are
4 budget neutral, meaning that any savings they generated are
5 recycled back into the fee schedule. The spending effects
6 of future changes is at the discretion of the Congress.

7 Next, we'll discuss global surgical services,
8 which are a type of service under the physician fee
9 schedule.

10 The payment unit for global surgical services is
11 broader than most services under the fee schedule and
12 includes the procedure itself and associated visits within
13 certain timeframes. Today, we'll mostly be talk about 10-
14 day and 90-day global surgical services. Ten-day global
15 surgical services include visits on the day of the
16 procedure and postoperative visits within 10 days. Ninety-
17 day global surgical services include preoperative visits 1
18 day before the procedure, visits on the day of procedure,
19 and postoperative visits within 90 days. In 2024, fee-for-
20 service Medicare spent about \$8.2 billion on global
21 surgical services, \$2.3 billion on 10-day services, and
22 \$5.9 billion on 90-day services.

1 To set the valuation for global surgical
2 services, CMS assumes a certain number and type of
3 postoperative visits take place on average. For example,
4 the valuation for a total knee replacement assumes 6
5 postoperative E&M visits: 3 office visits, 2 hospital
6 inpatient, observation visits, 1 hospital inpatient,
7 discharge visit. However, research from the OIG, CMS, and
8 RAND using medical records and claims, find that clinicians
9 actually furnish far fewer postoperative visits, on
10 average, than are included in the valuation of the
11 services.

12 For example, looking at the lefthand pie graph,
13 RAND found that only 17 percent of the postoperative visits
14 that were assumed to take place -- and included in the
15 valuation of services -- actually took place for 10-day
16 global surgical services. While you'd expect the number of
17 postoperative visits for any given patient to vary, average
18 differences of this magnitude reflect inaccurate
19 assumptions about the needed inputs for services. RAND
20 observed similar patterns for 90-day global surgical
21 services.

22 In our June 2025 report to the Congress, the

1 Commission recommended that CMS improve the accuracy of
2 Medicare's relative payment rates for clinician services,
3 including addressing overvaluations for global surgical
4 services. We noted two broad policy approaches to reform
5 these services: convert 10- and 90-day global surgical
6 services to 0-day services and let clinicians separately
7 bill for postoperative visits; or keep the current payment
8 structure but adjust valuations for 10- and 90-day global
9 surgical services to reflect postoperative visits actually
10 performed.

11 Both of these policies could be phased-in,
12 starting with relatively small number of services that
13 account for most of the spending.

14 The next topic is incident-to billing.

15 Medicare allows certain individuals to bill under
16 the NPI of a supervising physician if certain conditions
17 are met. This practice is known as incident-to billing.
18 Medicare's incident-to rules are complex and include that
19 services must be furnished in a noninstitutional setting,
20 such as a physician office; services must generally be
21 rendered under a physician's direct supervision, although
22 that provision has been relaxed in recent years; incident-

1 to billing is not allowed for new patients or established
2 patients with new problems.

3 Today, we focus on NPs, the largest subset of
4 APRNs, and PAs billing incident-to, because Medicare
5 beneficiaries increasingly rely on them to access care and
6 they can directly bill Medicare yet commonly bill incident-
7 to.

8 Medicare payment varies based on how an NP or PA
9 service is billed. The program pays 100 percent of the fee
10 schedule rate if billed incident-to and 85 percent if
11 billed directly.

12 The Commission has noted that incident-to billing
13 creates multiple issues for Medicare, including that it
14 reduces transparency and impedes program integrity
15 functions because the program cannot tell which clinician
16 is actually furnishing a service; increases beneficiary and
17 program spending, as more services are paid at 100 percent
18 of the fee schedule rather than 85 percent; inhibits
19 accurate fee schedule valuations and limits the ability to
20 evaluate the cost and quality of care furnished by NPs and
21 PAs, again because the program cannot tell who is actually
22 furnishing a service.

1 In our June 2019 report, the Commission
2 recommended that Congress require APRNs and PAs to bill the
3 Medicare program directly, eliminating incident-to billing
4 for services they provide. The recommendation would
5 enhance transparency and program integrity. The
6 recommendation would reform Medicare billing rules but
7 would not affect what care could be delivered by APRNs or
8 PAs. That is governed by state scope of practice laws and
9 collaboration agreements between NPs, PAs, and physicians.

10 For context, groups representing NPs and PAs
11 generally supported a direct billing requirement.

12 Since the Commission made its recommendation, new
13 research, using methods that we can discuss on questions,
14 has documented that incident-to billing for NPs and PAs
15 continues to grow, reaching an estimated 38 million
16 encounters in 2022, or about 39 percent of all these
17 clinicians' office encounters.

18 Research has also shown that physicians with a
19 surgical specialty had a higher share of their visits
20 billed incident-to compared with primary care physicians,
21 and that most NPs and PAs practice in specialty care.
22 These two data points suggest that most of the financial

1 benefits of incident-to billing accrue to specialty
2 physicians.

3 Also, beginning in 2026, CMS allows for
4 supervision of incident-to services via audio-visual
5 interactive telecommunications. This relaxation means that
6 an NP or PA can bill under the NPI of a physician even if
7 the physician is at a distant location

8 Also, beginning in 2027, Congress required a
9 modifier for telehealth services furnished "incident to,"
10 representing the first time that some incident-to services
11 are directly identified in fee-for-service claims.

12 Now moving on to telehealth.

13 Before the PHE, Medicare's coverage of telehealth
14 under the fee schedule was limited to a small set of
15 telehealth services provided to beneficiaries in rural
16 areas in certain settings, such as physicians' offices and
17 hospitals, with some exceptions. As a result, the use of
18 telehealth was very low.

19 During the PHE, CMS temporarily expanded coverage
20 of telehealth under the fee schedule. Congress has
21 permanently expanded telehealth flexibilities for mental
22 health services. For non-mental health services, Congress

1 has temporarily extended flexibilities through six short-
2 term patches ranging from a few months to a couple years
3 and once on a retrospective basis. Under the most recent
4 extension, the flexibilities are extended through 2027.

5 In a series of reports, the Commission has
6 discussed weighing principles of access, quality, and cost
7 when considering telehealth coverage, and has noted that
8 telehealth can be an important source of access, but the
9 policymakers should consider adding guardrails.

10 Telehealth use peaked in the second quarter of
11 2020, declined for the next few years, but has remained
12 relatively steady thereafter

13 In 2025, fee-for-service Medicare spent about
14 \$2.4 billion for telehealth services billed under the fee
15 schedule, and about 6.1 million fee-for-service Medicare
16 beneficiaries had a fee schedule telehealth visit.
17 Academic research on the effects of telehealth on cost,
18 utilization, and quality is mixed, but small increases in
19 utilization and spending are often found.

20 Consistent with past Commission work, permanent
21 access to telehealth should be balanced with appropriate
22 guardrails, which we discuss on the next slide.

1 Since the PHE, the Congress has implemented
2 multiple guardrails, which I list on the slide. The
3 Commission has also considered additional guardrails,
4 including eliminating incident-to billing for certain
5 clinicians providing telehealth to increase transparency;
6 reducing payment rates for telehealth services, which could
7 continue to allow widespread access to telehealth, but
8 limit any incentive for overuse that are often a concern in
9 fee-for-service Medicare; protections for beneficiaries
10 treated at rural health clinics, a topic that we'll discuss
11 at next month's Commission meeting; and in-person visits
12 before ordering certain services, such as high cost DME.

13 Medicare currently pays the same rate for in-
14 person and most telehealth visits. In contrast, the
15 Commission has said that CMS should pay telehealth services
16 lower rates after the PHE, and then collect data on the
17 cost of furnishing telehealth services and adjust
18 telehealth payment rates based on those costs.

19 Consistent with that, the AMA collected data on
20 the costs to furnish E&M office visits via telehealth. CMS
21 did not use these data to adjust telehealth payment rates
22 because the agency said the law requires it to pay an equal

1 amount for a telehealth service as a service furnished in
2 person. On the next slide, we'll review the data on the
3 cost of furnishing telehealth services and the implications
4 for Medicare payments.

5 These data suggest that for E&M office visits it
6 costs less to furnish similar services via telehealth. For
7 example, looking at the table on the left, for most common
8 telehealth service in 2025, an audiovisual telehealth
9 service requires 71 percent fewer direct practice expenses
10 compared with an in-person visit -- \$33.57 versus \$9.72, a
11 difference driven by fewer minutes from nurses or medical
12 assistants, which is shown in the far righthand column on
13 the table.

14 Using these data we estimate that adopting lower
15 rates for telehealth E&M office visits performed,
16 consistent with their lower costs, would have reduced 2025
17 fee-for-service spending on these services by an estimate
18 20 percent, or \$278 million.

19 Now we are going to pivot from the physician fee
20 schedule to the clinical laboratory fee schedule, or the
21 CLFS.

22 Medicare covers separately payable lab tests

1 under the CLFS. In 2025, Medicare spent about \$9 billion
2 on CLFS tests. CLFS tests are typically furnished by three
3 types of lab: independent, hospital, or physician office.

4 There is no beneficiary cost sharing for CLFS
5 tests, meaning there is no beneficiary coinsurance and the
6 Part B deductible does not apply.

7 Despite the lack of cost sharing, beneficiary are
8 still affected by lab spending because CLFS spending
9 contributes to Part B premiums.

10 Prior to 2018, CLFS payment rates were largely
11 based on historical lab charge data that were capped and
12 inflated over time. The OIG found that CLFS rates were far
13 above private-payer rates. In 2014, PAMA required the CLFS
14 to be based on private-payer rates. Specifically, payment
15 rates are set at the volume-weighted median of private-
16 payer rates. Labs are required to report data every three
17 years, so CMS can update payment rates. The first round of
18 data collection suggested Medicare rates were far above
19 commercial rates

20 Implementation of the first round of private
21 payer rates began in 2018. By law, the lower rates are set
22 to be phased in over time. But as of 2026, the reductions

1 have not been fully phased in yet.

2 In our June 2021 report on the first round of
3 data collection, the Commission estimated that CLFS rates
4 would decrease 24 percent once fully implemented. The
5 reductions were larger for routine tests compared with
6 newer, more expensive tests, such as genetic tests. We
7 estimated that CMS collected data from 51 percent of labs,
8 weighted by CLFS spending. Independent labs were
9 overrepresented and hospital outpatient and physician-
10 office labs were underrepresented. Hospital and physician
11 office labs had higher private payer rates compared with
12 independent labs.

13 For routine, low-cost tests, we observed that
14 higher private-payer rates for some lab types, such as
15 hospitals, likely reflect greater negotiating leverage.
16 Because of that, incorporating data from all labs could
17 result in higher-than-necessary rates. Policymakers should
18 therefore consider setting lab payment rates based on
19 private-payer data from certain types of labs, such as
20 independent labs, while excluding the data from others,
21 such as hospital outpatient labs.

22 For newer, higher cost tests such as genetic

1 tests, we observed that rapid spending growth and modest
2 effect of incorporating private-payer rates suggest that
3 relying on private-payer rates alone will not control
4 spending on such tests in the future and that additional
5 policy tools might be needed.

6 The Commission also monitors the utilization of
7 CLFS tests as one measure of access to care. Looking at
8 the figure on the left, you can see that since 2017, the
9 year before private-payer based rates were implemented, the
10 number of CLFS tests per Part B fee-for-service beneficiary
11 has remained relatively stable, with the exception of a dip
12 and then rebound during the peak of the coronavirus public
13 health emergency. These data suggest that Medicare
14 beneficiaries continue to have access to lab tests.

15 The second round of data collection had been
16 delayed, and CMS collected a second round of private-payer
17 data in 2026. The data are from January to June 2025
18 claims. CMS changed reporting rules to require more
19 hospitals to report data. CMS said that more labs reported
20 in the second round of data collection. Specifically, CMS
21 said that 875 hospital labs reported, up 4,067 percent from
22 the first round; 3,262 physician-office labs reported, up

1 195 percent from the first round; and 775 independent labs
2 reported, up 18 percent from the first round.

3 CMS recently posted preliminary rates based on
4 new private-payer data and found the rates based on the new
5 data would decrease 2026 CLFS rates by 16 percent, on
6 average.

7 In this slide I'll review some our preliminary
8 findings of the new private payer data. Some of the
9 reductions stem from the fact that the reductions from the
10 first round of private-payer data collection have not been
11 fully implemented yet.

12 Required caps in 2027 on rate reductions prevents
13 full payment reductions for nearly 800 tests. In contrast,
14 payment increases are implemented immediately, with no cap
15 on how much payment rates increase. Payment rate declines
16 would have also been slightly larger if CLFS rates were
17 based on independent lab rates, as MedPAC has suggested.

18 CMS collected data from labs that accounted for a
19 higher share of CLFS spending than the first round of data
20 collection. Preliminarily, we find that CMS collected data
21 from labs that accounted for roughly 2/3 of CLFS spending
22 in 2025, which is substantially higher than the first round

1 of data collection in which labs accounted for about half
2 of CLFS spending reported. Our preliminary estimate for
3 the new round of data collection involves some
4 methodological decisions that I can walk through on
5 questions.

6 In this slide, I will walk you through one of the
7 issues we mentioned on the previous slide, that some
8 payment rates reductions from the first round of private-
9 payer data collection have not been fully phased-in yet.

10 Looking at the first row of the table, the 2016
11 private-payer rate from the first round of reporting was
12 \$9.08. As of 2026, Medicare's CLFS rate was \$10.56. This
13 means that the first round of payment reductions were never
14 fully implemented. In fact, for this test, if the first
15 round of payment reduction had been fully phased in, there
16 would be no additional payment reduction due to the second
17 round of data collection, as the weighted median private
18 payment rate was nearly identical in 2016 and 2025 -- \$9.08
19 versus \$9.10.

20 The results of a long and incomplete phase-in
21 include that Medicare's payment rates remain above private
22 payer rates, 12 years after PAMA was passed in 2014.

1 Medicare spending is higher than it otherwise would have
2 been, and payment rates are less accurate.

3 In summary, accurate payments are important for
4 ensuring access to care, avoiding inappropriate incentives,
5 and limiting the financial burden on beneficiaries and
6 taxpayers. CMS has recently taken multiple steps to
7 improve payment accuracy, but opportunities for improvement
8 remain.

9 And with that, I'll turn it back to Amol for the
10 discussion.

11 DR. NAVATHE: Thank you, Brian, for an excellent
12 presentation across multiple different topic areas. Dana,
13 I'll turn it over to you to run the queue.

14 MS. KELLEY: Okay. We have Stacie first.

15 DR. DUSETZINA: Thank you so much, you guys, for
16 this work. I just had a quick question about the global
17 services bundle and what beneficiary cost sharing looks
18 like. Because I think for the couple of options you give
19 one is thinking about doing fee-for-service and the other
20 one is just reduce the amount you pay for the bundle.

21 If you did fee-for-service that would presumably
22 cost the beneficiary more in cost sharing, right, versus

1 the bundle. So I'd like to hear a little bit about how
2 their copay is structured under the current 10- to 90-day.

3 MR. O'DONNELL: Right. So currently the
4 beneficiaries pay 20 percent coinsurance on the full
5 bundle. So under either option, either kind of taking it
6 to a zero-day and then having them bill the postoperative
7 visits a la carte, or kind of shrinking the current
8 valuation but keeping the same structure.

9 I think we envision beneficiaries paying less
10 under both options. So I think that's the first and
11 probably most important thing, because you'd be paying 20
12 percent on the surgery, which the payment rate would be
13 lower, and because most visits aren't actually furnished
14 they would be paying 20 percent on each post-up visit but
15 on far fewer services.

16 So it would be going down in both situations.
17 There are obviously distributional effects within that, but
18 I think that's the high-level takeaway.

19 DR. DUSSETZINA: I think that will be super
20 important to highlight, because I think in my mind I
21 assumed that there would be some sort of efficient when you
22 say like a 90-day bundle that somehow the patient might be

1 capped at the surgical copay and maybe everything else is
2 on in. So I think being able to really show the out-of-
3 pocket for the beneficiary would be helpful for either of
4 those cases.

5 MS. KELLEY: Tom.

6 DR. DILLER: Yeah. Two quick questions. First
7 one on telehealth. Is there any data on the
8 appropriateness of the telehealth services? So services
9 could be provided that are not consistent with a visit, as
10 just a routine call that went back to the patient, or
11 services could be provided that exceed what is safe for a
12 telehealth visit. Is there any data out there, that you're
13 aware of, that is helping us guide that?

14 MR. O'DONNELL: So I can't think of any off the
15 top of my head, but I will note that there are codes, if
16 you do really short, like a 10-minute phone call, there are
17 separate codes for that, that should be being billed. So
18 that's an option for clinicians to bill those types of
19 codes. So I'll note that.

20 And the other thing I'll note is that there is a
21 review process to vet which services can be furnished via
22 telehealth. There are only maybe a couple hundred codes

1 under the fee schedule that's allowable to be billed via
2 telehealth. So that is one check that kind of limits the
3 types of services that can be performed via telehealth,
4 which I understand doesn't perfectly answer your question,
5 but I think those are the two thoughts I have.

6 DR. DILLER: Okay. Thanks. And on the lab
7 tests, is there any data out there, cost accounting data?
8 For example, what does it cost for a comprehensive
9 metabolic panel, not what the reimbursement is but what
10 does it cost?

11 MR. O'DONNELL: We don't have access to lab cost
12 reports, so I think there is limited data on that front out
13 there.

14 DR. DILLER: Okay. All right. Thanks. Great
15 job.

16 MS. KELLEY: Greg.

17 MR. POULSEN: Kind of following up on what Tom
18 was just asking, when we looked at the freestanding labs
19 versus the physician office and hospitals, do we have any
20 sense for the timing of those? I'm wondering if there's a
21 cost differential and a legitimate cost differential based
22 on the need to have rapid turnaround times and therefore

1 doing smaller batch sizes, things like that, that would
2 intrinsically cost more.

3 It would be nice if we had real cost data to know
4 that, but do we have any surrogates for that at all?
5 Because I can well imagine legitimate reasons why you would
6 want to have a faster turnaround time in those settings and
7 therefore be willing to pay a little bit more for it.

8 MR. O'DONNELL: Yeah, so I think the answer is
9 no, that I don't have those data.

10 But I do want to make a clarification that when
11 we're talking about these tests performed in the hospitals,
12 there's kind of three buckets of tests. There are tests
13 that are kind of bundled with the outpatient surgery or the
14 inpatient surgery. Set those aside. We're not talking
15 about those. Then there's other tests that hospitals run
16 that are separately payable, but they're for their
17 patients. So maybe I go to an OPD and I get a lab test
18 while I'm there, so I'm their patient.

19 And then there's a third bucket, which is called
20 "outreach labs," where the hospital is functionally
21 operating like a lab. And so you wouldn't presume that
22 there'd be any of those issues you talked about in kind of

1 that bucket.

2 So I would say disproportionately the bucket
3 we're talking about, the issues you mentioned kind of would
4 not be implicated. They'd be kind of living over here in
5 this bucket disproportionately, but I don't think I have
6 specific data to kind of litigate that question.

7 MR. POULSEN: Thanks so much, and great, great
8 report.

9 MS. KELLEY: Tamara?

10 DR. KONETZKA: Yeah, thanks for this work.

11 Back to the surgery bundles, you said the
12 original or the payment rates are based on a sort of
13 assumed or expected number of post-op visits. Were those
14 assumptions built around research as to the appropriate
15 number of visits? Or, alternatively, is there a good
16 research saying, you know, for particular surgeries, how
17 many visits there should be?

18 MR. O'DONNELL: So the way those data are arrived
19 upon is through the kind of RUC with CMS review. And so
20 they -- for the clinician societies that kind of perform
21 those surgeries, they send out surveys, and they say, hey,
22 how many of these visits post-operative do you deliver?

1 And kind of the number and the type, right? So they survey
2 them, and they say this is how many we think for the
3 typical patient kind of is delivered. So that's the data
4 source that feeds kind of the evaluation machine currently.

5 And so what would the other data we have are just
6 kind of claims and then medical record data saying that
7 just far fewer actually delivered? I don't think there's
8 that sweet kind of middle spot where you're saying to say
9 this is the number that are kind of clinically appropriate,
10 and obviously, that would vary a bunch. But I think those
11 are the two data points we have.

12 DR. KONETZKA: All right. Thank you.

13 Yeah, I just think the -- you know, obviously,
14 there are appealing things about putting this in a bundle,
15 right? Because patients are going to be different, and you
16 think there's some discretion about the number of post-op
17 visits that are going to be needed. And if we start paying
18 per visit, you're probably going to start seeing more post-
19 op visits, right? And so it'd be nice if that number that
20 is expected is based on some level of appropriateness. So
21 I don't know, you know, how we could get to that point, but
22 it would be great to see if there's research that could

1 inform that.

2 DR. NAVATHE: I'll jump in here for a second.

3 So, fellow clinicians, please feel free to jump in, but I
4 think that area that you're sort of describing is typically
5 not an area where we tend to have, like, society guidelines
6 or specific clinical trials to look at, things like how
7 many post-operative visits you would require.

8 So I think, from a clinical lens, we'd probably
9 be in somewhat of an evidence-free zone from the clinical
10 literature perspective. I think, I guess, perhaps the RUC
11 is trying to bring some of that perspective in, but then,
12 obviously, the utilization patterns that we see are not
13 syncing up with that.

14 And over time, I think there's also a
15 longitudinal piece to this where some of the patterns that
16 historically existed have changed over time as technology
17 has gotten better and, in general, care has shifted across
18 different settings. So there's a little bit of a moving
19 piece of this also kind of relative to when the data was
20 collected or when it's supposed to be represented from.

21 DR. KONETZKA: If I can, just for a second, yeah.
22 So I think -- thank you. That's really helpful. So, to

1 me, it would seem that it'd be better to sort of adjust the
2 payment rates for the reality or adjust the bundle for the
3 reality of how many visits are actually given on average or
4 whatever, right, and not go in the direction of being more
5 prescriptive about how many should there be.

6 DR. NAVATHE: Yeah, I think -- sure, yeah. I
7 think very valid for you to point that out.

8 I think the only other thing I would point out
9 just about the utilization pattern is that there may still
10 be visits that are being provided in the post-operative
11 care for these individuals that are just happening from
12 other clinicians, whether that's from an NP/PA or from a
13 different specialty-type physician. So I think we should
14 just be mindful that we're talking here about the fee that
15 is paid kind of for the physician and the other delegates
16 of that physician within that practice in a sense. And so
17 I just want to make sure that we kind of understand the
18 scope here, but your point is well taken.

19 DR. CASALE: Can I just since -- I'll just follow
20 up. Is that okay, Amol, on just that point? Because that
21 was going to be my one question, which was, yeah, that was
22 just looking at the physician visit, but potentially, there

1 could be other clinical care that's ongoing with others in
2 the office that are providing care. But I'm not sure we
3 can get insight into that, right, the other? Because
4 they're not necessarily billing, but providing, whether
5 it's a care managers or other clinical team members to try
6 to reach out to those patients but not necessarily bill for
7 that service. I'm not sure we can get at that, but --

8 MR. O'DONNELL: Yeah. So I think there's kind of
9 two things that I've heard here. Kind of one is like
10 members of the team that are providing care that are --
11 perhaps it's not an actual visit or a kind of office visit.

12 And then there's a second nugget in here about
13 there could be kind of office visits being kind of
14 furnished kind of outside the surgeon and the surgeon's
15 practice, which is where the bundle lives. And so if there
16 is a beneficiary has a surgery and they have an urgent care
17 visit, you know, that they go get an E&M from urgent care
18 visits outside of the practice, that is observable. That
19 is a separately billable E&M that happens.

20 And I think that's -- to be frank, that's one of
21 the arguments for why kind of the bundles need reformed is
22 that the practice of medicine, whether it be hospitalist or

1 urgent care, it is different than when these bundles were
2 developed 40 or 50 years ago. So that's one argument for
3 that.

4 DR. NAVATHE: Brian, can you just clarify one
5 more point? So you just pointed out there that the bundle
6 is going to the surgeon and the surgeon's practice. So,
7 for example, if an NP or a PA who's working with a surgeon
8 furnishes that postoperative visit, can you just explain
9 kind of what happens from a payment perspective there?

10 MR. O'DONNELL: Sure. And this was clarified a
11 couple of years ago in the rules, is that the bundle lives
12 with the surgeon and the surgeon's practice. And so if I'm
13 an NP or a PA and I'm working with a surgeon and the NP or
14 PA is doing the post-op visit, that post-op visit is
15 bundled and should not be separately billable. So that
16 includes the kind of NPs and PAs within your practice that
17 are furnishing care.

18 MS. KELLEY: Okay. Cheryl.

19 DR. DAMBERG: Thanks for this nice overview of a
20 number of different topics. I just wanted to ask three
21 different questions.

22 So let me start with the bundles. Have you done

1 any interviews with, say, primary care physicians? Because
2 one of the things that I've heard is that after the
3 surgery, the surgeons are actually pushing the patients
4 down to primary care. So they're not providing the follow-
5 up visit, but primary care is. And even when they try to
6 push it back to the surgeon, the surgeon just keeps pushing
7 it back to primary care. So I think it would be
8 interesting to try to understand that dynamic and if
9 there's anything that could inform future thinking on the
10 structure of this.

11 My second question was -- so I was interested in
12 your comment about there's no beneficiary cost sharing for
13 the clinical lab piece, and I don't really know the history
14 of that, because I know at least in my commercial
15 insurance, there is cost sharing. So is there a reason
16 there's not cost sharing for beneficiaries?

17 MR. O'DONNELL: Yes. I can give you the kind of
18 argument that's typically laid out as to why there was not
19 cost sharing, is that historically lab prices have been
20 kind of relatively low-cost services or low-priced
21 services. And so the thought was, do I really want to try
22 to collect co-insurance on a lab test that costs \$7, so 20

1 percent of \$7? Is the administrative burden and the hassle
2 worth it? I think that's one argument that has been out
3 there. Whether you believe that or not, I'll leave that
4 aside.

5 I think the thing that has happened under the
6 CLFS is that it's more from a lab fee schedule that's
7 comprised mostly of those services to those services plus a
8 lot of really high-dollar services. So a lot of lab tests
9 now cost 3-, 4-, \$5,000.

10 DR. DAMBERG: Yeah.

11 MR. O'DONNELL: And so it's grown in ways that
12 that initial policy couldn't have envisioned, and so I
13 think that's one of the other kind of things that folks
14 talk about when they talk about, should there be any cost
15 sharing? They talk about the development of the different
16 types of lab tests under the CLFS.

17 DR. DAMBERG: Yeah. Thank you.

18 And then my third and final question is in the
19 telehealth space. So I can't remember where are we in the
20 sequence, because Congress required some reports around
21 telehealth. And is MedPAC teeing up another report to
22 Congress that's due at some point? How do we keep feeding

1 them this information? Because there were some pretty
2 interesting findings on your slides.

3 MR. O'DONNELL: Yeah. So we don't have a
4 mandated report. This is just us following the topic and
5 kind of following up. We've issued three reports over the
6 last several years, but I don't think -- unless, Paul, I'm
7 missing something here, we don't have a mandated report.

8 MR. MASI: We do not. But, as Brian said, this
9 is an important issue that we're continuing to track.

10 We have continued publishing information in our
11 annual data book. That's been one home where some of this
12 information is live. But I think for your discussion, we'd
13 be interested in Commissioners' interest in how to
14 prioritize this moving forward.

15 DR. DAMBERG: Yeah. Thanks. Because the amount
16 of time being spent is really out of whack with what we're
17 paying, so yeah.

18 MS. KELLEY: Danielle.

19 DR. PIEROTTI: I have two questions on the
20 telehealth component.

21 One of them has come up a little bit here in that
22 before there was telehealth, there was still the ability

1 for an E&M charge for a phone call, and now I'm a little
2 bit concerned that that's being accepted as a telehealth
3 visit.

4 So I guess I just want to come back to a comment
5 you made about telehealth without video. Isn't that still
6 just a phone call?

7 MR. O'DONNELL: So I think at least by the rule
8 book, the differentiation is that if you were doing 20 to
9 29 minutes, which would be a kind of a standard E&M office
10 visit, and that's audio only, that would qualify for a E&M
11 payment rate just as it would in-person or virtually under
12 the current rules. And so that would qualify.

13 And if you are in a shorter time frame -- and I
14 can give the exact minutes if I looked it up, but it's
15 something like a 10-minute, quick check-in -- that's what
16 would qualify for the lower payment.

17 Now, again, we're relying on those billing rules
18 being adhered to and that that's the situation.

19 I will say that audio-only in general has shrunk
20 as a share of all telehealth. Now we're down near
21 something like 10 percent of all telehealth, and fee-for-
22 service Medicare is audio-only. So it is a declining

1 share, but that issue does exist for folks.

2 DR. PIEROTTI: Well, that leads to my second
3 question, which is differentiating the model of the
4 telehealth. And I don't know if it's possible to do this,
5 but there are two different ways of using telehealth. One
6 is the patient is wherever the patient is, and they log in
7 independently and engage directly with their provider.

8 The other one is a clinician-assisted model where
9 the patient, the beneficiary, is actually in an office.
10 There is some kind of clinician, whether it's a nurse, an
11 MA, whatever, that is facilitating and acting as the hands
12 of the provider if blood pressure gets taken or something,
13 or they're using some kind of equipment to project
14 respiratory sounds.

15 So I'm wondering if we have the capacity to tease
16 those out as we look at this data, because I think the cost
17 structure is pretty significantly different between those
18 two models.

19 MR. O'DONNELL: Yeah. We can do more work
20 looking at that a little bit.

21 I will just say that in the presentation, we
22 didn't use the verbiage, but we were talking about the

1 distant-site clinician payment. And there is a separate
2 payment that's separate from all the things we talk about
3 for the originating site facility fee, and so they get a
4 fee for the things that you were just talking about, about
5 assisting the clinician and doing that. And so that is a
6 minority of telehealth. So most telehealth occurs now when
7 the beneficiary is in their home, rather than the kind of
8 old-school telehealth where they go to a hospital or a
9 physician office. But for that small chunk of telehealth
10 services, there is this separate fee that is established.

11 DR. PIEROTTI: Can I ask one more tag-on to that?
12 So where do things like -- where I come from, they call it
13 the "easy button," where there isn't a specialist in a
14 rural area, but there is a network that allows -- say, the
15 emergency room in a high-risk maternity case that walks
16 through the door, they connect via telehealth to the
17 specialist. Where does that model fit in this?

18 MR. O'DONNELL: Yeah. And so we've gone out, and
19 we did a few site visits this summer into rural hospitals,
20 and we definitely saw some of those capacity. You see kind
21 of telestroke is kind of a common thing. And so it depends
22 on who is, kind of what's actually occurring. And so a lot

1 of that, if it's -- it can be kind of bundled into the
2 payment on the inpatient side of the house, or depending on
3 how it's structured -- and there's lots of permutations --
4 it could qualify for a separate clinician fee schedule
5 payment.

6 But it definitely exists, and there's definitely
7 different kind of ways in which it can be paid for,
8 depending on exactly how it's structured.

9 MS. KELLEY: Josh.

10 DR. LIAO: Just a quick question, going back to
11 the surgical global bundles.

12 What I took from the materials processing in real
13 time is the evidence suggests the assumptions underlying
14 the payments exceeds actual visits being furnished. Things
15 with EHRs and audits show that incomplete reporting doesn't
16 explain that full difference, and the residual raises an
17 evaluation question.

18 What I was thinking, and what I heard from the
19 earlier conversation, was that two areas of what we don't
20 know, the evidence -- I'm hoping you can just gut check me
21 on this -- is we don't really have a full sense of the full
22 work of post-op care, so the billable E&Ms outside of the

1 global, as mentioned, but also other things like portal
2 messages, phone calls, wound photograph, coordinators to
3 other clinicians. And as a result of that, we don't really
4 know if -- from that full work perspective, if fewer visits
5 within the global really leads to more efficient care or
6 insufficient care. There's no evidence that pushes this
7 more than the other. Does that sound accurate?

8 MR. O'DONNELL: Yeah, I think I would agree that
9 the mix of things being done has changed over time.

10 DR. LIAO: Yeah.

11 MR. O'DONNELL: And the appropriateness of that
12 mix isn't really reflected in our discussion.

13 We're talking about the tangible, billable
14 things, or things that feed the valuation over time. So if
15 there are -- the appropriateness is really -- we haven't
16 discussed kind of at all.

17 DR. LIAO: Yeah. I feel more confident that I
18 don't know of stuff looking at the number of visits within
19 a global and its effect on outcomes, efficiencies in care
20 versus insufficient care, which would be a big deal.

21 But I also can't think of literature looking at
22 all those other things I just mentioned and the

1 relationship to that post-operative. I just wanted to make
2 sure I wasn't missing something. Thanks.

3 DR. NAVATHE: Josh, the one thing I would clarify
4 there is to the extent that any of those activities that we
5 think fit under the broad umbrella of efficiencies,
6 different types of care, portal messages, phone calls,
7 telehealth visits, other things that might be in that
8 world, if they are billable against the fee schedule, then
9 they will generate a separate payment for that.

10 DR. LIAO: Right. And I think to that point,
11 there haven't been research that I'm aware of about taking
12 those other billable things and looking at that alongside
13 the globals, and then there's a bunch of things that aren't
14 observable, like portal messages, right?

15 DR. NAVATHE: Totally correct. So I think you're
16 right. I just wanted to clarify that one.

17 DR. LIAO: Thanks.

18 DR. PIEROTTI: For one example that gets in this
19 arena, though not exactly, is the ortho bundles that were
20 tried a few years ago, because there was evidence that came
21 out of that, that office visits versus physical therapy
22 visits and the interaction that those things had on care

1 outcomes. So I think there might be some information in
2 this space limited to the ortho joint replacement bundles.

3 MS. KELLEY: Gina.

4 MS. UPCHURCH: Yeah, thanks for the smorgasbord
5 of information here.

6 Just a couple of questions, and I may be losing
7 my mind, but I know if you're in fee-for-service Medicare
8 and you need labs, if they're considered medically
9 necessary and preventive, then you don't have cost sharing.
10 I think we need to clarify that, because I think a lot of
11 people, when they go on Medicare for the first time,
12 they're like, hold on, where's my -- you know, where is my
13 lipid panel? Where's my -- and that's unless it's
14 considered medically necessary, it wouldn't be covered
15 without cost sharing. Am I --

16 MR. O'DONNELL: Yeah. So just to be clear, I
17 think that's a broad -- that services need to be necessary
18 in order to be covered by Medicare, but they are kind of --
19 almost all lab tests that are covered have no cost sharing.
20 So there's no kind of subset of preventative lab tests that
21 are -- there's no cost sharing there. It's all lab tests
22 are -- have no cost sharing or deductibles applied to them.

1 So. like the lipid panel, the lipid panel is
2 covered in general, and there's no cost sharing.

3 MS. UPCHURCH: But you don't get the annual
4 physical with all those labs. When you hit Medicare,
5 people are sort of surprised that they're not getting that
6 covered.

7 MR. O'DONNELL: I think the thing that you might
8 be talking about is like a general wellness panel --

9 MS. UPCHURCH: Yes, yes.

10 MR. O'DONNELL: -- that sometimes folks think
11 they're getting.

12 MS. UPCHURCH: Yes.

13 MR. O'DONNELL: So that's not a cost-sharing
14 thing. That's a kind of, does Medicare kind of cover this
15 issue?

16 MS. UPCHURCH: Consider not medically necessary.
17 Okay.

18 But with Medicare Advantage points --

19 MR. MASI: Just to jump in real quick.

20 MS. UPCHURCH: Yes.

21 MR. MASI: I don't know that it's a medically --
22 and, Dana, you should certainly jump in here too.

1 MS. UPCHURCH: Yeah, please.

2 MR. MASI: I think it's just a coverage issue,
3 not a payment issue, just to clarify that.

4 MS. UPCHURCH: Okay.

5 MR. MASI: And, Gina, do you have in mind that
6 the USPSTF -- is that where you're driving with some of
7 this?

8 MS. UPCHURCH: Not really, but now that you
9 mentioned that --

10 MR. MASI: Oh, then pretend I didn't say those
11 letters.

12 MS. KELLEY: Well, I thought you were referring
13 to the annual wellness visit.

14 MS. UPCHURCH: Yeah. And I know that's more your
15 -- for the first time, providers -- or they can speak to
16 people about stuff, and it doesn't include the physical
17 exam. I do get that. But, yeah, I know the lab -- but
18 what I'm getting at is with Medicare Advantage plans, there
19 had been cost sharing with labs and stuff and not -- is
20 that -- is that still the case?

21 MR. O'DONNELL: Sorry. When I'm speaking about
22 no cost sharing, that is a Part B fee-for-service thing

1 that I'm speaking about. And so MA is kind of separate in
2 their policies. We haven't discussed in this presentation.

3 MS. UPCHURCH: Okay. And so people would be
4 surprised to know that that is another difference that you
5 do have to pay for some labs there. Okay.

6 So whether it is lab, test, telehealth, surgical
7 bundles, do we have any comparison -- and I know this is
8 not what we were doing here -- with what Medicare
9 Advantages decided to do in terms of payment for these
10 things? Like, are they paying less for telehealth? Do we
11 know?

12 MR. O'DONNELL: So oftentimes fee-for-service
13 Medicare is the kind of 800-pound gorilla in the room --

14 MS. UPCHURCH: Right.

15 MR. O'DONNELL: -- and MA follows. So I don't
16 think -- we haven't done specific analyses on what's being
17 done.

18 For incident-to, we've looked at -- obviously we
19 interviewed a bunch of MA plans a few years ago, and they
20 tended to follow fee-for-service Medicare, although a few
21 have tried to add modifiers and to add some transparency.
22 And so there's been some movement there.

1 For the lab payments, I will say that MA rates
2 are included in the private payer data, and so they are
3 included in the data that are used to set fee-for-service
4 rates.

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

6 So you talk about that delta of 15 percent, the
7 85 percent versus 100 percent if you're doing incident-to
8 or direct billing, and you mentioned that oftentimes you
9 have specialists that have PAs or nurse practitioners and
10 it's -- I'm assuming that money doesn't have to be
11 earmarked for anything in particular.

12 So if we think we -- if more of it does go to
13 direct billing and they lose that delta of 15 percent, do
14 we think there's going to be less likelihood of hiring
15 nurse practitioners and PAs? I mean, is that --

16 MR. O'DONNELL: Yeah. So, I mean, it's a
17 question about the supply, and I think over the years,
18 we've observed a really robust supply of NPs and PAs in
19 addition to billing Medicare, kind of the graduating new
20 kind of NPs and PAs. So there's really robust demand to
21 become an NP and PA. They're really robust demand from
22 patients to see them as seen in the claims data. So

1 whether that modification in payment policy will change
2 that demand, I think to me is unclear.

3 But I think when you speak to people, I think
4 that the payment rates for NPs and PAs is often driven by
5 kind of market demand from clinicians and hospitals and
6 things like that. So there's certainly not a direct
7 relationship, but one could envision that some kind of
8 modest kind of payment reduction could on the margins
9 affect things. But I think there's a whole pipeline of
10 robust kind of supply and demand that would lead me to
11 believe it wouldn't be substantial, but I think that's
12 borderline speculative.

13 MS. UPCHURCH: Yeah. Great. Okay. Thank you.
14 Just curious about that.

15 And the last question, I know a lot of
16 geriatricians that are focused on team building were really
17 appreciative of the G2211 modifier with CPT codes around
18 care management. Is that allowed with telehealth? I don't
19 know. Just curious.

20 MR. O'DONNELL: I do believe so. The code is now
21 transitioning into a modifier next year, but I do believe
22 it is. But I can double check that.

1 MS. UPCHURCH: Okay. Thank you. Great work.

2 MS. KELLEY: Paul.

3 DR. CASALE: Most have already asked my question
4 in the middle, which was around, can you capture some of
5 those additional services that may be part of the bundle,
6 and part of that has already been mentioned by others.

7 One is other providers who are providing services
8 not in the bundle, and then as Amol said, there are
9 billable services that might be captured.

10 And this is maybe a little going into the R2, but
11 I wonder if it might be interesting to look at some high-
12 volume surgery conditions in both the 10-day and 90-day
13 specifically to get a little bit more insight as to the
14 post-op visit cadence and such and if that might help us
15 understand some of these other -- whether there, the
16 services being provided by others.

17 And I can think of cardiology and open-heart
18 surgery, right? I mean, there's urgencies of initially,
19 but then a lot of it then comes to cardiology, and
20 certainly, some of that may be very appropriate. They may
21 have a rhythm issue, this and that.

22 So it may be interesting or it might be

1 insightful to look at some specific high-volume clinical
2 surgical procedures and then the workaround.

3 MR. O'DONNELL: Yeah. I just want to be clear in
4 case I wasn't before that -- so when RAND did their study,
5 they kind of -- for services that are billed, they did that
6 where they say we looked at the bundle, and then we looked
7 at leakage at kind of urgent care or other types of
8 provider. But they peeled back kind of one layer of the
9 onion, and they looked a level deeper, and they looked at
10 level over here. So they kept expanding kind of how they -
11 - what they looked at.

12 And even after going outside the proper bundle,
13 they found that the story was not that there was just this
14 tons and tons of leakage, although there were some, the
15 message was that the post-op visits, the billable visits,
16 were just not happening. So they've done that on the
17 billable side where they have the data to do it, and they
18 found that the message still holds, but just not on the
19 like innovations. If you have an app to follow up with
20 your patients, things like that, it's just really hard to
21 observe.

22 MS. KELLEY: Amol, that's all I have for Round 1.

1 Okay. I have Brian first in Round 2.

2 DR. MILLER: Great. A couple of quick thoughts,
3 actually quick. I'm getting timed now? We didn't time
4 Round 1. Those were pretty long comments. I've already
5 burned five seconds.

6 So incident-to billing I think treats other
7 practitioners as second-class citizens. We've talked about
8 this at length, like paying clinicians directly, nurse
9 practitioners, pharmacists -- pharmacists are not Part B
10 providers.

11 I think the record, though, here is clear. I'm
12 not sure we need to additional work when you think about
13 priorities, because it's pretty clear to me, global
14 surgical bundles, that number about 53 percent of paid-for
15 visits not being delivered. It's just we need to do
16 something, like take a gander. So that's probably an area
17 where we could dive in more.

18 Telehealth is definitely an area where we should
19 dive in, and for me this would be a super high priority.
20 The idea that we are paying the same regardless of the
21 modality of service seems sort of absurd. Because
22 obviously there are some services in rural settings where

1 the physician is in a clinic remotely and the patient is in
2 a clinic remotely with an assistant. That probably is a
3 similar rate, or at least on the surface we could think of
4 that. But me sitting in my home office, doing a telehealth
5 visit or calling a patient, it probably doesn't cost as
6 much, and we have reasonable evidence. So we should look
7 at that and try and model what we think that could be.

8 I agree with Cheryl that for the clinical lab fee
9 schedule, high-cost tests probably should have some cost
10 sharing. Administratively, it probably doesn't make sense
11 to have cost sharing for ordering a CBC for five bucks.
12 That just seems probably objectively dumb, just
13 operationally.

14 The last one that's not on the list, which I
15 wanted to put on the list for us, is the physician fee
16 schedule not being accurate. We've lots and lots of
17 discussions about rates being sort of out of whack and the
18 rec not being accurate, and I joke that if the rec's not
19 accurate the alternative proposals for another technical
20 expert panel with, you know, Bob's 10 people or Jane's 10
21 people is also probably just as inaccurate. The idea that
22 we could have that specific system microtargeting.

1 I think we need a dynamic and not a static
2 system. There was a recent JAMA Health Forum paper sort of
3 looking at how we could deploy utilization rates in MA,
4 full-risk contracts, to model them, and adjust relative
5 prices and fee-for-service in a budget neutral manner.
6 That might be something for us to consider for fixing the
7 physician fee schedule.

8 Pretty good on time.

9 DR. NAVATHE: Brian, one follow-up on that. So
10 on the global surgical codes, we have present two potential
11 options and Tamara had kind of weighed in on what she
12 thought. Do you have a thought about which direction you
13 would prefer?

14 DR. MILLER: I'm generally in favor of lowering
15 back to water levels. Is that specific enough?

16 DR. NAVATHE: We can make that work. Thanks.

17 MS. KELLEY: Stacie, Round 2.

18 DR. DUSETZINA: I feel like I'm partly Round 1
19 because I have questions about each of my comments, so
20 sorry about that.

21 For the global services, I think lowering the
22 amount that we pay for the bundle seems like a very

1 reasonable strategy.

2 I also have been thinking about some of Tamara's
3 comments and the back-and-forth with Amol, was, well, you
4 know, they have a very large number of visits that they're
5 not using right now, so maybe we could think that that's
6 what's clinically appropriate is kind of what's happening
7 across the population right now. So I think lower what
8 we're paying sounds better than fee-for-service.

9 For the incident-to billing space I do think this
10 is super important. I would really like to understand more
11 about who is actually delivering the care. I think one of
12 the thing that bothers me is, you know, it's like the
13 recommendation is have more people getting paid less,
14 because they're not adding the physician to the bill. That
15 worries me. And I wonder if there's analysis or data out
16 there about places that have higher billing by non-
17 physician workers, like less of the incident-to billing and
18 who are they taking care of. Because they're doing the
19 work, right? People are receiving the services. It would
20 be nice to compensate them, whether they're an MD or not an
21 MD, for that service.

22 But I do still wondering like where are the

1 places that are not doing a lot of incident-to billing, and
2 are they taking care of different patients than places that
3 are?

4 For the telehealth I also think that's really
5 important. One thing I could not quite figure out is, you
6 know, we know telehealth has just exploded nationwide. A
7 lot of the GLP-1 drugs are being prescribed through
8 telehealth, for everybody. And I wasn't sure if that could
9 be the case for Medicare beneficiaries as well. Like can
10 you, you know, some of the rules around when you have to
11 have a primary clinician and face-to-face visit to get a
12 new prescription. And I tried to google this but that was
13 very useless, and actually it came up with LillyDirect
14 website when I was trying to figure out, you know, can you
15 get prescriptions through Medicare through telehealth.

16 So I would be curious about that, and I would
17 also be monitoring telehealth more closely as we've seen
18 that, just nationwide, going up for a lot of people over
19 the last couple of years.

20 I think kind of more normalizing, too, people
21 getting care outside of their face-to-face clinician's
22 office, like a lot more advertising to the people.

1 And then I think the last one is the lab testing.
2 That doesn't make a lot of sense to me that Medicare is
3 paying a lot more than commercial. So that seems a very
4 strong argument for we should not be doing that.

5 But I wondered why -- and I'm sorry if you said
6 it, there was a lot of context -- but why haven't the
7 payment reductions been implemented yet? Is there like a
8 rational kind of explanation for that, that maybe would
9 make it hard for us to do more work to show that we should
10 have lower payments and expect that to happen?

11 MR. O'DONNELL: So there's really two reasons why
12 the first round has not been phased in kind of fully yet.
13 For kind of '18, '19, and '20 the payment reductions were
14 being phased in. There was a congressional floor of 10
15 percent per year. So to the extent that you are above that
16 amount you haven't been fully phased in. So that's kind of
17 one, is that they phased it in for a few years and then
18 they paused it, and that was congressional action.

19 The other one, and it's relatively important for
20 a lot of these tests but it's kind of more technical and
21 weighty, is that when the payment reductions were phased in
22 they actually phased it in starting at an amount that was

1 actually above what was actually being paid. So they
2 phased it in what's called the National Limitation Amount.
3 And so the first year or two of payment reductions were
4 often for certain tests, were kind of no reductions or
5 very, very small reduction.

6 So there was kind of this built-in floor for the
7 three years and then it freezes, and then this weird
8 technical issue, which really kind of nullified the effect
9 of the cuts in the first few years.

10 MS. KELLEY: Josh.

11 DR. LIAO: Thanks. Just a few comments on the
12 global surgical, to maybe address the most common a little
13 bit, on the suggestions made there.

14 I think of it as kind of a payment level and a
15 payment unit, I think I tend to favor keeping the unit as a
16 bundle, because to my knowledge we don't have evidence
17 about what unbundling does to access, continuity, et
18 cetera. And there is that concern about avoiding response
19 in a world where you have a zero-day. So I think that's a
20 judicious way of doing it.

21 I also think to the extent that there are
22 efficiencies from what we're seeing here, I think that's

1 part of the signal, the tension of as you close down the
2 valuation in that bundle you can decrease the incentive for
3 providers to get those efficiencies. So I think keeping
4 that structure makes a lot of sense and phasing in some of
5 the changes.

6 But I do think at the payment level it does make
7 sense, given that difference, given the limited leakage
8 you're describing to revalue. In an ideal world I would
9 revalue with the full work, with all the cool different
10 things that are not billable. At a minimum, though, having
11 billable service I think would be good.

12 And again, just to stress again that I think
13 phasing it in and acknowledging that some of the
14 efficiencies and incentive we want to retain, wherever we
15 leave the bundles, is important. But that would be kind of
16 my preference on that.

17 MS. KELLEY: Scott.

18 DR. SARRAN: Yeah, nice potpourri. So three
19 very, very brief comments and then one slightly longer.

20 The global bundling thing, I agree with Josh. I
21 think keep it as a bundle seems to make sense, and the idea
22 of taking something that we have bundled today and

1 splitting it, it's kind of going in the opposite direction
2 when we're trying to function more holistically and get the
3 system to function more holistically. But it seems logical
4 since sooner or later we make a recommendation to just
5 adjust it as per what the data shows.

6 In terms of incident-to billing, we already have
7 a recommendation, a few years old. I don't know that it
8 needs a lot more work.

9 Clinical labs, as you mentioned, there's already
10 sort of in play to reduce it, so I don't know that it needs
11 a lot more work.

12 The telehealth, I mean, clearly that's an area we
13 want to stay in touch with and on top of, as care becomes
14 more and more virtual, and a mix of virtual and in-person.
15 My only real comment there is when it's close to 50-50 I
16 would err on the side of access and not to heavy
17 regulation, because I think this is an area where there is
18 a lot of care innovation happening. And we don't want to
19 shut that down. We want to promote the ability for
20 providers to find innovative ways of managing, particularly
21 people with chronic diseases that need lots of different
22 touch points over time.

1 MS. KELLEY: Tamara.

2 DR. KONETZKA: Yeah. So I already said my piece
3 on the bundling. I agree with what was just said, as well.
4 Don't destroy the bundle. Just try to pay it
5 appropriately, given technological changes and actual
6 practice.

7 But I wanted to add a comment about the incident-
8 to billing, and just say on the record that I agree with
9 that older recommendation that nurse practitioners and PAs
10 should be able to bill directly. But I'll double down a
11 little bit on what Stacie just suggested, which is, you
12 know, it's not exactly clear where we don't have that yet,
13 and there might be some unintended consequences or things
14 that particular practices see as barriers to that being
15 desirable. So not just the type of patients but the type
16 of practices.

17 Starting with states, we know that some states
18 are a little bit different in their scope of practice
19 rules, et cetera. But you might pick some states and just
20 try to sort of tease out both the types of practices and
21 the types of patients where incident-to billing still seems
22 to happen, even though direct billing is allowed.

1 And similarly, I wouldn't do qualitative
2 interviews probably just for this question, but if there's
3 a way to add it in, or if somebody else has already done
4 that, it would be interesting to find out what practices
5 see as the barriers or the disadvantages to doing that,
6 right. Like there may be legal implications, sort of
7 litigation issues or something that could be involved in
8 that, or it might be an actual payment rate, the 85 percent
9 versus the 100 percent.

10 So it would be great to dig into that a little
11 bit more, but I still support that recommendation. Thanks.

12 MS. KELLEY: Robert.

13 DR. CHERRY: Yes. Thank you for the report.
14 Just brief comments, specifically around telehealth, and
15 especially since Paul asked about Commissioners' interest
16 in perhaps keeping this front and center. I would favor
17 that. Since the program is going to be coming up for
18 potential legislative action at the end of 2027, it's
19 likely Congress may ask us again what our opinion is
20 regarding telehealth and extension of it. So I think it's
21 something we should continue to talk about from time to
22 time.

1 I do remember those conversations being quite
2 challenging. Like for behavioral health it seemed
3 intuitive to kind of continue on with that. But when you
4 start thinking about what are the guardrails around
5 telehealth around specific conditions and specific
6 specialties, it becomes really harder to think through what
7 that looks like.

8 I do agree with Scott that overregulating it
9 might be problematic. I am concerned that if we reduce
10 payments in telehealth, though, that could result in
11 unintended consequences with an increase in in-person
12 visits, putting further pressure on access to care, and a
13 lot of dissatisfaction among patients, as well. But I
14 think it's worth having another conversation.

15 There may be other types of guardrails that are
16 reasonable, such as patients that are undergoing active
17 physical therapy or they have certain disabilities or
18 they're getting home health, and yeah, you should consider
19 telehealth. But I think it's hard to get condition and
20 specialty specific. But definitely would want to continue
21 the conversation. Thank you.

22 MS. KELLEY: Gina.

1 MS. UPCHURCH: Everybody's comments triggered
2 something in me. Talking about telehealth, I would be
3 interested if we know outcomes of telehealth as compared
4 to, you know, if I'm controlling somebody's hypertension
5 over the telephone versus when they come into the clinical.
6 Do we know if the outcomes are different? Is the A1c
7 different? Do we have any outcomes data to help guide that
8 decision. That's the first thing.

9 And the second thing, how much, regarding
10 Stacie's question, especially about some of these
11 telehealth that leads to prescriptions but the person has
12 never met you in person, how much of that has to be linked
13 back to the primary care provider, or is that just sort of
14 off on the side, floating in the ether, or does that
15 information have to go back to the clinician, the primary
16 care provider? Do we know that?

17 MR. O'DONNELL: So it's not clear that all those
18 visits in which you're being prescribed like a GLP-1, you
19 were talking about, are billable under the fee schedule.
20 So basically, under Medicare, if they meet the criteria for
21 the visit, let's say an E&M visit like we're talking about,
22 for telehealth, there's currently no restrictions on

1 whether it has to be a PCP or a specialist or whatever. It
2 is kind of specialty agnostic and they can do what they do
3 during that visit as you normally would kind of in person.

4 MS. UPCHURCH: And there's no necessity to
5 communicate with the PCP?

6 MR. O'DONNELL: Not for billing an E&M service.

7 MS. UPCHURCH: Wow. Okay. That's the first
8 question. The second question is when we're talking about
9 -- and I don't know the answer to this, and this is not
10 making a judgment. It's more of a question, I guess. So
11 if I'm a nurse practitioner or a PA, and I am under working
12 under the license of an MD, and then I start doing direct
13 billing, so I've mainly been doing incident-to but now I'm
14 going to do direct billing, I'm going to get less money, or
15 my practice is going to get less money, am I still working
16 under the license of a provider or am I free agent then?

17 MR. O'DONNELL: So I do just want to be clear
18 that what governs how you practice is no incident-to
19 billing rules. These are all state scope of practice
20 issues.

21 MS. UPCHURCH: Scope of practice, okay.

22 MR. O'DONNELL: And that is a state issue, and

1 the incident-to is an entirely separate thing, where we're
2 just talking about billing the Medicare program.

3 MS. UPCHURCH: Gotcha. Thank you so much for
4 clarifying that. Great work.

5 MS. KELLEY: That's all I have for Round 2,
6 unless someone else wants to hop in.

7 DR. NAVATHE: Great. Thank you. So thanks for
8 the enthusiasm and thoughtful discussion. It sounds like I
9 think, in general, there is particularly enthusiasm to
10 continue the work in telehealth, I think for the reasons
11 that folks have outlined, which I won't repeat here. Thank
12 you for the discussion on the global surgical codes.

13 A couple of things I guess I would clarify. On
14 the telehealth piece, we, at least I think the data that we
15 presented through 2025, end of 2025, showed pretty stable
16 use of telehealth. I think there might be some trends on
17 the commercial side that are different perhaps than what
18 we're seeing on the Medicare side.

19 And otherwise, the other piece is, I think, we do
20 have the two recommendations that are already standing for
21 the global surgical codes, so the discussion is still
22 helpful for us, and I'm very happy to have your input. And

1 we'll continue to track and monitor on the incident-to
2 side. I think that sounded also like something that folks
3 are pretty interested in.

4 So with that I think we will -- Paul?

5 DR. CASALE: Sorry. I was going to jump in but
6 no, no, no. I just wanted to say that telehealth is also,
7 I think, a priority that I would raise. And I guess on the
8 global billing, maybe on the bundles, does that have to go
9 back to the rec then to reevaluate? Is that the process?
10 I mean, we could kind of have a recommendation that these
11 should be reevaluated, but is that --

12 MR. O'DONNELL: So right, obviously the Congress
13 has the authority to change the rules. Under the current
14 process, if you wanted to go -- codes do go from 10-day
15 codes, for example, to zero-day codes. That happened just
16 this past year, where the RUC kind of reviewed evidence
17 from the OIG and said they transitioned the code from 10 to
18 zero. And that typically, under the current process, goes
19 to the RUC to revalue the codes for going from a 10- to a
20 zero-day or reviewing the number of visits. That does tend
21 to go to the RUC and then reviewed, obviously, by CMS.

22 DR. NAVATHE: Great. Okay. So we will close

1 session here and then we will start with our clinician
2 quality initiatives in fee-for-service Medicare at 3:25.

3 [Recess.]

4 DR. NAVATHE: All right. Now we will start our
5 presentation and discussion on clinician quality
6 initiatives in fee-for-service Medicare, and I will turn it
7 over to Ledia.

8 MS. TABOR: Good afternoon. For the virtual
9 audience, you can download the presentation from the
10 control panel on the right-hand side of your screen.

11 Today we will review current clinician quality
12 incentives in fee-for-service Medicare for your discussion.
13 We would like to thank Allison Kim for her work on some of
14 this analysis.

15 First, we will provide some background on quality
16 measurement. We will then review experience with the MIPS
17 program over the years, including discussion of some of the
18 concerns the Commission first identified in 2018. Then we
19 review literature on incentivizing clinician quality.
20 Finally, we would like the Commissioners' feedback on the
21 material and direction for future work.

22 MedPAC has weighed in publicly on the role of

1 quality measurement in the Medicare program. The
2 Commission supports Medicare's measurement of the quality
3 of care furnished by providers to Medicare beneficiaries
4 for the purposes of monitoring performance, informing
5 patients and payers to support decision-making, and
6 encouraging the provision of high-quality care across the
7 program.

8 In the June 2018 report, we published principles
9 to first address the proliferation of measures, many of
10 which are burdensome and not tied to clinical outcomes in
11 Medicare quality programs; and second, create incentives
12 for accountable entities, including providers, ACOs, and MA
13 plans, to offer high-quality care to beneficiaries. The
14 Commission has used these principles to recommend
15 redesigned quality payers and quality payment programs,
16 including for clinicians.

17 Now to focus on clinician quality payment
18 programs in fee-for-service Medicare. The Medicare Access
19 and CHIP Reauthorization Act of 2015, or MACRA, created two
20 new policies, an incentive payment for qualifying
21 participants in A-APMs and MIPS for those not participating
22 in an A-APM. Launched in 2017, CMS refers to these

1 programs collectively as the Quality Payment Program.

2 For APMs, participating entities assume financial
3 risk for their patients with payment based on meeting
4 quality standards, and they can receive payment incentives
5 for participating in the A-APM.

6 Clinicians not participating in an A-APM are
7 subject to additional reporting and payment requirements
8 through the pay-for-performance program called MIPS. MIPS
9 is intended to increase payment for high-value clinicians
10 or reduce payment for low-value clinicians.

11 Clinicians in A-APMs are not part of a
12 traditional pay-for-performance program. However, the A-
13 APM entities they are a part of are held accountable to
14 quality performance standards. CMS estimates that about
15 half of clinicians now participate in A-APMs with the vast
16 majority in MSSP ACOs.

17 CMS measures quality for all MSSP ACOs using
18 eight quality measures. ACOs that meet or exceed CMS's
19 quality performance standards receive their maximum shared
20 savings rate and reduce their shared losses if they are in
21 an arrangement with the highest risk. Because an ACO's
22 clinician participants change annually, it is difficult to

1 discern the extent to which MSSP ACOs improve quality
2 outcome, although studies suggest that APMs do not harm
3 care quality and in some cases can improve care quality.

4 We'll now review MIPS with a focus on the
5 Commission's concerns with MIPS and experience to date with
6 the program.

7 In general, MIPS is a system that calculates
8 individual clinician-level or group-level payment
9 adjustments based on four areas: quality, improvement
10 activities, promoting interoperability, and cost.

11 In MIPS, CMS assesses clinician performance for
12 the first three MIPS categories, mainly using measures that
13 clinicians themselves choose to report. Cost measures are
14 calculated by CMS. Performance scores are then used to
15 adjust Medicare Part B payments two years later.

16 In the March 2018 report to the Congress, MedPAC
17 described MIPS design's flaws and recommended that the
18 Congress eliminate MIPS as soon as possible

19 Flaws in the design include that it is
20 burdensome and complex, quality and payment adjustments are
21 determined at individual clinician levels, many clinicians
22 are not evaluated because they do not have a sufficient

1 number of cases, clinicians are evaluated and compared on
2 dissimilar measures, and because of self-chosen measures
3 and low-performance thresholds, most clinicians receive a
4 small, positive payment adjustment.

5 We also recommended creating a new value
6 component to take MIPS place. This was a conceptual
7 direction and not a detailed design.

8 Years into the implementation of MIPS, the
9 Commission's concerns with MIPS remain relevant, and we
10 will review some of those now.

11 Clinicians and practice leaders have reported to
12 researchers that there are substantial administrative
13 burdens and costs to practices for MIPS participation and
14 reporting. The practice costs to participate in MIPS
15 include clinician and staff time to check MIPS eligibility,
16 select a reporting track, collect performance data over the
17 calendar year, and submit it to CMS by March 31st of the
18 following year.

19 Another MIPS-related cost for practices is that
20 they often work with technology vendors and consultants to
21 collect data to meet MIPS reporting requirements, as well
22 as determine what reporting options and measures will

1 optimize their MIPS payment adjustments.

2 MIPS participants can collect and submit data to
3 CMS through different participation options. These options
4 indicate who is represented by the data being submitted, an
5 individual clinician, a subset of clinicians in a group
6 practice, all clinicians in a group practice, clinicians in
7 several small practices that have formed a virtual group,
8 or all of the clinicians in an APM entity.

9 In 2018, the Commission was concerned about
10 calculating performance measures at the individual
11 clinician level. But today, the vast majority of MIPS-
12 eligible clinicians in the 2024 performance year were
13 scored at the group level, 71 percent, or as an APM entity,
14 20 percent.

15 Clinicians being scored as groups is consistent
16 with the trend toward clinicians working in larger group
17 practices. Clinicians reporting as a group also help to
18 overcome a perennial issue in quality measurement for
19 clinician services, the challenge of small number of cases,
20 which can make results at the individual clinician level
21 unreliable.

22 Some clinicians are ineligible for MIPS or choose

1 not to report. Over the years, the estimate of Part B
2 billing clinicians who are exempt from MIPS has declined.
3 CMS estimates that 11 percent of Medicare billing
4 clinicians will be exempt from MIPS payments year 2029,
5 which is lower than the 50 percent they estimated in 2016.

6 The decrease is mainly due to two things; first,
7 a decline in the number of clinicians who are MIPS-
8 eligible, as more are participating in the APMs. And
9 second, among MIPS-eligible clinicians, more are reporting
10 as part of a group.

11 MIPS-eligible clinicians who do not submit data
12 still receive a MIPS payment adjustment. CMS reported that
13 6 percent of MIPS-eligible clinicians did not report in
14 2024. About two-thirds of these clinicians received a
15 neutral payment adjustment. Their score is based mainly on
16 the cost category.

17 As the Commission noted, MIPS will be inequitable
18 because clinicians will be evaluated and compared on
19 dissimilar measures. While this design allows participants
20 flexibility in determining which measures are most
21 meaningful and relevant to their practice, it also allows
22 clinicians the freedom to select measures on which they

1 perform best. The information is also unlikely to be
2 meaningful for beneficiaries to use in decision-making.

3 As demonstrated in this table, experience shows
4 that clinicians have the choice of hundreds of measures in
5 some categories. For example, the MIPS quality category
6 includes 764 measures to choose from. The table also shows
7 that median scores are very high, with the program design
8 of self-chosen measures in attestation-based measures
9 likely contributing.

10 Despite the significant efforts in reporting and
11 the resulting complexity of CMS calculation of MIPS scores,
12 most clinicians receive small positive MIPS payment
13 adjustments, which may provide a weaker or ineffective
14 incentive to improve quality.

15 In 2024, the median MIPS payment adjustment was
16 0.5 percent. This result is attributed to the fact that so
17 many clinicians score above the performance threshold,
18 combined with the requirement that projected positive
19 adjustments be offset by projected negative adjustments,
20 which by law are capped at 9 percent. Most clinicians
21 score above the performance threshold in part because they
22 can choose the measures on which they are scored, but also

1 because CMS has set the performance threshold well below
2 the median score.

3 Some researchers have also argued that MIPS is
4 inequitable because there are systematic differences in
5 performance across categories of clinician groups.

6 Low MIPS performers were more likely to be
7 safety-net providers. Positive MIPS performance was
8 associated with practices located in urban areas and with
9 larger patient populations and communities with higher
10 education level and health care spending. Findings suggest
11 that high MIPS scores may reflect the ability of physicians
12 to collect, analyze, and report data.

13 Clinicians caring for vulnerable populations are
14 more likely to be penalized by MIPS scoring, even when
15 delivering relatively high-quality care.

16 To ease clinician reporting burden, better
17 promote comparison of clinicians' performance to others
18 within their society, and ultimately reduce opportunities
19 for clinicians to strategically select measures to maximize
20 MIPS scores, CMS established an option for clinicians to
21 report MIPS Value Pathways, or MVPs, starting with the 2023
22 performance period. Each MVP includes a subset of measures

1 and activities related to a given specialty or medical
2 condition. For payment year 2028, there are 27 MVPs
3 available.

4 Looking at the bar chart on the left-hand side of
5 the slide, about 17 percent of MIPS-eligible clinicians
6 registered to potentially report an MVP in 2024. However,
7 actual reporting of MVP measure sets was optional, and
8 fewer than half of registered clinicians reported MVP
9 measures in that year.

10 Among these clinicians, most also reported
11 traditional MIPS. If a clinician's traditional MIPS score
12 was higher, CMS used that instead to score and determine
13 their MIPS payment adjustment. Thus, only a third of
14 clinicians who reported MVPs were ultimately scored on that
15 measure set for both years in 2023 and 2024.

16 CMS has proposed making MVPs mandatory in 2029
17 and sunseting the traditional MIPS program at that time,
18 but the final timing of these requirements will be made in
19 future rulemaking.

20 In summary, experience to date shows that many of
21 the MIPS flaws we identified in 2018 continue. Experience
22 to date shows that clinicians report that MIPS reporting

1 requirements are burdensome. MIPS reporting and scoring
2 requirements are complex, and some of that complexity is
3 described more in your meeting materials.

4 As the number of clinicians joining A-APMs and
5 larger groups, the vast majority of MIPS-eligible
6 clinicians are now scored as a group or APM entity.

7 An estimated 11 percent of clinicians are
8 ineligible for MIPS, and 6 percent of MIPS-eligible
9 clinicians do not report.

10 Clinicians choose from hundreds of measures, and
11 scores are high. Most clinicians receive relatively small
12 positive MIPS payment adjustments.

13 And I'll now turn it over to Katelyn.

14 DR. SMALLEY: Thanks, Ledia.

15 On that note, we're going to zoom out now and
16 talk about larger challenges with quality incentive
17 programs, bringing in evidence from the literature.

18 First, a reminder that while quality measurement
19 is an important step in improving care, there are some
20 inherent challenges to measuring clinician quality. Some
21 aspects of clinical care, such as teamwork, bedside manner,
22 diagnostic accuracy, and clinical judgment are difficult or

1 impossible to measure or quantify. Quality is also hard to
2 measure accurately. For example, small providers may see
3 only a limited number of cases for certain conditions,
4 which can produce unreliable results with high statistical
5 noise.

6 Risk adjustment is also imperfect, which makes
7 comparing providers with different patient mixes
8 challenging, and many providers perform similarly on some
9 quality measures, so performance differences are hard to
10 detect.

11 Beyond measuring quality, there are additional
12 challenges with paying for clinician performance. First,
13 it is difficult to assign incentives for performance-based
14 payment. Outcomes are the product of the work of multiple
15 individuals, including the patient, and external factors,
16 including non-health care-related circumstances. The time
17 lag between when care is provided and an incentive payment
18 is given may reduce the salience of the incentives.

19 There are also opportunity costs to choosing to
20 focus on aspects of care tied to performance incentives
21 over other aspects of care.

22 Payment incentives may introduce unintended

1 consequences, and the complexity of reporting and scoring
2 requires providers to invest in additional resources, such
3 as third-party consultants and technology, adding
4 administrative costs to these initiatives.

5 The literature on pay-for-performance, or P4P, is
6 extensive. We identified 12 systematic reviews of P4P
7 programs. Included studies ranged in scope for national
8 initiatives to local demonstrations, including some
9 Medicare quality incentive programs. We focused on studies
10 of clinicians.

11 The consensus across these reviews was that the
12 effects of clinician P4P on quality measures were small, if
13 extant. Studies consistently found that effects were more
14 likely to be observed for process measures than outcome
15 measures, and several reviews observed that higher-quality
16 studies, such as quasi-experiments and randomized
17 controlled trials, were more likely to find no impact of
18 P4P programs on a range of quality measures.

19 The factors associated with MIPS performance that
20 Ledia described earlier are echoed in the wider literature
21 and suggest that the effects of P4P may be sensitive to
22 program design and implementation.

1 There's some evidence that performance may be
2 associated with implementation processes, such as
3 communication and rollout and engagement of clinicians in
4 program development, the size of incentives, and
5 organizational and socioeconomic characteristics.

6 Performance also seems to be sensitive to the
7 choice of metrics. For example, clinicians have reported
8 that measures focused on quality and patient experience are
9 more motivating than those focused on efficiency or
10 reducing costs.

11 And measures with a clearer dose-response
12 relationship between activity and outcome, meaning changing
13 a behavior more reliably results in a different outcome,
14 are also associated with higher performance.

15 Studies have also demonstrated the potential
16 unintended consequences of paying for the performance of
17 clinicians. For example, financial incentives may
18 encourage detrimental behaviors, such as selective data
19 reporting, over-focusing on the measures being scored, and
20 favorably selecting patients.

21 Setting targets relative to group performance may
22 lead to rewards occurring to high performers who are

1 already well-resourced.

2 And clinicians have reported in qualitative
3 studies that while incentives can support internal
4 motivation to provide high-quality care, they can also
5 interfere with clinical judgment and a sense of autonomy
6 and create tension within teams.

7 As Ledia mentioned before, the administrative
8 burdens of MIPS and other P4P programs can be substantial
9 in terms of both time and other resources.

10 Survey data has indicated that physicians and
11 their staff spend substantial time on activities related to
12 quality reporting, about 2 and a half hours per week for
13 physicians and 12 and a half hours per week for other
14 health care staff.

15 Case studies of health systems have concluded
16 that participation in quality incentive programs, including
17 Medicare quality programs, generates millions in
18 administrative costs, a substantial portion of which goes
19 to third-party vendors.

20 And CMS itself has spent over a billion dollars
21 in measure development costs over a decade.

22 A broader view of P4P programs thus raises

1 questions about the trade-offs between the small, if
2 detectable, improvements to quality that these programs may
3 generate relative to their costs in terms of administrative
4 burden, unintended consequences, and Medicare spending.

5 While some research has identified implementation
6 factors that are associated with a higher likelihood of
7 positive outcomes, these are often organization-level
8 factors such as staffing, resource allocation, and culture
9 that Medicare has little influence over.

10 In summary, the majority of clinicians are being
11 scored as a group in MIPS, which obviates one of the
12 concerns that the Commission had in 2018. However, many of
13 the flaws that the Commission foresaw with MIPS persist.

14 The program is burdensome and complex. Some
15 clinicians are ineligible for MIPS or choose not to report.
16 Clinicians still choose from hundreds of measures, and
17 scores are high. And most clinicians receive relatively
18 small positive MIPS payment adjustments.

19 Experience to date also shows that MIPS may not
20 be equitable because performance varies across categories
21 of clinicians, including those caring for vulnerable
22 populations.

1 MVPs have potential to improve the ability to
2 compare clinicians, especially within the same specialty,
3 but it's voluntary, so it's rarely used.

4 The Commission's historic concerns with MIPS are
5 compounded by some challenges that are inherent to
6 measuring and paying for quality. The consensus across
7 systematic reviews of clinician P4P finds effects on
8 quality measures were small, if there at all, and better
9 quality studies are more likely to demonstrate no effect.

10 The effects of P4P may be sensitive to program
11 design and implementation, and the potential positive
12 impacts of P4P must be balanced with the potential
13 unintended consequences and administrative burden
14 associated with paying for the performance of clinicians.

15 We plan to return in March with additional
16 information on MIPS and quality incentive programs.
17 Potential analytic work that we could pursue include
18 further analysis of MIPS participation and performance
19 data; for example, comparing performance across individual
20 level and group level reporting, analyzing which quality
21 measures and collection types are being scored, the
22 distribution of performance across measures and changes

1 over time, and characteristics of clinicians reporting
2 MVPs.

3 We also plan to conduct stakeholder interviews
4 about experiences with MIPS, including benefits and
5 challenges of the program. We would aim to include health
6 systems as well as smaller providers, both rural and urban,
7 in these interviews. We could also investigate experiences
8 with performance incentives in other sectors.

9 Today, we'd ask for Commissioners to discuss the
10 following questions: What value is the Medicare program
11 and its beneficiaries getting from current clinician
12 quality incentive programs? Do the benefits outweigh the
13 costs? How can the Medicare program balance quality
14 measurement with administrative burden and costs,
15 reliability of data, and benefits to beneficiaries? What
16 types of approaches will be practical, feasible, and
17 improve beneficiary care?

18 We also look forward to your questions and
19 feedback on our potential analytic plan.

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

21 Thanks.

22 DR. NAVATHE: Thank you, Ledia and Katelyn. A

1 fantastic job, I think not only covering an update on the
2 MIPS program, but also, that is a vast literature that you
3 have summarized, I think, exceptionally well. So thank you
4 for that.

5 So before we turn it over to the queue, I just
6 wanted to remind you folks, we're not seeking
7 recommendations in this cycle around this work. But that's
8 not at all to take away from its importance. So, in
9 addition to the questions that we have on the screen in
10 front of you, I think we're here really interested in your
11 feedback around potential directions on this work, and that
12 includes obviously your analytic suggestions, but also
13 potentially more than that. And I'm looking forward to the
14 discussion. I'm expecting that it will be spirited, and I
15 also note that I think several of the Commissioners here
16 have actually contributed to the literature that Katelyn so
17 nicely reviewed. So we'll have a very informed discussion,
18 I think.

19 Dana, we'll turn it over to you.

20 MS. KELLEY: Gina, you're first.

21 MS. UPCHURCH: Yeah, thank you so much for this
22 work. Very, very interesting.

1 I think you have a nice balance of how much is
2 it costing us to do this work and then what is the benefit
3 of doing the work and how do we manage the trade-offs.

4 You know, I'm reminded of saying that it's hard
5 to measure what you prevent, and I think a lot of
6 medicine, especially primary care or whatever, it really is
7 about prevention. And that's hard to measure. So I think
8 that's one of the challenges that we face with this.

9 Also, the other thing, what matters most is often
10 very difficult to measure, right? So I think there's two
11 challenges, but you all laid it out really well.

12 My question is -- and you mentioned this at one
13 point. For any sort of pay for performance, whether you're
14 talking MIPS or A-APM models, are there any guardrails
15 around how that money can be used or is it -- you know, if
16 it goes to an ACO or if it goes to more of the health
17 system, working with providers or -- I know it can go
18 towards quality improvement. It can go to -- I'm assuming
19 gets passed through to physician payments. I mean, are
20 there any guardrails for where that money should go?

21 MS. TABOR: There are not --

22 MS. UPCHURCH: Okay.

1 MS. TABOR: -- for either program.

2 I know at one point, it could still be that for
3 A-APMs, for ACOs in particular, they had to report out how
4 they were using the money. So, at one point, it could
5 still be a requirement, but for MIPS, it just is a payment
6 adjustment to be used at the clinician health systems.

7 MS. UPCHURCH: Thank you so much.

8 MS. KELLEY: Cheryl.

9 DR. DAMBERG: This is terrific work, and I just
10 want to echo what Amol said, that this is kind of a vast
11 literature, and you guys did a really nice job summarizing
12 it.

13 So, Ledia, I just want to make sure that I'm
14 accurately understanding something you said. So this
15 statement that's in the chapter about an individual
16 physician facing 700 possible measures, I just want to make
17 sure. Like, that's not any single specialty. Like,
18 primary care doesn't face 700, but a health system that's
19 measuring across many different specialties might face 700
20 to choose from. So just I'm trying to understand the
21 context of that sentence.

22 MS. TABOR: Yeah, that's a helpful distinction.

1 So across the MIPS program, clinicians can choose
2 from 764 measures. To your point, not all 764 measures are
3 going to apply to one specialty or one type of particular
4 clinician.

5 DR. DAMBERG: Yeah, I think I might rephrase that
6 just to make it align more with a particular physician's
7 reality. So it may be that in primary care, they have -- I
8 don't know -- 75 measures to choose from, but say a
9 cardiologist might only have three, right?

10 MS. TABOR: Yeah.

11 DR. DAMBERG: And that's been one of the problems
12 of that program, is a shortage of measures for certain
13 subspecialties.

14 MS. TABOR: Yeah. And that's a good point.

15 So one thing we can do, to try to do coming back
16 in March is trying to better categorize like what
17 specialties are covered and not covered and what the kind
18 of 764 breakout looks like.

19 MS. KELLEY: Stacie.

20 DR. DUSETZINA: Take me out of R1.

21 MS. KELLEY: Then we can go to Round 2, Amol.

22 All right. I have Kenny first.

1 MR. KAN: I'm wildly enthusiastic about this
2 chapter. Ledia and Katelyn, there are three numbers that
3 jump out to the actuary in me: 764, 95, and 0.5 percent.
4 764 measures -- that's too much. 95 -- for a new physician
5 who wants to sit for instructions on how to participate in
6 MPS for the '26 performance year, you have to read through
7 95 manuals? That's like going through an MPH program. And
8 0.5 percent, in all this work for a 0.5 percent bonus
9 payout? It's surreal.

10 Where am I leading with all this? Overall I
11 believe that Medicare should measure fewer things, report
12 reliable comparisons, and pay for demonstrated value. MIPS
13 fails that test. A-APM quality payments offer questionable
14 incremental value.

15 Elaborating further, regarding the three quality
16 measurements, reporting and payment roles for former
17 Medicare, I suggest the following: measurement. Measure
18 what matters. Use significantly fewer common measures of
19 outcomes, perhaps 1 to 2 percent of the 764. Patient
20 experience -- avoidable utilization and value, primarily
21 from CMS readily available claims and electronic data.

22 Number two, reporting. Report credible

1 comparisons. We should measure primarily at the practice,
2 ACO, or accountable entity level. Individual clinician
3 scores are just not actually credible, and the fact that
4 clinicians can select what they want to be measured on
5 further undermines comparability.

6 Third, pay for results. To Gina's point, retain
7 a simple quality guardrail against poor care. Additional
8 incentives should demonstrate clinically meaningful
9 improvement that justifies their cost and burden.

10 So on the question of whether benefits justify
11 the cost of MIPS, I believe the answer is no, the benefits
12 do not justify the burden. Too many measures, weak
13 comparability, and small payments. The juice is not worth
14 the squeeze.

15 A-APMs, I believe the answer is questionable, at
16 best. The evidence supports savings without broad quality
17 deterioration more strongly than improvement caused by
18 separate quality incentives. With 94 percent of MSSP ACOs
19 meeting the standard, quality functions mainly at the
20 safety floor. If we make any changes we should question
21 whether participation incentives and quality payment
22 infrastructure adds sufficient value.

1 As an additional follow-up, armed with first
2 principles, I recommend that staff evaluate the feasibility
3 of a unified quality framework across traditional fee-for-
4 service, ACOs, and MA. Let's have a simpler quality
5 system, with fewer measures, based on common outcomes,
6 comparable performance, lower administrative burden, and
7 payment tied to demonstrated value. Thank you.

8 MS. KELLEY: Cheryl.

9 DR. DAMBERG: Okay. So I think overall you've
10 covered the core issues very well, so we appreciate that.
11 But I guess for context, I mean, over the past three
12 decades the quality measurement enterprise really emerged,
13 and it's continued to expand, and it continues to expand,
14 but it really isn't achieving what it was designed to
15 accomplish.

16 And I think in a broader space, quality
17 measurement needs a rethink and reform, and this is
18 particularly true in the Medicare program, because while
19 the commercial sector was sort of first in the pay-for-
20 performance space, Medicare adopted pay-for-performance
21 pretty much wholesale.

22 And this need for a rethink and reform is

1 especially true for MIPS. You know, you pointed out that
2 MIPS is a seriously flawed quality measurement and
3 incentive program that consumes a lot of attention and
4 resources on the part of physicians and organizations,
5 without commensurate improvement and quality performance
6 and quality of care.

7 And as you pointed out in the chapter, given the
8 low performance thresholds and the ability to cherry-pick
9 the measures that have provided reports on, it rewards most
10 providers with very small performance bonuses. But sort of
11 on the opposite side, those small bonuses are being
12 financed by a decrease in funding to the very practices
13 that need incentive dollars or funding to try to improve
14 their performance.

15 And so given that the practices that are sitting
16 out MIPS are solo or small practices, it just reinforces
17 the fact that MIPS didn't accomplish what it was intended
18 to do, which is to drive performance improvement across all
19 providers that serve Medicare.

20 And, you know, at the point at which MACRA came
21 into existence, large organizations were already engaged in
22 quality measurement, and it was really these smaller

1 practices that needed to be brought to the table, and the
2 design of MIPS really did not enable that.

3 As you point out, the information generated by
4 MIPS is not helpful to consumers for making any kinds of
5 choices or decisions. You also spotlight that the cost of
6 quality measurement and reporting are not trivial for
7 providers or the federal government. The federal
8 government has invested huge resources in this space, both
9 to create measures, manage those measures, and then manage
10 these programs.

11 But I would say that, in context, we need to
12 remind ourselves that despite the fact that it looks like a
13 lot of resources are being brought to bear here, quality
14 measurement and performance improvement is still a small
15 share of overall health care spending, and that could
16 potentially, at least on the quality improvement side, be
17 part of the reason we're not seeing any effects, or small
18 effects.

19 We know the design of the program is complex and
20 burdensome, and I think we've seen some signals that it's
21 helping to drive consolidation, so that's definitely a
22 downside.

1 You spotlighted that one of the key issues with
2 the program is having noncomparable measures, and clearly
3 the design of pay-for-performance programs should not let
4 providers choose measures they will report. And this
5 creates problems not only comparing across physicians but,
6 you know, when you set the program up that way you only see
7 a portion of the performance distribution, meaning you only
8 see the high performers. So anybody who is benchmarking
9 against it is not going to get an accurate read on what the
10 performance distribution is.

11 So as I kind of stepped back and thought about
12 what you wrote in the chapter, I mean, obviously this is a
13 poorly designed program and it needs to be eliminated and
14 rethought. And I'm not convinced that further analytic
15 work is necessary. You know, we have more than a decade of
16 evidence looking more broadly at pay-for-performance and
17 the design of these programs.

18 I do want to make sure, and I think the
19 Commission continues to reinforce this, that there remains
20 a need for public accountability and a focus on quality
21 within the Medicare program. And I do fundamentally
22 believe, and having done numerous interviews over more than

1 two decades with providers, that paying for reporting and
2 performance and public accountability generates focus
3 within these provider organizations and allows resources to
4 be brought to bear on the problem.

5 So I'm in favor of quality measurement, that it
6 should continue, but it requires a revised set of measures
7 that are required across all providers.

8 Ideally, you know, there's this tension out there
9 about sort of focusing on a narrow set versus a broader set
10 of measures. The advantage of a broad set of measures is
11 that it helps prevent teaching to the test. But ideally,
12 the measures that would be selected in the future would be
13 those that raise all boats for quality within an
14 organization, so a broader in their kind of conceptual
15 foundation, and don't just sort of target one individual
16 area.

17 And I think as Kenny was trying to spotlight with
18 meaningful measures, they need to be high impact areas, so
19 having a relationship to improving a patient's outcome or
20 functioning.

21 And I also think, as CMS rethinks its quality
22 measurement enterprise and investments, they shouldn't

1 settle for what I call easy, low-value measures that can be
2 constructed from claims. And I think what we're starting
3 to see, and particularly I think artificial intelligence is
4 going to change the dynamic around performance measurement,
5 we already see vendors who are able to extract clinical
6 information from electronic health records. So that may
7 bring down the costs of data abstraction.

8 The other thing that I've seen across all these
9 programs, and I think MIPS is no exception, is that CMS is
10 really slow to retire topped-out measures, and that process
11 really needs to be rethought. So oftentimes what you see
12 is high performance on measures, you know, the distribution
13 gets very tight and providers are now spending resources
14 chasing the tail, which is not good for anybody.

15 One of the statements in the chapter was about
16 that larger incentives were associated with larger
17 improvements, and I would urge caution for two reasons.
18 One is that as incentives grow too large they create
19 distortions and gaming to achieve the dollars, and we see
20 this in spades in the Star ratings for Medicare Advantage.

21 I think overall the evidence is weak on what size
22 of incentive is right to motivate behavior change. You

1 know, clearly within MIPS the incentives currently are too
2 small for many providers, but they are very large for
3 others. So I think that requires rethought.

4 Obviously I'm supportive of simplification. And
5 you had pointed out some of the design factors that are
6 important, and I think that is absolutely true. And one of
7 the things that I'm observing in the state of California is
8 that all of the different payers are starting to align
9 behind a core measure set, to try to bring that alignment
10 and focus for providers, whether that's Medicare, Medicaid,
11 or commercial.

12 And I just have a few more. Clearly Medicare
13 should be measuring at the individual physician level, so
14 there needs to be greater levels of aggregation, whether
15 it's across the group or composite measures that compile a
16 set of performance indicators for any given individual to
17 try to get a stronger signal.

18 And then I would say, lastly, the performance
19 measures thresholds have been set way too low. That
20 doesn't seem right. It's a really low bar. And if you've
21 got 94 percent meeting the quality performance standards,
22 where's the differentiation?

1 So thank you.

2 MS. KELLEY: Tom.

3 DR. DILLER: I greatly appreciate the
4 Commission's willingness to take up the topic on quality,
5 and I think you guys have just done a fabulous of putting
6 this chapter together. I'm very appreciate of it and the
7 information that was provided.

8 I believe the United States health care delivery
9 system is being held back by inadequate and poorly designed
10 quality programs. Unfortunately, the basis of this, I
11 believe, rests with this very poorly designed CMS quality
12 program, which is then replicated in the Medicare Advantage
13 program, the Medicaid programs, commercial insurance
14 programs, and even in employed physician and other
15 clinician bonus and incentive programs. Thus, the effects
16 of this poor CMS quality program design are magnified
17 throughout the health care delivery system.

18 I strongly agree with the thesis that the MIPS
19 program, and numerous other CMS quality programs, need to
20 be redesigned. However, I do not believe that they can be
21 tweaked, but rather they need to be dissolved and replaced
22 with a very thoughtful and innovative approach designed to

1 drive specific quality and cost goals for the Medicare
2 program and for the U.S. health care delivery system.

3 A dilemma, as I've been listening here, is the
4 complexity of the issue and the differences of opinion. So
5 I found myself agreeing with much of what Kenny and Cheryl
6 had said, but also disagreeing, very specifically, with
7 some of those things. And that, I think, is going to be a
8 dilemma in how do we craft a new program or how do we make
9 those recommendations.

10 To answer the questions posed by the staff for
11 the upcoming chapter, I believe CMS has an essential role
12 in measuring and reporting quality. I think it would be a
13 huge misstep for CMS not to have quality incentive
14 programs, but unfortunately, as was well outlined, those
15 current programs have largely failed. Consumers need this
16 information, and improvements in care delivery and health
17 outcomes will occur only when the program provides
18 appropriate measurement and incentives.

19 I'm relatively agnostic to whether programs
20 incentivize individual physicians versus group. There is a
21 reason for that. What is important is that individual
22 physicians have accountability for their practice and their

1 performance, and that accountability can be either to CMS
2 or to their group practice, depending on how things are
3 structured.

4 One issue that was not discussed in the chapter
5 to a great length is the suboptimal quality performance of
6 the current health care system in the United States. We
7 know from things such as the Dartmouth Atlas and other
8 studies of incredible unwarranted variation that occur. I
9 believe this variation in quality is a substantial driver
10 of excess utilization and cost of care that is plaguing our
11 system.

12 My day job or responsibilities are medical
13 management of a large provider-owned clinical integration
14 network. Our internal data, or where we're measuring
15 physicians on a variety of different measures, shows, at
16 times, a tenfold variation from clinician to clinician.
17 That is, some are performing ten times better than the
18 others.

19 I would agree that the incentive programs are
20 largely not changed with this improvement, as what we've
21 also found, or believe we've found, is that the
22 improvements in quality have been because we've put

1 infrastructure behind that as opposed to the incentive
2 program.

3 The chapter does a very good job of outlining
4 many of the flaws. I'm not going to reiterate those other
5 than to highlight two additional issues that I think are
6 playing into this.

7 First, providers can win in current CMS value-
8 based arrangements by doing three things. Number one, they
9 maximize documentation and coding to ensure their
10 population appears to be sicker or more ill. Secondly,
11 they rigorously close care gaps that drive their
12 incentives, and that's where one of the disagreements that
13 I would have with Kenny, for example, is I think we need to
14 measure broader numbers of things to get rid of this care
15 gap closure chase that we've got. And then, finally, they
16 will cherry-pick populations to maximize the positive
17 benefits of those programs.

18 The second issue is the current political desire
19 to allow any willing provider in the Medicare program, and
20 I think that's a significantly flawed issue. As previously
21 I noted, there is wide variation in the actual performances
22 of physicians, and some are just not cut out for value-

1 based care. This concept allows persistently low-
2 performing physicians to avoid accountability, which I
3 think needs to be part of the program.

4 In order to craft adequate programs I believe
5 it's essential to outline exactly what we are trying to
6 accomplish. In my opinion, the goals for the CMS program
7 should be the follows:

8 Number one, strongly encourage the clinical care
9 provided to beneficiaries to optimally mirror evidence-
10 based clinical guidelines. Further, the care provided
11 should be measured across a broad set of metrics and
12 clinical situations to understand how physicians and their
13 practice groups are actually practicing.

14 Second, focus on improving both process and
15 outcome quality measures as well as appropriate utilization
16 and total cost of care.

17 Third, create a mechanism for beneficiaries to
18 fairly, easily, and effectively evaluate their care and
19 their provider, and that is nonexistent at this point.

20 Fourth, provide financial support for these
21 quality improvement efforts. This can't be done in a
22 vacuum.

1 Fifth, optimize physician and practice
2 accountability by rewarding physicians who perform better,
3 and create significant penalties for those who fail to
4 improve over time.

5 And finally, encourage physicians to participate
6 in alternative payment models.

7 I would strongly encourage us to think about a
8 couple of other items. We should move away from individual
9 metrics toward a series of practice activity and disease-
10 based standards based on evidence-based guidelines. From
11 these we can craft measures from claims and pharmacy data,
12 and I completely agree with the use of AI eventually,
13 getting this information from electronic medical records.
14 This would provide CMS and beneficiaries with a broad
15 understanding of the performance of physician practices and
16 avoid the potential for gaming of the quality programs.

17 CMS quality programs should be mandatory with
18 significant penalties and/or the removal from the CMS
19 program for physicians who perform poorly over an extended
20 period of time or opt to not participate. Inadequate
21 funding of the program with significant increases in rates
22 for higher performers and penalties for low performers is

1 essential.

2 Once again, I want to thank the staff. Great
3 job.

4 MS. KELLEY: Brian.

5 DR. MILLER: Okay. A fun topic. Three starter
6 points. One, physician quality payment is Lake Wobegon.
7 In 2024, 88 percent of physicians received a positive
8 adjustment. That's right, 0.5 percent median pay. That's
9 clearly suggests we're not doing something right.

10 764 measures, even if they're not all for every
11 specific specialty, highlight the fact that MIPS is a jobs
12 program for the quality industrial complex.

13 APMs also not looking so great. We had a 5
14 percent participation trophy bonus, now 1.9 percent. And
15 not great outcomes for the last 15 years of expanding to
16 all of Medicare.

17 Hospital quality measurement, equally absurd. A
18 study from some colleagues actually at the Johns Hopkins
19 Hospital suggested that the hospital had to report 162
20 individual quality measurements in a year. Obviously, I'm
21 mentioning their study and my views represent my own and
22 not those of Hopkins.

1 Other quality measurement programs in hospital
2 world, like the Hospital Readmissions Reduction Program,
3 have reasonable evidence of increasing mortality for some
4 conditions, so that's pretty bad.

5 MA is an equal criminal in terms of poor quality
6 measurement. The Quality Bonus Program is tied to a litany
7 of quality measurements, and large health plans are
8 spending billions on reporting and getting billions back.

9 So to summarize, MIPS is Lake Wobegon, APMs
10 function mostly as a participation trophy on the finance
11 side for the programs, and then MA QBP is sort of like Las
12 Vegas gain sharing. This is not great.

13 We know from the U.K. pay-for-performance
14 experiments that microtargeting clinicians doesn't work.

15 So what do we do from here? My research team did
16 a crosswalk of fee-for-service, ACO, and MA quality
17 measures. These results highlight an important
18 opportunity. Nearly 4 out of 5 measures don't crosswalk
19 across programs. That's pretty bad, 4 out of 5 measures,
20 on average, don't crosswalk across programs. That's a huge
21 burden on hospitals, doctors, SNFs, everybody. All those
22 trade associations that are complaining about quality

1 measurement being burdensome, they're right.

2 We need a unified quality measurement system
3 across all of Medicare. These include fee-for-service, it
4 needs to include ACOs, it needs to include MA. You
5 shouldn't have gain-sharing. You should ideally have more
6 of a bonus withhold.

7 You should cap the number of categories, cap the
8 number of measures per category, and then as measures top
9 out you retire them or re-titrate them. If private market
10 actors like ACOs and MA plans want more measures, they can
11 negotiate with providers for that. You could pick some
12 categories. You don't have to pick my categories. One is
13 population health, the second could be beneficiary and
14 workforce satisfaction -- again, that hits on some of the
15 utilization management issues -- and then three could be
16 cost.

17 Everyone could have a star rating. You could
18 gradate it on 0.1 increments, so there's not thresholding.

19 You should automate quality reporting, and then
20 you should grade at the same geographic level, whether it's
21 a county, a state, or a region.

22 Policymakers, regulators, and consumers should be

1 able to compare, and it should be easy. Thank you.

2 MS. KELLEY: Tamara.

3 DR. KONETZKA: Thanks for this excellent work.

4 It's obviously inspiring. A lot of emotion and interesting
5 comments.

6 So I have two really broad comments. They both
7 go back to my Ph.D. dissertation days in one way or
8 another.

9 The first is, some of you may remember, there's
10 like an old economics paper by Holmstrom and Milgrom. It
11 was actually not about health care at all. It was about,
12 you know, firms and factory work, but it raised this idea
13 of multitasking, right? And if you want to incentivize
14 better quality and you decide to reward certain aspects of
15 quality, you might get -- if you reward a very narrow area
16 of quality, you'll get the multitasking problem where
17 there's, you know, teaching to the test. People just focus
18 on that.

19 But if you implement other kinds of quality
20 measures, if the production functions for that kind of
21 quality are different, you might get sort of broader
22 structural change, right?

1 And so, you know, I think what we really want is
2 the broader structural change, right? We want them to hire
3 the right staff. We want them to implement the processes
4 at a system level that really improve care.

5 And I don't think that having a hundred measures
6 or having a very broad set of measures makes up for that,
7 right? It just means that they're teaching to the test on
8 a hundred measures and trying to figure out a low-cost way
9 to improve on those individual measures.

10 So, as we think about possibilities, to me,
11 that's sort of a fundamental principle that we should try
12 to reward quality that leads to sort of systematic --
13 systemic change.

14 At the same time, I'd like to know more about
15 that. I don't know, like Cheryl, in some of your
16 interviews or if this is out there already, but you said
17 you might do more interviews. I would love to know the
18 things that the quality measures we do have. What are the
19 production processes behind those? What are people doing
20 to try to improve those? Right? Is it a small coding
21 change, you know, or is it actually something that's
22 meaningful?

1 Okay. So that's one point. I think the type of
2 quality and the associated processes underneath them are
3 really important to think about when we think about the
4 right way to do this.

5 The other goes back to our -- many of you know
6 Larry Casalino, our former Commissioner who left. Twenty-
7 five or thirty years ago, he wrote a paper in a commentary
8 in the New England Journal of Medicine that was titled
9 something like "The Unintended Consequences of Measuring
10 Quality on the Quality of Health Care," right? I feel like
11 for 25 years, like since I was doing my Ph.D., we've been
12 talking about the same issues, right?

13 We know that pay for performance leads to
14 unintended consequences, disparities, teaching to the test,
15 selection issues, right? And then after these 25 years of
16 people being very excited about P4P and implementing all of
17 this, you know, what we're left with is, you know, what you
18 say in the chapter, which is basically, there's been very
19 modest improvements in quality, right?

20 I actually think maybe it's time to give up on
21 the idea that we are going to get quality improvement out
22 of pay for performance. And I differentiate this a little

1 bit from quality reporting, because I think there is a
2 monitoring aspect. But, you know, we've been tweaking
3 these things and working on them, and that's usually like
4 the way I like to work, right? Like, we're just going to
5 incrementally improve these quality measures in these
6 systems. But I just think we maybe need to reframe how we
7 think about pay for performance.

8 And ACOs, you know, in a sense, capture some of
9 that, you know. Like it says over and over in the chapter,
10 like, quality isn't worse under ACOs, right? But we don't
11 see a lot of improvement. And I'm thinking that's not bad.
12 Maybe that's what we should expect, right?

13 So instead of thinking of P4P as a quality
14 improvement tool, maybe we should be thinking of it as a
15 way to identify low-value care. We're going to have this
16 quality measurement, not necessarily the P4P, but the
17 quality measurement, and consumers and others should know
18 when somebody's like a low outlier, right? Like, we have a
19 hard time differentiating the whole middle anyway, right?
20 But we need to know when somebody's providing really bad
21 care or there's some warning signs that need to be
22 investigated. And then there are other tools for quality

1 improvement that could be implemented. So, to me, you
2 know, I really think it may be time to sort of rethink the
3 whole thing.

4 So, you know, sort of leading to sort of, you
5 know, your thoughts on where we go from here, I don't think
6 -- I agree with what others have said. I don't think we
7 need a lot more analysis of the MIPS. I think there's
8 broad agreement in this group that it's a deeply flawed
9 system. So I don't think we should spend a lot more time
10 analyzing the MIPS.

11 I would love to see us instead think about some
12 of the options for replacements, and as we think about the
13 options for replacements, one, I would think about this
14 reframing I was just talking about, that we shouldn't have
15 high expectations about quality improvement, but just think
16 of it as sort of providers have to meet a certain level of
17 quality to participate, to participate in Medicare even.

18 I think such a system that we think about when we
19 think about these policy options moving forward, we should
20 think about it including measures of quality that are
21 associated with broad structural improvement and not just
22 sort of narrow, potentially gameable or easily achievable

1 targets.

2 I think when possible, we should use measures
3 that don't increase burden on providers. I had written in
4 here that we should use administrative measures based on
5 administrative data, but I think others have brought up the
6 issue of other kinds of measures may become easier with AI.
7 So I think just think about measures that don't increase
8 the burden on providers.

9 And then, finally, I really like the idea of some
10 sort of unified system of measurement across all of fee-
11 for-service and AMA, if possible.

12 Thanks.

13 DR. NAVATHE: Dana, can I jump in for a second?

14 So I just want to clarify one point because
15 several of you pointed out that we may not need additional
16 work on MIPS to understand whether MIPS is working or not,
17 and I think that I just want to clarify. Our intention in
18 any potential analytic work is not really to judge MIPS per
19 se. I think we already have a standing recommendation
20 that's existed for many years, and I think the staff have
21 done a good job of outlining that many of the things we're
22 worried about have kind of played out.

1 So I think it's less about that, and it's more
2 about are there analytic pieces from just experience over
3 the past almost, you know, several years to inform what any
4 future directions might look like.

5 So, if that could be helpful, that's really what
6 we're kind of seeking in terms of analytic direction from
7 you all. So, hopefully, that's helpful.

8 MS. KELLEY: Robert.

9 DR. CHERRY: Well, first, thank you for this
10 report because it is in many ways a complicated topic, and
11 I think you summarized it very nicely in terms of pulling
12 the literature together and what the current state is and
13 what the problem statement is.

14 I can think of very few questions that
15 Commissioners have been asked that is so unifying than,
16 hey, what do you think about MIPS? So thank you for that.

17 [Laughter.]

18 DR. CHERRY: You know, I will say, to put a
19 little bit of a positive spin on, you know, because there's
20 a time and place for everything, I think, you know,
21 clinician quality metrics has served a purpose in terms of
22 raising awareness, having individual physicians and groups

1 look at their practices and do some self-assessments. And
2 I think it has, overall, improved the quality care across
3 many patients, not just Medicare beneficiaries. But that
4 was then, and now we're in 2026, and we have to think, you
5 know, kind of forward-looking.

6 One of the things that we don't want to do is to
7 replicate some of the drawbacks of MIPS. It's very
8 difficult to explain what it is to clinicians and how the
9 methodology works, and we definitely don't want that. We
10 don't want the resource intensity associated with MIPS, the
11 costs associated with it in terms of investment in
12 technology and people resources, and the increased burden
13 of reporting, particularly when many clinicians, not just
14 physicians, are facing issues with burnout and resiliency.

15 And then there's this unfortunate narrative among
16 some physicians that quality metrics are really being used
17 as a financial takeaway instead of an enabler for
18 performance. So I think as we think about the future, we
19 need to think about, sort of, you know, the past and how we
20 came to this particular point.

21 There are other complicating factors. If you
22 take a look back at the "quality industrial complex," which

1 is becoming a more familiar term with a few of the
2 Commissioners here, including myself, we have a lot of
3 quality measures out there. And it's confusing because
4 there's various data definitions that have been modified by
5 the states, by health plans, by different specialty
6 programs that measure quality, such as the Quality
7 Improvement Program, or QIP.

8 There's also, you know, private entities that
9 take the same quality data definitions and put it through
10 various statistical models to make judgments on hospitals
11 and providers.

12 And there are great companies out there:
13 Premier, Vizient, Press Ganey, NRC, U.S. News & World
14 Report, Newsweek, LeapFrog. They all do great work. It's
15 just that it adds to the complexity of things.

16 And then there's the clinical registries, you
17 know, NSQIP, STS. You know, how many ways can we capture
18 surgical-site infections and put it under a new context?

19 And, of course, there's patient safety
20 indicators, and that's problematic, too, when you need
21 software to identify that there's a safety event in a
22 particular encounter.

1 So it's really problematic, and I do agree. It's
2 a quality industrial complex that's generated a lot of jobs
3 and a lot of time for some people, and then on the
4 receiving end, a lot of burden and a lot of costs and
5 expense.

6 Interestingly, much of what hospitals know about
7 their own physicians and the quality of care that they give
8 is actually not in the public space at all, and it's
9 protected from discovery. And it's less about quality but
10 actually more about safety.

11 So what hospitals know is that we have internal
12 data on adverse event reporting. We understand peer-review
13 conversations that are done behind closed doors. Pending
14 malpractice litigation. There's compliance and
15 whistleblower reports that we have access to, including
16 regulatory concerns and as well as health and wellness
17 interventions that are desperately needed for some
18 physicians because of the burnout issues. And then there's
19 disruptive behaviors that are also addressed under peer
20 review.

21 A lot of this is really about safety, and that is
22 more important in many ways than some of the quality

1 measures that we get from various public reporting
2 entities.

3 I think we need to create a balance between
4 quality incentive programs and quality measures and
5 actually maybe also keeping an eye towards patient-
6 centered, patient-reported safe practices and how patients
7 perceive of safety when they go to a clinician's office or
8 under their care in the hospitals.

9 To put a finer point on it, you know, patients
10 generally like their providers and then rate them actually
11 quite highly, the overall majority of them. And patients
12 that have concerns around physicians and particularly when
13 those concerns are validated by other patients that
14 interact with the same physicians, there's likely something
15 there.

16 A good example where this pans out is in the
17 Vanderbilt PARS program, where patient surveys are
18 utilized, and they use a statistical model to identify
19 outlier physicians, because they have a higher rate of
20 medical malpractice.

21 Now, the good thing about that is that they don't
22 have to stay as outliers. There's evidence-based practices

1 where 85 percent of those physicians that are outliers
2 actually can get back into a normal mean again.

3 So I would propose really that while we're trying
4 to figure out the quality measures, to do something simple
5 using existing patient surveys and identify outliers. And
6 if we had to ask a few questions that can identify who
7 those are, it might be questions like, did you have timely
8 access to care? Were you satisfied with your diagnostic
9 and care plan? How would you rate the communication with
10 your doctor or clinician? Did you find your care being
11 coordinated effectively? And would you recommend your
12 physician to others?

13 I think that the focus should be on physicians
14 that are grossly underperforming, perhaps even two standard
15 deviations below the mean, because that's where the risk
16 and a lot of the costs and problems are actually occurring
17 and where we can actually intervene and salvage practices
18 and improve care while we rethink what quality measures
19 need to be.

20 Ultimately, I think if we emphasize safety more
21 and emphasize the importance of patient feedback and de-
22 emphasizing other programs like MIPS, that may be the way

1 to go. So looking forward to further discussion on this.

2 DR. NAVATHE: Dana, I'm going to jump in here for
3 just a second.

4 So thanks, Rob, for your comments, and thanks for
5 all the Commissioners who have spoken up to this point.

6 One thing that I think might be helpful just as
7 we're going through the rest of the Commissioners -- and if
8 we have time, obviously, we can come back to those who have
9 spoken -- is, you know, one of the challenges. And we are
10 -- while I appreciate some of the questions around unified
11 framework, and that's obviously totally fine for you all to
12 comment on, we are sort of thinking here specifically about
13 the clinician measurement program.

14 So one thing that would be nice if you could
15 weave into your comments, those who are going to comment
16 subsequently, is thinking a little bit about the unit of
17 measurement and where we can do reliable measurement. I
18 think if I take -- pull on the thread a little bit from
19 what Rob was saying, just to kind of connect some dots, if
20 we're trying to do quality measurement for a variety of
21 metrics at the individual clinician level and we want to
22 differentiate somebody who's at the 50th percentile from

1 the 70th percentile, the sample size that we would need in
2 terms of beneficiaries becomes very large relative to, say
3 -- I think one of the things that Rob was saying is think
4 about, think about this almost from a patient safety angle,
5 so who are clinicians who may be on the lower end of the
6 distribution or the very low end of the distribution. And
7 that sample size requirement then becomes different and
8 smaller.

9 So I think that's helpful for us because from a
10 practical perspective, as we go forward, I think many of
11 you have already commented about the notion of needing
12 reliable measurement to support anything that's done, and
13 that's a really practical piece that we would need to
14 grapple with as part of the individual clinician
15 measurement program.

16 MS. KELLEY: Scott.

17 DR. SARRAN: Excellent work and clearly teeing up
18 great discussion.

19 Okay. Three comments or suggestions. First, I'd
20 suggest for practices below a certain finite size, scrap
21 MIPS entirely, or potentially, if we think there's more
22 juice to be squeezed out of interoperability, just keep a

1 continuously updated measure of interoperability, right?
2 Because we do know that providers talking often and
3 effectively to their patients and to each other is a
4 necessary, albeit not sufficient, process measure to create
5 high quality.

6 So I think we could -- for practices that are
7 below a certain size, we could keep just a measure of that.
8 Frankly, if you want to make it real simple, I'd give the
9 full payment out for physicians who give out their cell
10 phone numbers to patients. That's just an off-the-cuff
11 comment.

12 [Laughter.]

13 DR. SARRAN: Second, for practices above a
14 certain size, and I'd set the number pretty darn big, maybe
15 100, maybe 200. Since we've all in this room, I think,
16 grown tired of practices that are being acquired, acquiring
17 somebody else, merging, et cetera, promising higher quality
18 as both their motivation for merging and the outcome from
19 the merger, let's hold them accountable and clearly above a
20 certain size. And, again, I'd set it pretty big. We could
21 do a self-funded, meaning it's zero-sum. So the lower
22 performers pay in; the higher performers get paid out.

1 And there, we could use a core measure set,
2 because there's enough validity in the numbers, right? And
3 there's enough administrative capability in large
4 practices, regardless of who owns them to do measure
5 gathering.

6 By the way, the only adjustment I would do if we
7 went down that road would be some measure or measures of
8 socioeconomics of the population. I'd keep it really
9 simple, LIS or Area Deprivation Index, some kind of rolled
10 up measure of that, so that it's not easily gameable by
11 coding. So that was the second comment.

12 The third is somewhat out of bounds per Amol, but
13 as we go through further work, I think we should try to
14 keep the lens of how will we -- how could we get to a
15 common approach of measuring quality across fee-for-service
16 Medicare, Accountable Care Medicare, and MA, because there
17 would be so much value to be created by that, both in terms
18 of the usefulness of the take-homes, as well as the
19 reduction in burden of measurement.

20 Thanks.

21 MS. KELLEY: Josh.

22 DR. LIAO: Thanks for this work.

1 Some of you know I have many thoughts on this,
2 but I will try to be disciplined and speak because I have
3 something to say, not because I have to say something.

4 And I think, most importantly, this work is
5 important. I think we have many years of experience now
6 with A-APMs and MIPS, and I do think actually there's an
7 opportunity to extract more insight, whatever comes of the
8 program. So, as a part of that, I want to just kind of do
9 four things in my comments. One, make a quick, broad
10 observation of clinician participation and quality; second,
11 kind of provide a framework focused on clinicians and
12 thinking about these programs in particular; a few design
13 principles; and then maybe a few suggestions for what comes
14 next.

15 I think the materials are probably focused on the
16 QPP and MIPS and A-APMs within it. But I think, as other
17 Commissioners have mentioned, I do think clinicians
18 contribute to a lot of work outside of these programs.
19 Here, I'm thinking about facility programs like the
20 inpatient, outpatient, and ASC Quality Reporting programs.

21 The payment consequences may sit with the
22 facility in those cases, but the clinicians help deliver

1 the care, adjust the workflows, document the evidence that
2 the programs actually deliver the care, which in some
3 cases, actually, I think the financial relationships are
4 such that those financial consequences actually cascade to
5 the clinicians.

6 So I just want to say that even though we might
7 want to think about reporting as MIPS or QPP or A-APMs, I
8 don't think that's experienced by most clinical delivery
9 operational teams. I think they experience it together.
10 It doesn't mean we don't try in interviews and other ways,
11 but it's just important to recognize that. In any case, I
12 think this, even, focus on clinicians is broader than what
13 we're talking about today.

14 Second, from my framework, when I think about
15 some of the comments that have been said, when I looked at
16 the materials, you know, I kept coming back to this idea of
17 thinking about programs -- and I'll get to MIPS in a
18 second, but thinking about programs in general, kind of
19 being systematic about assessing them based on intended
20 purposes, and then through the lenses of what I call kind
21 of incentives, costs, and fairness.

22 I think the materials do a good job of

1 distinguishing quality measurement and quality payment. I
2 think I appreciated how you outlined things like monitoring
3 performance, clinician feedback, rewarding improvement,
4 high performance, et cetera, as like purposes.

5 I would love to see in the next iteration us
6 being more direct about that and talking about, for
7 instance, some potential tensions between them.

8 So, as an example, information that may be useful
9 for internal improvement for a certain group or provider
10 may not actually support public comparisons, may not be
11 strong enough for financial penalties, but it doesn't mean
12 it's not useful. Certain data may reflect a minimum
13 standard of care, even if it can't distinguish good, great,
14 and excellent care. So I think just noting these tensions
15 even succinctly could be good.

16 The materials also kind of talk in different
17 places about kind of what I consider an incentive frame.
18 Do the payments compel the behaviors or the changes we
19 want, kind of a cost frame? Does it account for the cost
20 it takes to deliver this care and report on that care? And
21 then a fairness frame, are providers and participants kind
22 of treated and compared equitably?

1 I would actually think about being very explicit
2 and direct about those lenses because I think, you know, at
3 the risk of stating the obvious, I don't think success in
4 one dimension means success in the others. So consider --
5 actually, a number that I think has been mentioned a few
6 times here -- about the median MIPS score of 88 against a
7 threshold of 75 or the fact that 94 percent of ACOs met
8 their quality standard. I was sitting here listening and
9 trying to kind of internalize other Commissioners'
10 thoughts, and it felt a little bit like a Rorschach. I
11 heard someone say it was a safety floor. Some people said
12 it was Lake Wobegon. Some people said different things
13 about it. And that just kind of, to me, underscores the
14 need to say, systematically, when we look at results at
15 that, what would help us interpret it?

16 And I think, again, what the materials get at,
17 but I'd love to see kind of crystallized, would be if you
18 took a score like that, 94 percent of ACOs, 88 median
19 score, but you ask the following questions: Is that data
20 useful for feedback, internal improvement? Is that useful
21 for program monitoring? Is it useful for beneficiary
22 choice? You might come up with assessments one way or the

1 other, but a systematic accounting of that would be
2 helpful.

3 I think you can think about the fact that some
4 people mentioned small payment adjustments not being great.
5 I think by themselves, it's hard to say exactly how they
6 establish success or failure. I think their significance
7 depends, actually, on how you, again, think about the
8 purpose and how you think about the value of the
9 information we're getting, the full incentive structure, et
10 cetera.

11 And so I think just being clear about what are
12 the purpose or purposes and then how do we think about it
13 in terms of when we see that finding, is it an incentive
14 that's happening? Are we moving that behavior through the
15 incentive? Is it accounting for the cost required to
16 deliver that care? And then is it fair? I think, again,
17 the materials have it, but I'd love to see a kind of more
18 systematic carry through, and I think it would bring some
19 perspective to some of the comments that we've heard today.

20 My third kind of comment is on MIPS. I think a
21 number of Commissioners have mentioned design flaws with
22 programs like MIPS. I agree with a number of them.

1 Really, fundamentally, I think it's hard to imagine a
2 quality program without comparability and reliability.

3 I think back to work that I've done over the last
4 10 years, and when you look at the individual level,
5 individual clinician level, in many large systems, it's as
6 low as 6 percent, tops out at 50 or 60 percent. When you
7 get to the practice or group level, it gets to 70 to 90. I
8 think it's very hard to do anything I just said, think
9 about purposes, think about incentives, cost fairness, if
10 you don't have those two things. So I do very much agree
11 with those two flaws that other Commissioners have
12 mentioned.

13 But I think it's also possible to be really
14 dissatisfied with MIPS as it is and still recognize that a
15 lot of the things we don't like about it pose difficult
16 questions that any alternative would need to answer. I
17 think some of the things you don't like about the program,
18 in my view, are particular MIPS things. But other things
19 like who to hold accountable, what to measure, how to
20 distinguish performance, mandatory versus voluntary,
21 whether to put HIT and improvement opportunities with
22 quality and cost, those are all design things that I think

1 any alternative would face.

2 My view is that I think an alternative is needed
3 because the absence of that would be maybe a historical
4 focus on cost expenditure only. I don't think that's
5 ideal.

6 I also don't think we want no focus or
7 orientation around quality or value for clinicians in the
8 Medicare program.

9 So I think, you know, identifying defects -- and
10 I think other Commissioners have done a good job of that --
11 is really necessary. But, to me, it doesn't establish what
12 replacement would be better and how we do it better.

13 So, in that view, I do think that -- you know, I
14 do think a few more analyses would be useful. I have to
15 say, it's not to judge whether MIPS works or not. As
16 someone who's done work in this space, I actually have a
17 hard time seeing how you could figure that out. But it's
18 very much that I think there's still learning to extract.
19 I think it informs what potential decision-makers are
20 thinking about in the near term, and I think you can inform
21 what future initiatives and alternatives would be. So I
22 think what's worth retaining, what needs redesign, what

1 should just be thrown out, I don't think we've squeezed all
2 the juice out of that, personally.

3 So, in that spirit, let me end with a few
4 suggestions for kind of proposed analyses. I think
5 recognizing the low uptake, I'm particularly interested in
6 the MVP participation and performance. I think the
7 materials do a good job of explaining how they narrow
8 measure selection. I think they can improve comparability.
9 To my knowledge, actually, many of the MVP reporters report
10 their traditional MIPS and the MVP, and I think actually
11 that comparison side by side can be very useful in
12 illuminating about how they pick scores and whether there's
13 selection there.

14 I do think actually comparing kind of what you've
15 talked about related to measure of distributions,
16 collection types, and in particular how they change over
17 time would be useful as well. I think using those
18 consistent measures where we can, I think would help
19 investigate the distinction between whether things are
20 changing because of quality of care or the resources that
21 report that care.

22 I want to make a comment on the poor, kind of the

1 low-quality outliers. I'm supportive of that idea. Here,
2 I really think about if we can identify a persistent group,
3 you know, whether other measures that we have in Medicare
4 data corroborate that low performance. I think about if
5 there's ways to test sensitivity to patient mix, sample
6 size, reporting completeness across all the components of
7 MIPS and in other programs. I think that would be very
8 useful.

9 But again, there, like just to kind of revisit
10 that framework that I'm kind of proposing, let's say we
11 found a consistent group of low performers. What is the
12 purpose of that? Is that useful for internal improvement
13 for those performers? Is it useful for Medicare's program
14 monitoring? Are we going to tie dollars to it? Are those
15 dollars for the incremental improvement? Is it for
16 hitting a benchmark? Is it for something else? Is it for
17 safeguarding low care -- kind of low-quality care? I think
18 anything that we generate in these analyses would be useful
19 to contextualize in a systematic way.

20 So, anyway, I think really great work, and I very
21 much respect what other Commissioners said about MIPS, but
22 I would just encourage us to think about all the things we

1 don't like about it and which ones are MIPS particular and
2 which ones, even if we like took it to the ground, we'd
3 have to deal with anyway and do that in a practical way.

4 Thank you.

5 MS. KELLEY: Paul.

6 DR. CASALE: Yeah, thank you. Thank you for this
7 chapter. This is one I am particularly passionate about
8 and agree you did just a terrific job with a lot of
9 material.

10 Some of what I'm saying is probably repeating,
11 but I think MIPS was flawed from the beginning because it's
12 trying to focus on individual clinicians. And you can't
13 imagine a program where you were trying to measure
14 surgeons, surgical specialists, medical specialists,
15 subspecialists within medicine, primary care in one system.
16 And that's why we end up with 764 measures.

17 You know, having been, and I'm sure others around
18 this table, as well, as an expert on a lot of these panels
19 for cardiovascular measures, it's really quite a complex
20 process for measure development, and it has led, within the
21 MIPS program, to a lot of measures that over time have
22 really not been, have moved quality forward.

1 Having said that, and again, if we think about it
2 not as the individual but what is the right level of
3 accountability or attribution, it needs, I think Scott
4 said, something larger.

5 You know, in my experience in ACOs the quality
6 measure, although all primary care, we made improvements,
7 you know, breast cancer screening, colorectal cancer
8 screening, flu vaccination, all primary care. But we
9 actually saw what our baseline measures were and we
10 improved them, you know, and that's a good thing.

11 But in the ACO, again we have mostly not primary
12 care, mostly specialists, who are not being measured on
13 primary care. So that, in the scheme of things, doesn't
14 really make sense. But I would say at the higher level we
15 were able to move quality forward.

16 And I would say that there have been a lot of
17 well-intentioned initiatives around quality measurement.
18 The most current one, and a couple of Commissioners
19 mentioned, sort of the core quality set, and currently the
20 cardiologists on the Core Quality Measures Collaborative,
21 CMS and AHIP. That would make perfect sense. Now we can
22 get multi-payer together, decide on a core measure set for,

1 whether it's primary care or specialists, and then look for
2 adoption.

3 So those measures have been developed, but what
4 we haven't seen is any adoption of any of that. Just an
5 example of, I think, well-intentioned but just
6 operationally hasn't worked.

7 In terms of measures to think about focusing on,
8 as others have said, patient-reported outcomes I think is
9 really important. I think that will get easier as
10 obtaining that measurement from patients is easier, and I
11 think AI and other ways will be helpful.

12 And the other thing I wanted to mention was
13 registries. Again, this is more in the specialty area than
14 in primary care, but, you know, my experience is in
15 cardiology. We have several registries. Some were
16 mentioned, NSQIP and the surgical registries.

17 You know, I talk to cardiologists. They always
18 turn to their registry data and say this is something that
19 they think is important and it's reliable and helpful. And
20 how that data can be used as we rethink how to measure
21 clinicians, I think it's something to think about in the
22 broad spectrum.

1 And then the final comment is around the MVPs. I
2 think a couple of things. One is, again in cardiology, we
3 know the Ambulatory Specialty Model is starting in January
4 of this year. They're using the heart failure MVP,
5 mandatory. There is only two years of experience with
6 that. So any further analysis you can do, and you
7 mentioned about looking at MVPs, and the characteristics of
8 the clinicians' reporting of MVPs, and that's just one.
9 Again, there are others.

10 But since CMS has since declared, currently, that
11 MVPs are going to be mandatory, I think we're not sure if
12 that's going to continue. But any analysis you can do
13 around MVPs, as Josh mentioned, as well, I think would help
14 us in understanding maybe the direction that they may be
15 going.

16 And then finally around, again, emphasizing the
17 multi-payer importance of any of this. We think about how
18 quality should be measured, because as we all know,
19 clinicians don't decide, oh, I'm seeing a Medicare patient
20 or I'm seeing a Medicaid patient or a commercial. So the
21 more those can be aligned I think is going to be really
22 important.

1 So thank you.

2 MS. KELLEY: Ben.

3 DR. IPPOLITO: I'll try to be brief and focus on
4 stuff that hasn't come up. You know, you mentioned this
5 question about what's sort of a profitable use of resources
6 in terms of future work, and you mentioned this idea of
7 stakeholder interviews. I almost think, and this is
8 probably not what you had in mind, but better understanding
9 why exactly MIPS has been -- you know, we've had a
10 recommendation since 2018, and yet Congress has not enacted
11 any changes -- just better understanding of what exactly
12 are the dynamics that are leading to that inaction? And
13 maybe people here already have a pretty good understanding.
14 Maybe Amol can already answer this question.

15 But more color on that might be useful, just in
16 the sense of, to Josh's point, if you want to propose
17 something, presumably it's going to have to pass this bar.
18 So helping to understand what are these, you know, what's
19 stalling action here, seems quite relevant for designing
20 whatever your potential replacement is. So I don't know.
21 Maybe it's just me, but I would like to know a little bit
22 more about that.

1 The only other thing I'll mention, to Tamara's
2 point, is I like the idea of focusing on sort of the tails
3 of the distribution. And there are some sectors where
4 we've seen people do this. The education space is one,
5 where there are some areas -- I think D.C. actually is one
6 of them -- where they really try to identify teachers, in
7 that case, who consistently are in the tails of a
8 distribution, year after year. That might be an area where
9 we can learn something about some of the measurement
10 challenges that are going to be inherent to something even
11 beyond MIPS. But thanks.

12 MS. KELLEY: Danielle.

13 DR. PIEROTTI: I don't know if you guys got the
14 short straw that you had this assignment, but good job.
15 Clearly this is an incredibly passionate discussion from
16 all of us, and I really do want to thank everyone in this
17 room for the expertise, because being able to sit here and
18 listen has been worth the travel.

19 I particularly want to acknowledge the comments
20 that have been brought by a couple of people here, starting
21 with Tamara and Robert and Josh, and this idea of to
22 reconceptualize, to use Tamara's words, about what we're

1 doing here, and that if we reimagine these measures as
2 minimum safety as opposed to rewarding performance
3 improvement we have an entirely different way of thinking
4 about this. Which, in my historical interpretation, would
5 be more consistent with the beginnings, because this entire
6 conversation about what the value and quality of health
7 care was started from clinicians being concerned that the
8 focus of the cost factor was crowding out the conversation
9 on quality of care. So I think there's something really,
10 really meaningful in that examination.

11 Specifically to the discussion questions that
12 were posed to us, What value is the Medicare program and
13 its beneficiaries getting from current? None. Do the
14 benefits outweigh the costs? No. We've clearly
15 established that. I don't think I need to repeat it.

16 In terms of the question that is more intriguing
17 to me of how kind of the program balance measures with
18 administrative burden, reliability, and the rest of the
19 components in here, I want to pull on one thread that was
20 in the chapter, in that there were repeated references to
21 the evidence that, one, we talk about all the evidence that
22 the current plan isn't working, many, many, many pages and

1 lots of minutes of conversation.

2 What we haven't talked about was the evidence
3 that shows the things that are impactful. And it was
4 referred to a couple of times in the chapter as
5 organizational level factors, including staffing, resource
6 allocation, culture. Later on culture was broken down to
7 include teamwork and communication.

8 And every time that these items were brought
9 forward as components of the research demonstrating value
10 to improving a patient outcome there was also the comment
11 that these things can't really be measured. And I would
12 say they can. They are.

13 So from a policy point of view, if the evidence
14 tell us what we're currently measuring and capturing isn't
15 really getting us what we want, and there is no evidence
16 that says there are other things that are measurable, that
17 are demonstrating, when we have high teamwork as measured
18 by Leapfrog, AHRQ, Press Ganey, magnet hospital
19 organizations, and I will say it, nurse scientists since
20 the early '80s, have been measuring these things and
21 demonstrating consistency in that evidence to patient
22 outcomes. Then I would love to see policy following the

1 evidence, and really being adherent to what we say we want
2 to do, which is support evidence-based practice.

3 So if the evidence is telling us that the process
4 measure we're currently looking at and valuing -- yes, I
5 told the patient they should stop smoking, good, check box
6 -- isn't actually moving the needle, and we have evidence
7 from lots of places saying the development of teamwork and
8 communication within that team does move the patient
9 outcome, then what could we do differently if the 15 hours
10 a week spent on administrative burden of tracking these
11 measures was actually invested in the staffing and resource
12 allocation that supported teamwork and good communication?

13 I would further just add one last comment on this
14 idea of standard and uniform outcome measure, what would
15 that possibly be? Well, I have one to suggest. If the
16 whole point of health care is keeping people healthy, then
17 the opposite of that is being sick. And we do have one
18 marker of sick, and that is unplanned admissions to a
19 hospital. If we are all trying to keep people at home, per
20 se, then we do have at least one thing that we could be
21 aiming to do as a shared team of specialists and providers
22 and pharmacists and nurses and therapists in all of our

1 different ways and spaces. That would be to reduce,
2 continue to reduce, not just readmissions but original
3 admissions, as an overall marker of is the whole process
4 working? Are we doing the things we want to do to help
5 people stay as healthy as they can be?

6 Thirty seconds over. Thank you.

7 MS. KELLEY: Lynn.

8 MS. BARR: Thanks for this great work. It's a
9 big topic. Ah, MIPS, APMs. I've got a lot to say. I've
10 been quiet all day. I've been saving my minutes.

11 [Laughter.]

12 MS. BARR: So I think we all agree that MIPS is
13 not useful, and I think we also have to think about who is
14 the audience here. Because if it's your hospital, you're
15 monitoring quality performance at a way that makes sense
16 for you. And there's a lot of group practices, et cetera.

17 But what about the consumer, and the consumer is
18 getting nothing out of this. And the providers themselves
19 are burdened with cost and complexity, and they're not
20 getting anything out of this. So it is time to rethink it.

21 I think with the patient, and really, I've been
22 thinking a lot about the patients lately, because one way

1 to fix this terribly broken system we have is to put in the
2 control in the hands of the patients. We need the market
3 to speak, which means we need to give information to the
4 market that is useful, and today, none of the quality
5 scores are of value to the patient.

6 So the patient wants a way, regardless of who
7 their payer is, right, so they want all-payer information,
8 on physicians, and that also helps us solve a lot of these
9 scale issues, I mean, not completely, but brings the scale
10 up.

11 So they want one place to go. They want to know
12 what things cost, and I'm tired of harassing hospitals to
13 try to figure out what things cost, because they really
14 don't know. But if you actually looked at claims data, you
15 would know what things cost, and not just what is the price
16 for this knee replacement but what is the 90-day cost
17 associated with a variety of things that patients are
18 likely, elective things where patients are likely to go and
19 search and try to find the best answer. And they want to
20 know about how do other patients feel about that provider?

21 So I think patient satisfaction, and again, why
22 are we making all these people do their own CAHPS surveys,

1 and put that burden on them? Why can't we just do the
2 surveys ourselves? I think we're all getting polled about
3 10 times a day right now, so there's obviously ways to
4 reach people and get information.

5 We care about the outcomes, and we want to avoid
6 really bad things. So this idea of outliers is really
7 ripe. We really want to protect people from making bad
8 decisions, and so if we can put some of those things
9 together I think we can help give the patients what they
10 need.

11 MIPS today, scale is a joke, the information is
12 useless, the cost analysis is unbelievably flawed. I mean,
13 you tens of thousands of patients to really differentiate
14 the cost of one provider versus another. There's just no
15 way to get there from here. So we need to just stop trying
16 to pretend that we can.

17 The fact that the current measures penalize
18 safety net providers is not talked about nearly enough, but
19 I appreciate you including that in the chapter. And again,
20 what does that mean? If you're just going to reduce access
21 for vulnerable patients, and I've heard this so many times
22 out in the field. It's like, "Oh yeah, boy, I really try

1 to avoid Medicaid patients because they're just going to
2 bring my quality scores down. And I don't want to be
3 penalized like that."

4 So I do recommend that we abandon MIPS. And as
5 I've been advocating for, I think, with the Commissioners,
6 I think that we need to move to an all-payer claims
7 database that is accessible to the patients. So the first
8 person that should be using that is patients, so that they
9 can go onto a website and ask questions, and then we can
10 apply AI, and maybe AI can help us figure out what are the
11 two or three things we really need to know to differentiate
12 a patient's own outcomes?

13 And somebody was commenting about, you know,
14 admissions, about readmissions. I mean, what can we find
15 in claims data? Because I don't want to force doctors to
16 do quality reporting that has no value anymore. I don't
17 want to create this whole administrative mess and then
18 pretend we're solving the problem.

19 I think that it's very interesting -- and then
20 I'll go on to APMs -- I think it's very that only 20
21 percent of MIPS is reporting through APMs, yet 35 percent
22 or more of providers are in APMs. So this means they're

1 reporting twice. They still have to report through the
2 ACO, which MIPS will accept, and then they have to report
3 again, in order to not be considered reporting for an APM.

4 So what that tells me is I can get a much better
5 score that way so it's worth my time to do this twice. I
6 think that's really, really unfortunate that we are
7 creating this system that is ridiculous.

8 The thresholds for quality, I mean, does anybody
9 remember when they'd take your shared savings number and
10 multiply it by your quality score, and everybody worked
11 really hard to have 95 percent quality because it cost them
12 a lot of money to not have that level of quality? That's
13 gone. Now I think you have to hit a 40 percent threshold
14 and you get the money. No multiple. They're not
15 multiplying that against that. And that just is really
16 unfortunate. And if you look at the quality scores in
17 APMs, they are -- I mean, there are a lot of 50 percents
18 out there. There's a lot of ACOs that are reporting at a
19 50 percent level. Eeew. I mean, that is not what the
20 purpose of this program was. It's supposed to support
21 quality and reduce costs? Well, not if the threshold is
22 where it is.

1 The very high payment rates that are happening in
2 APMs today should be of great concern, and I strongly
3 encourage the Commission to find out how much we're losing
4 on the Medicare Shared Savings Program today. because it is
5 not the Shared Savings Program that saved money. And the
6 average cost per beneficiary, or payment per beneficiary
7 has more than doubled from the days of when we were saving
8 money, back before Pathways was introduced, and that's the
9 last time we've looked at it.

10 So I think that these very high payment rates now
11 have increased the number of clinicians very, very rapidly.
12 We've had about a 20 percent increase in the number of
13 patients in APMs in the last couple of years, after being
14 flat forever. Because everybody has figured out how to
15 gain it now, and very, very high payments are being
16 promised and are going out to clinicians.

17 I mean, last time we saw data was '24, so I can't
18 wait to see '25. I think it's going to be really
19 disturbing when you see how much we're paying people. But
20 we're not actually getting anything more for it than we
21 were before MediFact. I would argue we used to do a lot
22 more for our patients in ACOs, because we had to work

1 really hard to get to that shared savings threshold, but
2 not anymore. Now we can just code our way out of it. So
3 once you can do it easy, why would you do it hard? So it
4 doesn't really make any sense.

5 We need to measure cost savings to Medicare. I
6 think that's very important.

7 And my final point, as I wrap up here, is I think
8 we should go back to pre-Pathways rules. I think that
9 there's been a lot of people in there, mostly people that
10 profit from the Medicare Shared Savings Program, mostly not
11 providers, that have been lobbying CMS to increase their
12 payments. And you may be aware that Aledade has announced
13 they made a billion dollars this year. I know what their
14 margins are. It's probably in the 90 percent. I know what
15 it costs to actually do the work.

16 So, I mean, if a vendor is making a billion
17 dollars off of the Medicare Shared Savings Program, how
18 much is the government making, and how much of that has
19 been created by all of the coding that was advocated for by
20 the same people that are now making this money.

21 So I just feel like we have lost our way
22 completely on both of these programs, and I think that just

1 getting rid of both of them would be a really good idea at
2 this point, because I don't think they are providing the
3 value that we used to see. Thank you.

4 MS. KELLEY: Stacie.

5 DR. DUSETZINA: Thank you very much for this
6 work. I guess just a couple of things reflecting on what
7 others have said. When you read the chapter I think two
8 things came up for me, like who wants this, and I think to
9 Ben's comment, was like there has to be a reason it still
10 exists, given how problematic it is, and it doesn't seem to
11 be serving anyone well. And how do we get rid of it and
12 start over was the other thing I kept thinking.

13 A couple of things I'd like to point out and
14 plus-one on what people have said. Everyone appreciated
15 Tom's comments about, you know, we threw this out and
16 started to try to measure quality differently. Care that
17 matches guidelines seems like a good place to start. And I
18 think more sticks and fewer carrots, you know, like low-
19 performing people being penalized rather than trying to
20 spread about extra money as reward I think would be better.

21 To Rob and Tom, both I think mentioned safety
22 being key. When I think about quality, knowing about never

1 events, some of the things I'm channeling Scott a little
2 bit here, from other work, that seems really core. You
3 know, you can measure a small set of things we hope never
4 happen to us when we go and interact with a health care
5 system, and know when those have happened.

6 To some of the comments Brian made about some of
7 the ways of measuring quality, I really liked the idea of
8 workforce satisfaction in addition to beneficiary and
9 patient satisfaction. I feel like that's a key marker. If
10 I'm looking for where I want to go get care I want to know
11 what other patients have thought.

12 And then I think to a point that Tamara made
13 about how can you do less but get structural change, that
14 should be a guiding principle, because just I think we're
15 in a terrible mess right now. It's not serving
16 beneficiaries or any of us. And it would be nice to see
17 quality still measured but in a much more meaningful way.

18 MS. KELLEY: Gina.

19 MS. UPCHURCH: Yeah. Thank you again so much for
20 this work. And this is mirroring a lot of what some other
21 people have said but maybe in a little different way. I'm
22 not a measurement expert, but I do kind of know what

1 matters to Medicare beneficiaries because we deal with them
2 daily. And a lot of it is relational, and it's relational
3 with the system and it's making sure they have a decent
4 quality of care, avoiding the never events.

5 So thinking along the lines of the CAHPS survey
6 to ask these questions, asking patients about their
7 experience and would they recommend their primary care
8 practice, their specialty practice. Because I do believe
9 that it needs to be about the team, and the team that's
10 delivering that care. Do they return phone calls? You
11 don't need to ask all these questions. It would be
12 embedded in this, do you recommend your primary care,
13 because, by the way, they return phone calls, they have
14 less staff churn, you're in a relationship with somebody,
15 they deliver difficult news with empathy. Like those
16 things would come up in asking would you recommend this
17 practice?

18 Now, it needs to be peer grouped, because if
19 you're talking to pain specialists, you know, somebody may
20 constantly complain they're not getting the medicines they
21 want for their pain. So you have to do peer grouping
22 around that.

1 But I do think those questions about the
2 relationships with the practice are really important,
3 because then it would support the team and supporting the
4 staff and less churn.

5 And lastly, so we need clinical standards,
6 obviously. I do agree that we look at the outliers that
7 safety be a driver. But I also love this idea that Paul
8 brought up, about these measurement sets or some sort of
9 standard of care measures. But it has to be small, and as
10 much as we can extract from the current system. We have
11 electronic health records. Extract it from the system, not
12 all this measurement and mess that we've created.

13 So thank you for the work, and I look forward to
14 hearing more as we continue this.

15 DR. NAVATHE: Thank you. So a lot of really
16 wonderful comments from the Commissioners. As predicted, a
17 wonderful, spirited, passionate conversation, and very
18 wide-ranging. So thank you, Ledia and Katelyn also, for
19 the work that you did. I think the Commissioners certainly
20 articulated an appreciation for the quality and synthesis
21 of the work that you've done.

22 So I'm going to actually forego recapping, just

1 for the sake of time here. I think you gave us a lot of
2 input and a lot of stuff for us to chew on. We will do
3 that. We're going to, of course, come back in the spring
4 and have another quality session, and continue the
5 conversation there.

6 DR. NAVATHE: With that I wanted to open up the
7 ability for anybody who is here in person to make in-person
8 public comment. Great. Please come forward. Please
9 identify yourself and your affiliation, and you will have
10 three minutes to make your comments.

11 MR. HALL: Thank you. I am Philo Hall with
12 Epstein Becker & Green. I am here today representing my
13 client, the American Association of Hip and Knee Surgeons.

14 I want to thank you all. I am speaking about
15 your work on the global surgical bundle, and I hope in your
16 work going forward on this topic that you keep in mind your
17 recommendation from June of 2025 on physician payment, that
18 physician payment accuracy must be based on collecting and
19 using timely data on the procedures in question, and not
20 cutting corners on that question.

21 Accuracy is something other than just rationing
22 down each component of payment. I think in taking on this

1 topic you have to also ask the global surgical bundle, is
2 the payment unit accurate? Because there was some great
3 discussion and questions among the membership here on the
4 degree to which some of these procedures, some of these
5 surgical procedures are changing and evolving, that the
6 payment system was set up decades ago and some of these
7 procedures have certainly changed. Certainly those
8 procedures that are a part of mandatory, at-risk payment
9 bundles for the facilities, where there is an incentive to
10 change how care is delivered. And as more of these
11 procedures are moving to outpatient there is absolutely a
12 change in where the physician time is being expended.

13 As my clients are very happy to explain, it's a
14 success and it saves the Medicare program money to make a
15 procedure go from a 5-night hospital stay to a 1-night
16 hospital stay. But that takes work to make that happen.
17 And some of that work is not maybe captured. That needs to
18 be kept in mind in looking at the global surgical bundle.

19 For instance, there is a lot more patient portal
20 interaction, a lot more demands on staff, and a lot more
21 preop visits, some of which are not separately
22 reimbursable. Some of them are not captured by current

1 codes. So there is some uncovered preop work, that again,
2 the Association has done a lot of trying to educate CPT
3 Editorial Panel, the RUC, and CMS on this topic. We'd be
4 happy to talk to MedPAC more on this.

5 So the fact that a joint replacement, for
6 example, takes less hospital nights does not mean that a
7 patient needs to interact with their provider less, but
8 they're interacting with their surgeon in a different way.

9 And the last sort of specific point, as you're
10 fleshing out your two options for the future of the global
11 surgical bundle it would be helpful, I think, to illuminate
12 those options. If you dig in and expand a bit more on the
13 research, on the RAND study and the OIG study.

14 The RAND study on the reduction of postop visits
15 is based on claims data. That's the data that's available.
16 That's what they have to look at. But there are
17 limitations in using that, and I hope MedPAC will be modest
18 or humble in the value of that, because the OIG study
19 points out that they believe there is extensive
20 underreporting, or under-submission of claims, that using
21 claims data undercounts the postop visits.

22 And finally, when you're looking at the RAND data

1 on postop visits, they actually break it out by postop
2 visits in certain procedures. So there is wide variation
3 among surgical procedures and the number of postop visits
4 still. While the trend might all be going down, some
5 procedures, RAND found that there are no postop visits, and
6 in other procedures RAND found they might be down but it's
7 still two postop visits.

8 I think that kind of information will be helpful
9 in more nuanced guidance on the options that you're looking
10 at going forward. Thank you.

11 DR. NAVATHE: Great. Thank you very much for
12 your comment.

13 Seeing no other public comments in person here,
14 for those who are listening through the webcast we also
15 would love to hear from you. You can submit written
16 comments to us at meetingcomments@medpac.gov.

17 We will adjourn our session for this afternoon,
18 and we will be starting tomorrow morning at 9 a.m. with
19 work around Medicare's late enrollment penalties.

20 [Whereupon at 5:16 p.m., the meeting was
21 recessed, to reconvene at 9:00 a.m. on Friday, October 9,
22 2026.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 9, 2026
9:01 a.m.

COMMISSIONERS PRESENT:

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GREGORY P. POULSEN, MBA, Vice Chair
LYNN BARR, MPH
PAUL N. CASALE, MD, MPH
ROBERT A. CHERRY, MD, MS
CHERYL L. DAMBERG, PhD
THOMAS DILLER, MD, MMM
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P R O C E E D I N G S

[9:01 a.m.]

DR. NAVATHE: Welcome, everyone, to the second day of our October public meeting. Today we'll be discussing two topics, and we will start with Medicare's late-enrollment penalties. And I will hand it over to you, Eric.

MR. ROLLINS: Good morning. I'm going to start off this morning by talking about Medicare's late-enrollment penalties. Before I start, I'd like to remind the online audience that they can download these slides from the control panel on the righthand side of the screen. I'd also like to thank Jennifer Druckman for her help with this presentation.

Today's presentation continues the work that the Commission began last year on the complex enrollment decisions that beneficiaries make. Medicare's enrollment requirements and time frames for action can be confusing, and they may have lifelong implications, such as the penalties we will discuss today.

Beneficiaries also choose between fee-for-service Medicare and Medicare Advantage, which requires them to

1 weigh factors such as financial protection, access to care,
2 and the extra benefits offered by plans against their own
3 needs and preferences. Beneficiaries need to weigh these
4 factors considering both their current and future health
5 needs, even though their future needs may not be evident at
6 initial enrollment. Researchers have found that
7 individuals are often unfamiliar with insurance concepts
8 and are prone to various decision-making biases when
9 selecting health plans.

10 As part of our work last year, we analyzed the
11 complexity of the choices that beneficiaries make when
12 enrolling in Medicare, including such topics as the
13 multiple enrollment periods and late-enrollment penalties,
14 selecting and choosing MA plans, standalone Part D plans
15 and Medigap policies, and the motivations for, and barriers
16 to, switching between MA and fee-for-service. We also
17 described the sources of information and advice that
18 beneficiaries use to make their choices, such as the 1-800-
19 MEDICARE help line, Medicare Plan Finder, and insurance
20 agents.

21 We also reported on findings from our focus
22 groups and the Medicare Current Beneficiary Survey about

1 beneficiaries' understanding of the Medicare program,
2 conducted interviews with a variety of stakeholders about
3 the State Health Insurance Assistance Program or SHIP,
4 which provides free counseling to beneficiaries about their
5 coverage options, and reviewed the marketing of MA plans
6 and the financial incentives and training requirements for
7 insurance agents. All of that work led to a chapter in our
8 June 2026 report, and Commissioners expressed interest in
9 doing further work on these issues during this meeting
10 cycle. Today's presentation on late-enrollment penalties
11 is the first installment.

12 Okay, now that we've covered some of the
13 background for this work, let's move on to today's topic.
14 When beneficiaries first become eligible for Medicare, some
15 do not enroll in Part B, which covers physician and
16 ambulatory services, or Part D, which covers prescription
17 drugs. Both programs are voluntary and typically requires
18 enrollees to pay monthly premiums. Some individuals may
19 wait to enroll because they are still working and have
20 employer-based coverage, which would make Part B and Part D
21 at least somewhat duplicative. Some individuals may not
22 enroll inadvertently because they find the enrollment

1 process confusing. And some individuals with relatively
2 low spending may want to delay their enrollment (and thus
3 avoid paying premiums) until they develop greater health
4 care needs.

5 This behavior can result in what's known as
6 adverse selection, which occurs when the individuals who
7 enroll in a health insurance program have higher spending
8 than the individuals who are eligible but choose not to
9 enroll. Adverse selection can lead to higher premiums for
10 the individuals who do enroll because their premiums are
11 based on average per enrollee costs. However, it's worth
12 noting that the impact of selection on Part B and Part D
13 premiums is limited by the fact that they only finance a
14 relatively small share of program spending.

15 When people delay enrolling in Part B or Part D,
16 Medicare distinguishes between those who have another
17 source of coverage while they are not enrolled and those
18 who do not. The people who have another source of coverage
19 are not viewed as a risk for adverse selection. They can
20 usually wait until their other coverage ends to enroll via
21 a special enrollment period and typically will not incur
22 any late-enrollment penalties. However, the rules for Part

1 B and Part D differ in some respects that we will return to
2 later.

3 In contrast, the people who don't have another
4 source of coverage are viewed as a risk for adverse
5 selection and encouraged to enroll on time in two ways.
6 First, they have limited chances to enroll after their
7 initial enrollment period ends, which makes it harder to
8 enroll at a time that matches when your health gets worse.
9 Second, they may incur late-enrollment penalties, which are
10 added to the regular Part B and Part D premiums and make it
11 more expensive to enroll later.

12 As for how the penalties are calculated, the Part
13 B and Part D penalties are both based on the number of
14 uncovered months, where you were eligible for that part of
15 Medicare but not enrolled. Some months aren't counted if
16 the individual had other health coverage. The number of
17 months is then used to determine the amount of the penalty
18 in percentage terms. That percentage is multiplied by the
19 standard Part B premium or Part D base beneficiary premium
20 and the resulting dollar amount is added to the enrollee's
21 monthly premium. As a result, the amount of the penalty
22 changes from year to year in line with changes in the Part

1 B and Part D premiums. This year, we estimate that
2 Medicare will collect an estimated \$1.1 billion in
3 penalties.

4 The rules that Part B and Part D use to calculate
5 their penalties differ in several ways. I've listed the
6 key differences here and we'll discuss them in more detail
7 later on. They include the formula used to calculate the
8 penalty percentage, how long you can delay enrollment
9 before incurring a penalty, the types of other coverage
10 that are considered when calculating the number of
11 uncovered months, and when you can enroll after missing
12 your initial enrollment period.

13 This figure shows how Part B and Part D determine
14 the penalty percentage. You can see that their formulas
15 differ. In Part B, which is the orange line, the penalty
16 equals 10 percent for every 12 uncovered months.
17 Beneficiaries thus do not incur a penalty unless they go
18 for an entire year without coverage. In Part D, the dotted
19 blue line, the penalty equals 1 percent for each uncovered
20 month. Beneficiaries do not incur a penalty unless they go
21 63 consecutive days, so more than 2 months, without
22 coverage. There is no cap on the penalty percentage. As a

1 result, in both programs individuals who take longer to
2 enroll pay higher penalties.

3 Part B and Part D also differ in how they treat
4 other types of coverage that people may have while they are
5 not enrolled. One area where this shows up is the
6 calculation of uncovered months for the penalty. Part B
7 excludes months where the person had employer coverage, but
8 only if they, or their spouse, was actively working. Part
9 D excludes months where the person had so-called
10 "creditable" drug coverage, meaning it's as generous as
11 Part D. Relative to Part B, this standard is broader in
12 some ways, because coverage that isn't tied to current
13 employment, like retiree coverage or the VA, can be
14 creditable, and narrower in others, since some employer
15 coverage may not qualify as creditable.

16 Another area of difference are special enrollment
17 periods or SEPs. SEPs give people more flexibility to
18 enroll outside of regular enrollment periods, which may
19 help you avoid a penalty, but only certain people --usually
20 those with some other type of coverage -- qualify. The
21 main Part B SEP is for people with employer coverage, but
22 here again it's limited to active workers. Some

1 beneficiary advocates have noted that the SEP cannot be
2 used by people with retiree health coverage or COBRA
3 because those are based on prior employment instead of
4 current employment. If these people do not enroll in Part
5 B, they may effectively find themselves without coverage
6 because retiree coverage and COBRA are usually secondary
7 payers relative to Medicare and may not provide any
8 coverage to someone who does not have Part B. The Part D
9 SEPs are broader: they target beneficiaries with any form
10 of employer coverage, including retiree coverage and COBRA,
11 as well as anyone who involuntarily loses creditable
12 coverage.

13 Now let's take a look at the impact of the
14 penalties. For starters, relatively few beneficiaries pay
15 them. In Part B, about 1.4 percent of enrollees pay
16 penalties, and that figure has been pretty stable over
17 time. In Part D, the share of enrollees who pay penalties
18 is higher, at about 5.3 percent in 2024. The share of
19 enrollees who paid a penalty increased between 2014 and
20 2024, although this growth leveled off towards the end of
21 that period.

22 The higher prevalence of penalties in Part D is

1 likely due to several factors, particularly a steady
2 increase in the share of beneficiaries enrolled in Part D,
3 which has been partly driven by people who didn't enroll
4 when they first became eligible, and the fact that Part D
5 can impose smaller penalties than Part B. About a third of
6 the Part D enrollees who were subject to penalties paid a
7 penalty of 11 percent or less, which means that they had
8 less than 12 uncovered months and would not incur a penalty
9 under Part B rules.

10 It's worth noting that we cannot determine
11 exactly why beneficiaries incur penalties. In some cases,
12 beneficiaries may be fully aware of the penalties and make
13 a deliberate choice to delay their enrollment, but there
14 may be other cases where beneficiaries incur a penalty
15 inadvertently due to confusion about Medicare's enrollment
16 process.

17 The penalty amounts vary widely. In 2024, the
18 average penalties are actually fairly similar in percentage
19 terms, 29 percent in Part B and 36 percent in Part D.
20 Given how the penalties are calculated, these figures imply
21 that the average beneficiary delayed enrollment by about
22 two to three years. The average Part B penalty was larger

1 in dollar terms, \$51 per month vs. \$12 per month, due to
2 the higher premiums in that program.

3 There's also a lot of variation within each
4 program. I'm not going to go through all the numbers here
5 on the slide, but just to focus on Part B, about 45 percent
6 of enrollees paid the minimum 10 percent penalty, which was
7 \$17 per month, while at the 90th percentile, the penalties
8 were much larger, and enrollees paid a 60 percent penalty,
9 or \$105 per month.

10 There are also differences between the
11 distribution of enrollee-level penalty amounts on the one
12 hand and the distribution of the aggregate penalty payments
13 on the other. Since the Part B and Part D penalties get
14 progressively larger when people take longer to enroll, the
15 people who incur bigger penalties account for a
16 disproportionate share of the aggregate penalty payments.

17 In 2024, among the enrollees who paid penalties,
18 the subset with penalties that exceeded 50 percent of the
19 premium accounted for 13 percent of the Part B enrollees
20 and 42 percent of the aggregate penalties. In Part D,
21 those who paid more than 50 percent accounted for 24
22 percent of the enrollees and 64 percent of the aggregate

1 penalties. So a substantial portion of the penalties that
2 Medicare collects comes from a relatively small number of
3 enrollees.

4 The length of time that enrollees pay penalties
5 also varies. The Part B and Part D penalties are generally
6 permanent, so the beneficiaries who incur them must
7 continue paying them as long as they remain enrolled.
8 However, the penalties do stop when a beneficiary turns 65
9 or their premium starts being paid by either Medicaid, in
10 the case of Part B, or the low-income subsidy, in the case
11 of Part D. In 2024, the average length of time that
12 affected enrollees had been paying penalties was 7.3 years
13 in Part B and 6.0 years in Part D. Some enrollees had been
14 paying penalties for much longer periods of time. The top
15 10 percent of the affected enrollees had been paying
16 penalties for more than 16 years in Part B and more than 13
17 years in Part D.

18 Late-enrollment penalties aim to limit adverse
19 selection by providing an incentive for individuals with
20 relatively lower spending to enroll in Part B and Part D on
21 time. However, as far as we can tell, very little research
22 has been done on whether the penalties actually deter

1 adverse selection. The most relevant study was by Atherly
2 and Dowd, who examined whether healthy 65-year-olds should
3 enroll in Part D immediately or wait until they developed a
4 health condition that was typically treated with
5 prescription drugs. With the penalty, they found that
6 these individuals would spend less during their lifetimes
7 if they enrolled at age 65, but that without the penalty,
8 waiting to enroll was more advantageous.

9 Our ability to assess the impact of the penalties
10 is limited because we do not know how much Medicare would
11 have spent on these individuals if they had enrolled on
12 time.

13 As an alternative, we compared the Part B and
14 Part D spending for people who paid penalties, so after
15 they had enrolled, to the spending for other enrollees. We
16 focused on people who qualified based on age since they
17 account for more than 90 percent of the people who pay
18 penalties. We also excluded certain types of
19 beneficiaries. We excluded dually eligible beneficiaries
20 from our Part B analysis and beneficiaries who receive the
21 low-income subsidy from our Part D analysis. These groups
22 tend to have higher spending, on average, but they are

1 exempt from the penalties, and including them in the group
2 that does not pay penalties would distort our comparison.

3 We also excluded beneficiaries who have employer
4 coverage because they or their spouse are still working;
5 this group tends to have lower spending, on average, since
6 Medicare is the secondary payer. Finally, our Part B
7 analysis used fee-for-service claims to calculate spending
8 and thus excluded beneficiaries in MA, and our Part D
9 analysis did not account for rebates that plans collect
10 from drug manufacturers.

11 We found that enrollees who paid penalties had
12 lower spending, on average, than other enrollees. Between
13 2015 and 2024, average monthly spending for the enrollees
14 who paid penalties was between 10 percent and 20 percent
15 lower than spending for other enrollees in Part B and
16 between 20 percent and 30 percent lower in Part D. Our
17 analysis isn't definitive but does suggest there is some
18 adverse selection in Part B and Part D, even with the
19 penalties. However, the effects on Part B and Part D
20 premiums are limited due to their high participation rates
21 and the fact that both programs are largely financed by
22 taxpayers rather than enrollee premiums.

1 The penalties may nonetheless play an important
2 role in keeping participation rates high given that a
3 substantial number of enrollees in Part B and Part D pay
4 more in premiums than they receive in benefits. For
5 example, about 40 percent of Part B enrollees spend more on
6 premiums in a given year than they receive in benefits.
7 This distribution suggests the number of people who delay
8 enrollment, and the corresponding amount of adverse
9 selection, could be higher if the penalties were eliminated
10 or greatly reduced.

11 As part of its work during this meeting cycle,
12 the Commission could consider potential changes to the
13 late-enrollment penalties. The penalties are a safeguard
14 that help ensure that Part B and Part D have participation
15 rates and premiums that reflect a broad risk pool.
16 However, there are inconsistencies between the Part B and
17 Part D penalties, and their design raises some fairness
18 concerns because some enrollees may incur penalties
19 inadvertently due to confusion, pay large penalties, or pay
20 penalties for an extended period of time. The impact of
21 the penalties could be reduced in a variety of ways, but an
22 overarching challenge is that we do not have a good basis

1 for assessing how changes in the penalties might affect the
2 participation rates in Part B and Part D and thus their
3 premiums.

4 On this slide, we've outlined some potential
5 directions that the Commission could pursue if it were
6 interested in considering changes to the penalties. Before
7 I walk through these I want to note that next month we will
8 have a presentation that looks at how individuals are
9 notified about their Medicare eligibility when they turn 65
10 and funding for the SHIP program. Reforms in those areas,
11 such as requiring that everyone be notified about the
12 Medicare enrollment process when they turn 65, could
13 potentially reduce the confusion that some people
14 experience when they become eligible for Medicare and serve
15 as either a complement or an alternative to changes to the
16 penalties.

17 So for these policy directions, we've also
18 included a few examples of potential policy options, but
19 they should be viewed as illustrative. First, you could
20 make the penalty rules more consistent between Part B and
21 Part D. For example, you could broaden the Part B SEP to
22 include retiree health coverage and COBRA, which would make

1 it more like Part D. Second, you could reduce the size of
2 the penalties. For example, if you wanted to target
3 enrollees who pay large penalties, you could consider
4 capping the penalty at a certain percentage. Third, you
5 could look at ways to make the penalties time-limited
6 rather than permanent, such as limiting the length of time
7 that enrollees pay penalties in a manner similar to the
8 Part A penalties, which now apply to very few people.

9 That brings us to the discussion. First, I'll be
10 happy to answer any questions about the material in this
11 presentation. Second, we'd like to know whether you're
12 interested in developing policy options related to the
13 penalties and, if you are interested, which of the
14 directions that we listed on the previous slide you think
15 we should focus on.

16 If there is sufficient Commissioner interest,
17 then we would come back in January to discuss policy
18 options. That discussion could potentially be followed by
19 consideration of a draft recommendation in March, a vote on
20 a final recommendation in April, and a chapter in our June
21 2027 Report to the Congress.

22 That brings us to the end of the presentation,

1 and I'll now turn it back to Amol.

2 DR. NAVATHE: Thank you, Eric, for that excellent
3 presentation. So as Eric highlighted, there are multiple
4 sessions planned for this cycle, so we're keenly interested
5 in your input and feedback, and then we'll be back talking
6 about the notifications piece and the SHIP counselor piece
7 in November. So we'll have another bite at the apple, if
8 you will.

9 Dana, I'll turn it over to you to run the queue.

10 MS. KELLEY: All right. I have Lynn in Round 1.

11 MS. BARR: Thank you so much, Eric. It's a great
12 presentation, and this is a really complicated topic.

13 As a former employer I was always very confused
14 about what to do with people that reached 65, you know,
15 because we paid for their health insurance, of course, your
16 self-insured. So can you explain to me what is the policy,
17 from Medicare's point of view, of 65-year-olds that are
18 employed? Should they be allowed to go into Medicare? Do
19 we prevent that?

20 It was very confusing to me that my employees
21 would routinely forego going into Medicare, no matter how
22 small the companies. Can you help me understand what

1 happens there when people turn 65 and work for companies,
2 and what do we recommend, as a government?

3 MR. ROLLINS: Sure. I can talk through it at
4 kind of a high level. It is admittedly a complex area, so
5 I do understand that it was challenging.

6 At sort of a broad level, Medicare requires
7 employers to be the primary payer for people once they
8 reach 65, so they cannot be forced onto Medicare. That's
9 only for large employers, so if you have more than 20
10 employers --

11 MS. BARR: 20 employees?

12 MR. ROLLINS: 20 employees, yeah.

13 MS. BARR: Those are pretty small employers.

14 MR. ROLLINS: Yes. If you have more than 20
15 employees, Medicare has to be the secondary payer. So if
16 I'm an individual, I turn 65, and I'm still working, I have
17 employer coverage, I can just keep that coverage. I don't
18 have to enroll in Part B or Part D at that time. I can
19 wait and do it later. As I noted in the presentation,
20 there's a special enrollment period to get into Part B and
21 Part D, you know, once you decide I'm going to stop
22 working, my employer coverage is coming to an end, and now

1 I want to shift to Medicare.

2 If you wanted to you could still enroll in
3 Medicare in those situations, but you're not required to.
4 So those are like larger employers. Small employers, those
5 rules don't apply, so in those situations you generally
6 should enroll in Medicare. It's a little murky whether or
7 not some of the employers know that you have reached
8 Medicare age or how that's enforced, but the requirement
9 that Medicare sort of sits behind employer coverage does
10 not apply to sort of smaller firms.

11 MS. BARR: And is that in a statute? Has that
12 always been there?

13 MR. ROLLINS: It is in the statute. I believe
14 the Medicare as secondary payer provisions I think were
15 added in the mid '80s.

16 MS. BARR: Thank you so much.

17 DR. NAVATHE: Gina, did you want to get in here?

18 MS. UPCHURCH: Just to add a few things. Thank
19 you. So a large employer is defined as 20 or more, for 65-
20 year-olds 100 or more if you're disabled going on to
21 Medicare. So that's one distinction.

22 One of the issues with, you know, you could join

1 Medicare even if you're with a large employer, is that
2 you're wasting your money because your employer would still
3 be primary, so you're just wasting those premium dollars.
4 Many of those people pay IRMAA, because they're still
5 working, so they'll pay a lot of money.

6 But the bigger issue for protection down the road
7 is that you, in many ways, lose your -- and this is what's
8 debatable, and I'll ask about this -- a lot of Medigap
9 policies say you do not have guaranteed issue rights to a
10 supplement, okay. Some of them say yes, you do. Some of
11 them say you don't. It's by insurance company whether you
12 have guaranteed issue rights.

13 So if you were working for a large employer,
14 we've had this before where the spouse had rheumatoid
15 arthritis, so she wanted to make sure she had all this
16 coverage, right. He was still working for a large
17 employer. By the time she got around to it, they paid all
18 this extra money and then the insurance companies, most of
19 them said, "You don't have guaranteed issue rights because
20 you had Medicare for a while. You had to be in place for a
21 while. It's past the eight months."

22 So there is no standard federal law that says the

1 Medigap, as far as I know. That was going to be one of my
2 questions. That's one of the problems. If you take B too
3 early it can be a real problem, and if you take it too late
4 you pay penalties.

5 DR. NAVATHE: Paul.

6 MR. MASI: Thank you for this. I think this
7 underscores the complexity of the existing process. And I
8 wanted to put in a plug, in the November public meeting
9 we're going to be coming back with some additional
10 information on how beneficiaries are notified, what kinds
11 of information they get, and to continue the conversation
12 that the Commission had started last cycle.

13 DR. NAVATHE: Do you want to get in here anymore?
14 Okay.

15 MS. KELLEY: Lynn, was that --

16 MS. BARR: Yes, I'm finished. Thank you so much.

17 MS. KELLEY: Cheryl, you are next.

18 DR. DAMBERG: Really interesting work, and I'm so
19 glad the Commission is taking this on.

20 I found it interesting -- or I always learn
21 something when I read these chapters, and there was the
22 text about some high-deductible health plans not being

1 considered credible coverage for Part D, and this sort of
2 raised a red flag in my mind because, increasingly,
3 employers have moved to these high-deductible health plans.
4 And as people migrate into Medicare, I'm just worried about
5 more and more people potentially getting penalized or at
6 least not understanding these kind of crazy rules that are
7 not very transparent to most people. So do we have any
8 sense of how often that's happening?

9 MR. ROLLINS: We don't.

10 DR. DAMBERG: All right. And then the second
11 thing that occurred to me -- and, again, I realize you
12 don't understand all the possible reasons why people aren't
13 signing up. But it occurred to me that potentially people
14 who fall between, say, 100 percent of poverty and, you
15 know, pick another cut point, 400 percent of poverty, I'm
16 just wondering that there may be an affordability issue in
17 play, and I don't know if there's some opportunity to
18 explore that space.

19 MS. KELLEY: Tamara.

20 DR. KONETZKA: I'm also very excited we're taking
21 on this work. Thank you, Eric.

22 My question is about the adverse selection

1 research. I think you reviewed very well the kind of
2 sparse ex post research on what effect the penalties might
3 have. My question is, do you know anything about how the
4 original penalties were set? Why did they decide on
5 lifetime penalties for Part B? Was there -- I guess,
6 specifically, was there sort of adverse selection research
7 that the designers of these policies drew on and that led
8 them to those particular policies?

9 MR. ROLLINS: I do not know. Sort of the select
10 for Part B, the 10 percent has been there from the get-go.

11 I wasn't around when Part D was being developed
12 and the 1 percent was chosen. I don't know -- I don't know
13 that there was a body of analysis or research that was
14 necessarily informing that. There could have been. I just
15 -- I don't know.

16 MR. MASI: And, Eric, I think there's a wonderful
17 footnote in your paper that talks about the Part A
18 experience, how the late enrollment penalty for Part A has
19 changed over time. Would you mind giving us a perception
20 on that?

21 MR. ROLLINS: Sure. We talk about this in the
22 paper. There is a Part A late enrollment penalty for the

1 very small number of people who don't have enough covered
2 employment where they need to pay a premium, and the
3 penalty for that part was originally much like Part B, 10
4 percent for every 12 months you were out, generally
5 permanent. But Congress did change it in the mid-1980s.
6 So it now looks fairly different actually from Part B. The
7 amount of the penalty is capped. It's fixed at 10 percent
8 of the premium, and it's not permanent. You're going to
9 pay it for twice as long as the period of time that you
10 were not covered.

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

13 MS. UPCHURCH: Yeah. Thank you.

14 I'm thrilled we're doing this. Eric, you did an
15 amazing job of pulling lots and lots of details together.

16 Just a couple of quick questions. Footnote 13,
17 I'm just curious about this, and I don't know it. So, if
18 somebody has a late enrollment penalty for Part B, but they
19 go back to work for a large employer, say for two months,
20 does that reset the clock for a late enrollment penalty? I
21 know with Part D, it's just you count number of months, but
22 with Part B, you have to be out a full 12 months. If I

1 work -- you know, say it's a three-year period, and one of
2 those years, in the middle of the year, I work for a few
3 months for a large employer and have coverage through them.
4 Does that mean for that year, that 12-month block, I won't
5 pay late enrollment penalties for B? Do we know? Because
6 I haven't dealt with that.

7 MR. ROLLINS: My understanding is -- so you're
8 talking about somebody who has Part B, and then goes back
9 to -- was paying penalties.

10 MS. UPCHURCH: Yeah. So they retire. They start
11 B, then they go back to work for a large employer.

12 MR. ROLLINS: And have employer coverage.

13 MS. UPCHURCH: Have employer coverage that's
14 considered, you know, credible or whatever. Do we know if
15 that whole 12 months they then don't pay penalties because
16 two of the months they had coverage, or is it --

17 MR. ROLLINS: Again, in terms of your uncovered
18 months, it would be whether or not you had employer-
19 sponsored coverage because you were currently employed.

20 MS. UPCHURCH: Right. But it's supposed to be
21 for a full 12 months, and you only work two of the months.

22 MR. ROLLINS: Right. But they would be keeping

1 track of sort of over the course of your life, how many
2 uncovered months you had.

3 MS. UPCHURCH: Okay. In that 12 months.

4 MR. ROLLINS: So, if I had no uncovered months to
5 begin with and, all of a sudden, I have two uncovered
6 months, that's not going to incur a penalty. If I already
7 had 10 uncovered months, for example, and I added another
8 two uncovered months, when I come back in Part B later, at
9 that point you would have like a full 12 months.

10 MS. UPCHURCH: Okay. So you're saying they
11 count months. Okay. Well, yeah. I don't know that we're
12 going to fix that, but that's super complicated. Okay.
13 It's just not complicated enough.

14 Then just a question about the late enrollment
15 penalties for A, you said 40,000 people, but then states
16 can have Medicaid pay that, or you can have the group payer
17 arrangement. Thank you so much for explaining that.

18 I guess the question I have is, if I'm in a group
19 payer arrangement and they say the person should pay, it
20 sounds like, you said 10,000 people -- you said 10,000
21 people end up paying. You mean the group pays on their
22 behalf?

1 MR. ROLLINS: No, the 10,000 people are not on
2 Medicaid. So, if I am enrolled in Medicaid and they're
3 paying the Part A premium on my behalf, if I'm a buy-in
4 state, there's no penalty at all.

5 MS. UPCHURCH: Right.

6 MR. ROLLINS: If I'm a group payer state, there's
7 still a penalty, but the state is going to pay it for you.

8 MS. UPCHURCH: Okay. So when you said about
9 10,000 people pay the penalty, who are those 10,000 people?

10 MR. ROLLINS: People who are not on Medicaid.
11 They're actually paying the premium themselves. They're
12 paying the penalty themselves.

13 MS. UPCHURCH: Okay. So are there people who
14 just -- do we know how many people just can't even afford
15 to do that, that would be in that group that rely on
16 hospital charity care kind of thing?

17 MR. ROLLINS: How many people could not afford to
18 enroll in Part A?

19 MS. UPCHURCH: Or not pay the late enrollment
20 penalty for A, yeah. They should pay a late enrollment
21 penalty. They're late. They should pay, but they just
22 can't.

1 MR. ROLLINS: I've not seen any information on
2 that.

3 MS. UPCHURCH: Okay, okay. And, lastly, just to
4 point out what Lynn was bringing up, on page 14, I just
5 want to make clear that people understand that some
6 insurance companies -- this is North Carolina's experience.
7 Some insurance companies don't think you have guarantee
8 issue rights to Medigap policies if you leave -- if you
9 choose to leave. Now, if your employer pushes you out,
10 yes, you do. But if you choose to leave a large employer
11 group health plan, some insurance companies don't think you
12 have guarantee issue rights to Medigap. And I just want to
13 make sure that we make that clear.

14 Thanks. Thanks so much.

15 MS. KELLEY: Tom, Round 1?

16 DR. DILLER: Yeah, Eric, great, great work. I
17 enjoyed the chapter.

18 My question -- I think it was 1.1 billion is the
19 total amount of penalties that are collected. That money
20 is going into the pool that's paying for the care. Do we
21 have any sense of what percentage increase in premiums that
22 would -- if we were to replace that money? In other words,

1 if we had to apply that to all of the premiums for
2 everybody, is it a 1 percent increase, a 2 percent
3 increase, anything along that line?

4 MR. ROLLINS: That would require me to do a
5 dangerous amount of math off the top of my head.

6 MR. MASI: Good answer, Eric.

7 [Laughter.]

8 MR. ROLLINS: But, certainly, across the entirety
9 of the Medicare program, the aggregate amount that we
10 collect in Part B premiums and Part D premiums is a fairly
11 large amount of money. I would think that the 1.1 billion
12 stacked up against that is relatively small.

13 MS. KELLEY: Robert.

14 DR. CHERRY: Yeah, thank you for this report.
15 Very nicely done. It's one of the few areas where you kind
16 of put yourself into a beneficiary mode and see if you can
17 actually go through these steps without a misstep, and I
18 have to tell you, I don't think I could go through the
19 enrollment process without some help.

20 Two clarifying questions. One is on Slide No. 14
21 where it mentions Part D and Part D penalties are generally
22 permanent, but then it goes on to say that penalties will

1 stop when beneficiaries turn 65. I was confused by that
2 statement because, generally, you start to enroll three
3 months before turning 65. So then it sounds like it falls
4 and it would stop on that beneficiary's birthday.

5 MR. ROLLINS: No. Sorry if that is confusing.
6 So the initial enrollment period you're talking about is
7 for somebody who's qualifying based on age, which is the
8 majority of people on Medicare. You also have the people
9 who are under 65 who are qualifying on the basis of
10 disability. Their initial enrollment period is going to be
11 sooner. It's tied to the 25th month they've been receiving
12 disability benefits.

13 So people who come into Medicare at that stage
14 can also incur a late enrollment penalty for whatever
15 reason they're late to take Part D relative to sort of that
16 first initial enrollment period. So you have people who
17 are under 65 who are paying late enrollment penalties.
18 It's not a large share of the overall sort of population
19 that's paying these penalties, but they are there.

20 But then under the rules, once these
21 beneficiaries reach the age of 65, now they also qualify
22 based on age, and so they get another initial enrollment

1 period. And so, at that point, the slate is kind of white
2 clean. So, if they had been paying a penalty stemming from
3 when they qualified based on disability, once they reach
4 65, it will stop.

5 If for whatever reason they stopped enrolling in
6 Part B at some point beyond the age of 65, they might get a
7 second penalty later on. But it would only be based on
8 whatever happened after that sort of second initial
9 enrollment period at age 65.

10 DR. CHERRY: Yeah. Thank you. So maybe that
11 slide can be clarified that that's referring to patients
12 who enroll early based on a disability and, therefore, it's
13 clear what you're trying to articulate.

14 The second question I had is more around the how
15 process of how potential beneficiaries are identified. So
16 many of us, if not all of us, around tax season time get a
17 1095-B form, which basically says that you and other
18 members of your household have some sort of qualified
19 health insurance plan.

20 Now, I would imagine that if you don't have that
21 and you're 65, maybe you've missed the enrollment period,
22 and could that be utilized as a way to reach out to

1 potential beneficiaries, "Oh, by the way, we see that you
2 don't have qualified health insurance. You're 65. Maybe
3 you want to come in and have a discussion around enrolling
4 in Medicare"?

5 MR. ROLLINS: I will simply note that, I think
6 maybe that's a topic we can maybe bank for the discussion
7 we'll have in November. I think that maybe is a little
8 more sort of getting into how we're going to talk about how
9 people are notified or not notified at age 65.

10 DR. CHERRY: Great. Thank you.

11 MS. KELLEY: Okay. That's all I have for Round
12 1, unless I've missed anyone.

13 Shall I go to Round 2, Amol? All right. We'll
14 start with Kenny.

15 MR. KAN: Eric, thank you for the very insightful
16 chapter.

17 I believe late enrollment penalties are necessary
18 to mitigate adverse selection. Of the various ideas
19 proposed today, I will support two ideas to help mitigate
20 accidental penalties potentially arising from beneficiary
21 confusion.

22 Number one, harmonize the rules. Develop a Part

1 B special enrollment period for COBRA and retiree coverage,
2 which Part B treats less favorably than Part D. Evaluate
3 extending Part D's penalty-free gap from 63 days to 12
4 months. Resolve coordination of benefits so enrollment
5 relief also protects coverage.

6 Second, fix notification first. I know that
7 there will be a follow-up discussion in November on this.
8 While I don't wish to be presumptuous, I do want to put in
9 a plug for this session. I would support Social Security
10 Administration, SSA, outreach before the initial enrollment
11 period to everyone approaching 65 or SSA disability,
12 including those delaying Social Security. The notification
13 needs to explain who must enroll and who can defer with
14 qualifying coverage. This will address potential
15 beneficiary confusion, especially at the vast majority
16 Medicare age of 65, as this is before normal Social
17 Security retirement age of 67.

18 I look forward to next month's follow-up
19 discussion. Thank you.

20 MS. KELLEY: Lynn.

21 MS. BARR: Thank you very much.

22 Obviously, let's just simplify all of this. This

1 is so ridiculous.

2 And, by the way, I'm putting Gina's phone number
3 out there for anybody that needs to enroll in Medicare
4 because she's probably the only person I know that
5 understands it. I definitely could have sent all the
6 people that asked me.

7 DR. NAVATHE: Don't forget Eric also. He
8 understands, but don't give out his phone number.

9 MR. MASI: Eric doesn't have a phone number.

10 [Laughter.]

11 MS. BARR: That's so funny. Oh, my God. You're
12 picking up Mike Chernew's sense of humor. It must have
13 something to do with the chair.

14 So the other thing, the other policy option to
15 consider that's not on the table, is cleaning up this whole
16 mess with employers.

17 In 1985, the average premium was about \$50 a
18 month, and so putting a commercial premium on an elderly
19 person -- and that's for somebody who's 64, right? So
20 putting a commercial premium on somebody at \$50 a month
21 isn't a big deal. Today it's about \$1,500 a month. So I'm
22 sure this was an unintended consequence, but how does this

1 affect -- and as a former employer, I can tell you, I want
2 people with experience, but, God, the cost of insurance is
3 ridiculous. And now I believe it's about \$24,000 a year on
4 average for a family of four. So how do I hire somebody
5 for \$40,000 a year and pay \$24,000 a year for insurance?

6 So I think that we need to think about how this
7 shift is maybe really penalizing -- and I've heard this out
8 in the world -- really penalizing our employment for our
9 seniors and causing them to lose their jobs or to not get
10 hired which, of course, has to be all very much under the
11 table because that would be, you know, discrimination.

12 So I think we should consider as a policy option,
13 as we're talking about this, to allow employers to buy
14 Medicare policies for their patients when -- for their
15 employees when they qualify at the cost of the government,
16 so not at the taxpayer subsidized rate. But why don't we
17 just -- I mean, Medicare is a fabulous policy, and we
18 shouldn't be forcing these people to be in high-deductible
19 HMOs when they could be on Medicare for similar cost.

20 So I think that we should be looking to maybe
21 advise Congress on how to update these policies, given the
22 reality of our ridiculously high cost of health care in the

1 United States.

2 Thank you.

3 MS. KELLEY: Greg.

4 MR. POULSEN: Okay. Let's see if I can multitask
5 doing the timer. Yeah, okay. Anyway, this could go really
6 badly.

7 I'd also like to say, Eric, this is great stuff,
8 and I appreciated your stating that there are important
9 things that we don't know that just isn't good data on yet
10 and maybe never will be, but I thought that was really,
11 really helpful, so thank you.

12 I'd like to step sideways just a little bit and
13 talk about adverse selection in a commercial world, which
14 is a very different thing than what we're thinking of here.

15 So sort of the classic example that we all think
16 about is the family -- and let's assume here that the
17 premium covers the total cost of care, the collective
18 premiums cover the total cost of care. So the classic
19 example would be a family that chooses to not have
20 insurance because everybody's basically healthy. They
21 decide that they're going to have a baby. So they sign up.
22 They pay for coverage for a year, which covers all of the

1 normal care and potentially the cost of something going
2 badly wrong, the cost of a NICU stay and things of that
3 sort. And then as soon as the babies all arrived and
4 healthy, they discontinue their coverage again. That's
5 sort of the classic thing where they end up paying the cost
6 of premiums for a few months and collect an enormous amount
7 of insurance benefits.

8 We don't have any evidence. In fact, we've got
9 counter-evidence that that's not what is happening here.
10 The data that you put in the chapter, which is really,
11 really helpful, is the people that are incurring penalties
12 are actually less expensive than the people that aren't
13 incurring penalties. So they're not waiting to -- it
14 doesn't appear at least that they're waiting to get
15 coverage, and then they're having both knees and both hips
16 replaced six months after they started to get coverage. So
17 I think there isn't evidence that there's massive abuse.

18 The other thing that's very different than the
19 commercial example is that the taxpayers are covering 75
20 percent of this, or in the case of Part D, more than that.
21 So, collectively, when somebody chooses not to be insured,
22 the numbers that I think I pulled out -- I think they're

1 accurate -- is that about 40 percent of the cost of the
2 coverage for the taxpayer is significantly more than the
3 amount that we receive from the beneficiaries' premiums.
4 So, in other words, if somebody chooses not to have
5 coverage, taxpayers are actually a net beneficiary of that.
6 And I'm sure that that is not the -- well, we know that's
7 not the case from the data that you've had for some of the
8 beneficiaries, but across the whole cadre of beneficiaries,
9 that appears to be the case.

10 So, in this case, collectively, the people that
11 are foregoing coverage are putting themselves at risk,
12 because when something does go badly wrong, they're in
13 trouble. It's putting the health care system, who may end
14 up with bad debt, to some degree at risk. And it does have
15 some adverse selection impact on the people that are still
16 in the program. It doesn't appear to be a really big
17 number, but it is there, and it's not zero.

18 So, as we think about all those, there's reasons,
19 I think, to say penalties make sense. It makes sense to
20 encourage people to get into this, but the kind of
21 draconian penalties that we're seeing appear to me to be
22 way beyond what is justified by the net impact on

1 taxpayers, other enrollees, and the health care system at
2 large.

3 So I really liked, and I appreciated, that we'd
4 mentioned the Part A journey and their penalties piece,
5 because that seems like a model that to me at least feels
6 like it has the appropriate balance of there's something
7 there that says, no, just don't hang around and wait until
8 something goes bad and then enroll, but neither does it do
9 something that has lifelong consequences or even
10 consequences to the degree.

11 But I don't think -- another of the things I
12 think, Eric, that we don't know is to what extent once you
13 start getting into the penalty phase does that make you
14 even less likely to get coverage because it's become more
15 difficult to get in and, oh, by the way, I'm still pretty
16 healthy so I can get away without doing it. And they just
17 dig themselves deeper. It's kind of a death cycle kind of
18 a thing where you get yourself deeper and deeper in and
19 can't find a way out.

20 So that'd be my thoughts, and thanks so much for
21 the great stuff.

22 DR. NAVATHE: Can I jump in here for just one

1 second? So thanks, Greg, for that.

2 I think we've had a couple of comments about
3 adverse selection. So I just wanted to make sure we
4 clarify that there's several things that are sort of true
5 at the same time. So I think it might be helpful to think
6 about this in that way.

7 So, as Greg is pointing out, I think the way that
8 we think of the adverse selection spiral in traditional
9 insurance markets is not going to apply here in the same
10 way. I think that is definitely true, because of the data
11 that Eric showed on average, that the individuals who
12 enroll late -- later and therefore incur late penalty are
13 at lower than average cost, the premiums would not go up.
14 The premiums would come down.

15 That being said, when they enroll, government
16 spending would go up. And so, when Greg says that, when
17 you delay, if an individual delays enrollment, then
18 government spending is not happening for them until they
19 enroll. That is also true. So I just wanted to make sure
20 that we like outline those facts so everybody has that in
21 their mind as they are considering kind of what the
22 different policy options are.

1 MS. KELLEY: Okay. Stacie is next.

2 DR. DUSETZINA: Thanks so much for this work,
3 Eric. I realized as I was reading the chapter, I was
4 reading it in your voice. And I was like, okay, I've maybe
5 been here too long.

6 MR. ROLLINS: That might make two of us.

7 [Laughter.]

8 DR. DUSETZINA: So I think the chapter is very
9 convincing to me that this is a mess. I think if you gave
10 us a quiz after having read the chapter, we would all fail
11 to get all the rules correct, because they are just --
12 they're so different by program. So I really love the idea
13 of harmonizing across the programs. That makes total sense
14 to me and would be much, much simpler for people to
15 understand.

16 I also think that adding the penalties after
17 starting at Social Security age is a more fair thing to do
18 considering that has moved up. It doesn't make a lot of
19 sense to me to add the penalties earlier.

20 And I especially liked the idea of shortening the
21 time frame for paying penalties. I think that might also
22 help to avoid the accruing such very high penalties, and

1 then you don't have them for that long. So I think that
2 that to me all seemed like really commonsense things to do.

3 The last thing is just, you know, it was kind of
4 shocking to think about the difference of starting to
5 accrue penalties after 63 days in Part D versus a year for
6 Part B. I think that should be on the same timeline, and
7 it should be a year for everybody.

8 MS. KELLEY: Cheryl.

9 DR. DAMBERG: So I'm going to plus-one what Lynn
10 said and Stacie said and Robert, which is this is all
11 crazy-making, and it needs to be simplified. And we would
12 all fail the test in terms of selecting.

13 One of the concerns that I have is -- you know,
14 so while a small fraction of people are paying the penalty,
15 the size of this penalty is going to increase as premiums
16 continue to rise. And we have continued to see premiums
17 rise and represent a substantial share of people's income
18 that they have in retirement. So that part is concerning
19 to me.

20 I recognize the issue of adverse selection, and I
21 do think penalties need to be in place. They're an
22 important safeguard against adverse selection.

1 But that said, I agree with Stacie's comment
2 about tying them to the age of retirement, moving that up
3 to 67. And I wondered if there's an opportunity. I know
4 CMS sends notices to people who are enrolled in low-
5 performing plans and Medicare Advantage. And I don't know
6 to what extent CMS is actively sending messages out to
7 people to kind of remind them to enroll and what the
8 consequences of late enrollment are. Maybe that's
9 happening, but if it is, I think we should spotlight that.
10 And if it's not, I think it's something that should be
11 considered just as a prompt to get people -- more of these
12 people in.

13 I agree with the idea of phasing out the penalty
14 after some period. I'm not sure whether that should be 5
15 or 10 years, but I think we could model that.

16 And I also am in favor of making the penalty
17 rules consistent across the two. It just adds to confusion
18 and complexity, and it doesn't seem to have any underlying
19 rationale for the differences.

20 I look forward to the November discussion around
21 the SHIP program and how beneficiaries are notified once
22 they turn 65.

1 MS. KELLEY: Gokhan.

2 DR. METAN: So first of all thank you very much
3 for this work. I really enjoyed the chapter.

4 I would say that when I first read the chapter my
5 initial reaction, my heuristic brain kicking in, and
6 reading \$1.1 billion in the penalties, like why do we
7 really bother? This is like peanuts in the grand scheme of
8 things.

9 But then my analytic brain kicked in and I said,
10 okay, but how much deterrence do we really get out of these
11 penalties? Like if you take the penalties out of the
12 equation completely, what will be the impact of true
13 adverse selection on the system?

14 So I think that's where I started to lean more in
15 the camp of not completely eliminating the late-enrollment
16 penalties but making sure that we make adjustments in the
17 proposed recommendation to eliminate some of the
18 inconsistencies and such.

19 So I think from that perspective I believe some
20 deterrent is needed to ensure that the adverse action is
21 prevented, and I believe a reform should change the design,
22 not abolish penalties. So from that perspective I'm in the

1 same camp as Kenny.

2 In terms of developing options, I think I support
3 the following, in the following order. The first, making
4 the rules consistent is extremely important -- I think many
5 of the Commissioners called it out already -- and extending
6 the Part B special enrollment period to retiree and COBRA
7 coverage and lengthening the Part D grace period. I think
8 these are really important to make the rules consistent.

9 Second, I believe time limiting the penalty, like
10 using a similar approach like Part A is a good change in
11 the policy, as well. So we should take a look into that
12 and how analytically we can quantify what we would
13 potentially expect to see.

14 And then as an alternative, a secondary option,
15 we can also treat the cap on the amount. So A and B would
16 kind of like, at risk of saying this, with the least damage
17 to the deterrence of the adverse selection, I think, my
18 belief. But we should also consider the administrative
19 feasibility, because extending the Part B special
20 enrollment period to COBRA and retirees would require
21 Social Security Administration and CMS to do certain
22 things. So I think we should articulate what that would

1 mean, and if these entities can really kind of implement
2 these.

3 I also really liked, actually, Lynn's suggestion
4 in terms of looking into employers, kind of like tapping
5 into the providing the Medicare coverage. She said it
6 better than I could articulate, but I think it makes sense
7 to really look into that potentially different kind of
8 policy recommendation from the analytical lens and what
9 would that mean. I think it's worth looking into.

10 I also believe, when I look at some of the data,
11 that there might be certain other adjustments we can
12 recommend, such as, for instance, when I look at Part B
13 penalties there is a substantial, like 32 percent receiving
14 less than, I think it was Table 5 or something, no, Table
15 3, 32 percent of the Part B penalties is just less than 5
16 percent. It sounds to me like from the data that these are
17 the people who are really unintentionally missing these
18 enrollments. And it's a very small dollar but it affects 1
19 million people. So I think forgiving some of those
20 penalties of a certain amount might also kind of eliminate
21 some of the unintended penalty happening for some of the
22 enrollees.

1 And the other question, and maybe in the follow-
2 up research that I would like to understand is when I look
3 at Figure 2, how the penalty amounts are decided, I'm not
4 sure if there was any analytics behind it, like
5 justification, or just arbitrary selection of how the
6 penalties are decided. So I think it would be helpful to
7 understand whether the penalty levels are justifiable from
8 the data, meaning is this like the adequate amount of
9 penalty that would effectively deter adverse selection and
10 relative to the kind of like financial burden it has on the
11 beneficiaries. So I can see looking into that.

12 But I'm really looking forward to progressing on
13 this body of work, and I really appreciate the analytical
14 rigor. Thank you.

15 MS. KELLEY: Tamara.

16 DR. KONETZKA: This is going to be one of those
17 sessions where I think there's just so much agreement we're
18 all going to be saying somewhat similar things because the
19 complexity is so baffling that nobody could actually
20 support most of it, because there's just not any good
21 rationale behind some of it, just historical accident. I
22 think in a previous meeting I called some of this the sort

1 of stupid complexity. There's some complexity around
2 avoiding adverse selection that might be necessary, but the
3 sort of stupid inconsistencies and complexity that don't
4 seem to have any justification, I think it's great that
5 we're going down this road of coming up with options to try
6 to reduce that.

7 So Eric, as you said, I believe, as Cheryl said
8 and other people said, that there needs to be some penalty.
9 I think adverse selection is a thing. And when we think
10 about Part B, and one could argue with this, but when we
11 think about Part B and people thinking they may not need
12 that, I feel like there's probably less there. I think
13 there's a lot of potential for adverse selection in Part D,
14 just people who don't have expensive drugs now, when
15 they're like, why should I be paying this? So maybe that
16 was some of the origin of different penalties, but the
17 severity of the penalties kind of goes in reverse.

18 But anyway, I do think we should have some
19 penalties. We do have to think about adverse selection.
20 But the way the rules are set up there is inadvertent
21 selection, inadvertent adverse selection, or inadvertent
22 delays in signing up, and perhaps intentional sort of

1 adverse selection behavior. And Eric, as you mentioned,
2 it's really hard to separate the two. So what I think we
3 need to do is sort of modify these enrollment rules to try
4 to reduce the inadvertent delays in signing up.

5 I do think it doesn't make any sense that we have
6 different time periods for the delays, for the penalties
7 being applied in Part D and Part B, and that the amounts
8 are very different. I think we should have a parallel
9 structure across the two to reduce the inconsistency.

10 I would love it if we had more research to inform
11 exactly what those penalties would be, to reduce the
12 behavior we don't want to see. I don't think we have that,
13 based on Eric's answer to my one question and the research
14 that was reviewed in the chapter.

15 So, you know, something a little bit arbitrary is
16 just fine probably, something that sort of combines the
17 Part B and the Part D and implements some penalties that
18 don't seem as severe. I think Greg's point is well taken
19 that this isn't going to make a huge difference in the end,
20 and yet we do want to disincentivize adverse selection. So
21 something that's just uniform across the two programs,
22 that's not lifetime, and that's maybe not as severe as what

1 they are right now in the Part B. So sort of pick
2 different options and see what the penalties might be, so
3 that we can still include a penalty. Yeah, so that
4 includes capping the number of years as well as the actual
5 amounts.

6 I also think we should not only have the sort of
7 harmonize across the number of months or how the lack of
8 enrollment is calculated, but also to reduce the
9 inadvertent delays. You know, think about loosening the
10 rules for some of the special enrollment periods.

11 I don't know exactly how this works. I don't
12 even know if I want to go down that road of trying to
13 figure it out. But people have different birthdays, right,
14 and so some people have longer until the next open
15 enrollment period than other people. And I just feel like
16 during that first year or two we should be very lenient
17 about delays in signing up.

18 So anyway, I'm obviously very enthusiastic about
19 this work. I think it's hard to separate it from the
20 session in November about notification, because that could
21 clear up a lot of this inadvertent delay. But I'm very
22 supportive of making the penalty rules more consistent,

1 reducing the size of the penalties, and that probably
2 includes making them time limited, just to have a little
3 bit of incentive for people not to delay. Thanks.

4 MS. KELLEY: Gina.

5 MS. UPCHURCH: First of all, I'm just super
6 thankful for the brilliance of the fellow Commissioners in
7 their comments, and Eric, just tremendous job. Really,
8 thank you for digging in.

9 While some people may have health insurance
10 literacy expertise when they are hitting the ages of 65 or
11 they have employers that give them really good information
12 and limited choices and that kind of thing, our experience
13 is that many, many people are flummoxed by the alphabet
14 soup of Medicare A, B, C, and D, and what to do when, and
15 it's just too much. It's not like buying a car.

16 So one of the issues is that many people are
17 overinsured, or they are fearful because they have a
18 condition and they become overinsured, and that creates
19 problems. Because if you have a primary coverage and a
20 secondary coverage it's administratively burdensome to try
21 to figure out who is doing what and being told different
22 things by different people. But also if you start B too

1 early, again, you're wasting your money if your employer is
2 still primary coverage, you may be paying IRMAA, and in
3 many states you may not have guaranteed issue to Medigap
4 when you decide to leave or you retire.

5 One of the things I care about is that I think
6 regardless of the size of your employer, large employer,
7 small employer, when you leave your work, not when you
8 start B but when you leave your employment you should have
9 guaranteed issue rights to a Medigap supplement. So not
10 when you start B but when you leave your employer, large or
11 small. That would clarify a lot of things for people.
12 That's the first thing.

13 Second thing, in the executive summary you
14 mention that some people delayed their enrollment. I wish
15 we'd put in parenthesis "intentionally or unintentionally."
16 Because a lot of the people we deal with, it's not like
17 they sat around and thought, "Let me delay that." They
18 didn't even understand. They didn't get a notification.
19 And I know we're going to have a chapter about that, but I
20 just want to make it clear that people aren't intentionally
21 necessarily delaying.

22 In Figure 1, one of the questions there is that

1 you have a graphic that shows how many people at 70 haven't
2 started A yet. I think that's going to just continue to
3 grow, because we have -- and I just heard on a podcast this
4 morning -- people that have employer coverage right now, 30
5 percent of people have a high deductible health plan with
6 an HSA. So I think we're going to have more and more
7 people who are going to be delaying joining Medicare, and
8 many have no clue that it's retroactive six months, and you
9 have this 6 percent excise tax, as well, that you shouldn't
10 have been paying, and you have penalties for that.

11 So I feel like we need to give people a choice to
12 make their A retroactive or not. That's the second thing.

13 Just so everybody knows, when you're helping
14 people with the Plan Finder tool, two things are missing
15 from that Plan Finder, so it would be super helpful if we
16 could get that added when we directly put people's
17 information in who aren't doing a general search. One is
18 the late enrollment penalty and how much they'll owe. The
19 system should be able to figure that out if we keep
20 delaying all the penalties. And the second is IRMAA.
21 People are just surprised when they hear about that, so if
22 we could add those to the Plan Finder tool, and since we're

1 talking about late-enrollment penalty I thought I'd put
2 that out there.

3 Page 19 says that "it may be particularly
4 attractive for beneficiaries who do not initially enroll in
5 Part D because they were unwilling to pay for the
6 coverage." Again, I just think for a lot of people it's
7 not that they weren't unwilling. They just didn't
8 understand. Because if they had known there was a zero
9 premium Part D plan or a \$3.60 Medicare Part D plan they
10 would have enrolled. So if we could just make that clear
11 that it's not just unwilling, it's oftentimes not
12 understanding.

13 I've asked for this before, and I know we're
14 starting to look for recommendations, but we see a lot of
15 people that were relying on safety net clinics, whether it
16 be an FQHC, a community health center with a pharmacy, a
17 free pharmacy, patient assistance program, saving us lots
18 of money. But then when they realize their 340(b)
19 formulary is shrinking and they need a drug benefit, and
20 they saved us lots of money already by not joining already,
21 they have these late-enrollment penalties. They are a stop
22 for many people with limited incomes.

1 So I'm going to ask that we at least waive the
2 late-enrollment penalties for people who have relied on
3 safety net providers, at least 300 percent of the federal
4 poverty guidelines. We just waive their late-enrollment
5 penalties. Because there are a lot of people, I believe,
6 that are not joining Part D, not because they don't need it
7 but because they can't get past those late-enrollment
8 penalties.

9 And lastly, of the three choices you have here,
10 and I'm going to give some arbitrary ideas of what we might
11 do there, so you have a couple of options here for us, and
12 I say yes to all three. The penalty rules need to be more
13 consistent with B and D. I agree that a year's time,
14 giving people at least a year, not starting with month one
15 of the penalty but 12 months of the penalty. Decrease the
16 size of the penalty, again, especially for people who have
17 relied on safety net providers and really struggle to get
18 in the game. And then, lastly, make it time limited, so
19 you're out a year and then you have a penalty for a year.

20 We need to keep it simple. We are losing SHIP
21 people because it's too confusing. So we have to have
22 these rules be simply, not only for the beneficiary but for

1 those of us trying to help the beneficiary. So you're out
2 a year, you have a late-enrollment penalty of a year. And
3 I think there needs to be a max on that, and I'm
4 arbitrarily saying three years. Why not?

5 Thank you so much for this work.

6 MS. KELLEY: Brian.

7 DR. MILLER: Well, I had a very brief thoughts
8 and then they have grown longer. I'll start with my brief
9 tactical solution-oriented thoughts.

10 First is that most of these penalties in terms of
11 dollar amount are small, so looking at the tables, this was
12 a hard topic that was well put together and made clear, so
13 I appreciate that. The 50th percentile is \$7 per month for
14 D and \$35 a month for Part B, as in boy. I think that in
15 that vein, though, we should make things a little simpler.
16 One is the Social Security Administration should notify
17 people at age 65 of Medicare, because Social Security kicks
18 in at 67. It seems like a pretty easy solution, a calm
19 solution.

20 The second thing that we should probably do is
21 try and converge Part B, as in boy, and D, as in drug,
22 rules. So maybe a special enrollment period for COBRA and

1 retirees for Part B, and then expand the Part D penalty-
2 free gap year from a relatively arbitrary 63 days -- I love
3 that number 63, not 62, not 64, but 63 was the right
4 number. So align them both at one year, and then I would
5 say you'd have a better notification system, you'd solve
6 that interface with the employer-sponsored insurance, and
7 you'd have that clear one year. Those are three things
8 that I think would go a long way towards solving these
9 problems.

10 So those are my initial thoughts.

11 My additional thoughts, one is a philosophical
12 thought and the other is a reaction thought. My
13 philosophical thought, that many of us here, and this is
14 not necessary right or wrong, operate under the assumption
15 that more government intervention is the answer. I'd like
16 to point out that there is a difference between Medicare
17 and the employer market. And many folks here have
18 mentioned how challenging Medicare enrollment is, and you
19 get that giant handbook, and you have all these parts, et
20 cetera.

21 If you look at employer-sponsored insurance,
22 enrollment is not easy but it's a lot easier. So you have

1 the Federal Employee Health Benefits Program, which when I
2 joined the federal government they had a nice session and
3 then you had your open enrollment, the rules were very
4 clear, and there were lots of choices, and they had people
5 who would counsel you on the choices. That was the Federal
6 Employee Health Benefits Program.

7 I am Vice-Chairman of the Board of the North
8 Carolina State Employee Health Plan. We have our open
9 enrollment next week. There is a comms plan. You know,
10 there are counselors. We work with the employee
11 associations and unions. That works pretty well. It's not
12 perfect.

13 I am also employed at a university, which again,
14 universities are not perfect but we have a very -- I got my
15 email recently about the annual sort of enrollment for
16 health, disability, life, et cetera. And I remember when I
17 joined I had a counseling session, and we had our annual
18 enrollment.

19 One of my other friends works for the Boston
20 Consulting Group, and when they joined they had a pretty
21 clear annual enrollment.

22 So I would actually say maybe we should think

1 about what the private market is doing and what the private
2 market does and does that work better. That's my
3 philosophical thought.

4 My reaction thought is on the other topic, which,
5 honestly, I don't really think it's our role to opine on a
6 Medicare public option buy-in. I think that's sort of
7 outside our scope. But since it's been brought up I do
8 want to say a few things about that.

9 One is I think crowding out private markets is
10 problematic. Why is that problematic? One is -- and I'm
11 pretty tough on hospitals, so take this for what it is --
12 this would absolutely be financially devastating to them,
13 because hospital rates in Medicare are 50 to 60 percent
14 lower, sometimes 70 percent lower, because commercial is
15 paying 200, 230, 250. So do we think that the hospital
16 industry -- which I think can be more efficient by several
17 percentage points -- I don't think it's reasonable at all
18 to suggest that they could be 50 to 60 to 70 percent more
19 efficient, and for them to be 50 or 60 or 70 percent more
20 efficient in one year is just patently, operationally, and
21 physically unreasonable, and would cause widespread
22 insolvency. And I am probably the toughest person in

1 Washington on the hospital industry, so if I'm saying
2 that's not reasonable, it's probably not a reasonable ask
3 for them.

4 I think the other thing is that public programs -
5 - I'm very supportive of public health benefit programs and
6 public welfare programs, but they need to be targeted to
7 those who need them. Currently, we have IRMAA, which has
8 not been updated, and I did a little digging, and we are
9 providing support and subsidy to very wealthy folks -- 1.4
10 million couples make over \$410,000 annually in retirement,
11 which means they have a very solid upper middle class or
12 upper class income, or they have millions and millions and
13 millions of dollars in the bank in investments. And
14 congratulations to them for doing so well. They do not
15 need an additional subsidy, and people working and making
16 that much money also do not need an additional subsidy.

17 I think the other thing we need to realize is
18 that when you expand public programs you're raising taxes.
19 This is not without friction. Public and private spending
20 are not in a one-to-one relationship. Public spending is
21 powered by taxes. That changes production incentives for
22 individuals and businesses, which dampens supply and also

1 dampens broader economic growth. So I'd be veery cautious
2 about suggesting expanding public programs, because the
3 tradeoffs are not as clear as people have been led to
4 believe. Thank you.

5 MS. KELLEY: Tom.

6 DR. DILLER: Yeah, again, thank you very much for
7 a great chapter. Greg, I appreciated your take on the
8 adverse selection, and I think you're spot on with that. I
9 think there is evidence that there does need to be a
10 penalty but that the penalties are probably onerous at this
11 point in time. So what do we need to do with that?

12 I'm not going to go into all of this because I
13 think people have talked through a lot of the choices.
14 Gokhan, I especially appreciated your take on it and some
15 of your recommendations, and I basically agree with those.

16 So I think that Part B and Part D need to be
17 simplified. They need to be standardized. That certainly
18 is one. I think the length of time of the penalties is
19 probably excessive and that needs to change, and there
20 needs to be some sort of a cap on it.

21 Eric, to my previous question of what to do with
22 the \$1.1 billion, I did a quick Google search and I don't

1 guarantee my math at this point either. But it looks to me
2 that it would be about 0.42 percent that we would have to
3 raise all the premiums, and that's \$9 to \$10 per
4 beneficiary per month, if my math was correct.

5 So we have to account for that in some way,
6 shape, or form. And I think that's the other thing that is
7 maybe not being addressed at this point, is if we do
8 decrease these penalties we're not going to decrease them
9 by the full \$1.1 billion, but we've got to come up with the
10 additional money that that decrease is.

11 But anyway, thanks very much for a great chapter.

12 MS. KELLEY: Paul.

13 DR. CASALE: Yeah, Thanks, Eric. Terrific
14 chapter. And as Tamara said, I think there's a lot of
15 agreement amongst the Commissioners so I'll be relatively
16 brief.

17 I agree, the penalty rules need to be consistent
18 across the program, and I think including retiree coverage
19 and COBRA, that is particularly confusing to those who sign
20 up for COBRA during this transition and they don't realize
21 that actually doesn't count. That seems, well, easy to
22 fix, but I would certainly think that would be a good

1 recommendation.

2 Again, on the penalties, I think the permanent
3 makes it such a high stakes, stressful experience, even if
4 you're doing everything correctly. And I think that
5 following Part A, in this sort of time-limited and twice as
6 long as you're not covered seems like, again, consistent.

7 And on Part A, you know, you saw that 90 percent
8 plus enroll on time. I think the employers can play a
9 role. Again, this is anecdotal, but my employer I noticed
10 was quite proactive about saying, "It's time to start to
11 sign up for Part A." Again, I know Part A, there's no cost
12 to it, but the employer was proactive about it.

13 They have a resource to sort of help people
14 navigate the Part B, but they're not very proactive about
15 it. And we can talk about. There is notification on the
16 CMS part, but I think the employers can also play an
17 important role in being much more proactive, you know, as
18 people are transitioning from their employment to provide
19 that notification. Anyway, I think there is opportunity
20 there, as well.

21 So thanks, and I look forward to the further
22 conversation in November.

1 MS. KELLEY: Scott.

2

3 DR. SARRAN: Excellent work as usual, Eric. I'm
4 just going to put a few thumbs on the scales on top of
5 other great comments.

6 I think some of the simple steps that people have
7 teed up make a ton of sense. I would include first syncing
8 up the Part B and D. That just seems like a no-brainer and
9 would in and of itself make a lot of people's decision-
10 making easier.

11 I think the way that the penalty exists for Part
12 A, if I read that correctly and heard you correctly, it's
13 capped both in the magnitude and duration. So it's not
14 infinite in either of those two dimensions. That also
15 makes sense. I mean, we can sort of make the point about
16 there being a penalty but not have it overly onerous, and
17 so capping magnitude and duration, I think seems to make
18 sense.

19 Gina's point about or suggestion about a
20 guaranteed issue to Medigap when losing employment, I think
21 the whole discussion around access to Medigap deserves
22 ongoing work, and I know we have other topics that touch up

1 against that. But, particularly, if we're entering a time
2 period where MA plans may be pulling back on networks and
3 benefits because their business is getting somewhat harder,
4 I think giving beneficiaries a fair access at market prices
5 to Medigap is an important one.

6 And I like Gina's suggestion also about some kind
7 of access to Part D without a late enrollment penalty if
8 their previous source of drug coverage was some type of
9 safety-net provider. I don't know how we'd operationally
10 define that, but, boy, it sure resonates with me.

11 And then look forward to next month's discussion
12 around better front-end notification because certainly that
13 there's just both loads of room for improvement there.
14 Thanks.

15 MS. KELLEY: Josh.

16 DR. LIAO: I just want to very quickly underscore
17 a couple of things. My overarching principle as I was
18 reading this chapter is really about, you know, while I do
19 think a penalty is needed, I think it should be strong
20 enough to encourage the timely enrollment but not be kind
21 of longer, more severe than necessary to achieve that
22 purpose. So, ultimately, I think a lot of good ideas that

1 other Commissioners have mentioned. I would just add my
2 support for the time duration limit as a potential
3 perspective.

4 I think we need to recognize, as others have
5 said, that people delay for different reasons. We want to
6 discourage just holding out until we need care. That's the
7 dynamics that Greg mentioned. But, also, as other
8 Commissioners have said, there are other reasons,
9 unintentional reasons that people don't get into
10 enrollments, and I think we just can't reliably distinguish
11 those. I think that lack of being able to distinguish that
12 means that things like proportionality should really guide
13 our next response.

14 So I think whether it's intentional or not, I do
15 think a finite lapse -- I have a hard time reconciling that
16 with like a lifelong penalty. So I think limiting that is
17 sound from a proportionality perspective.

18 I think also when we think about limiting that, I
19 would favor suggesting future analysis. I appreciate
20 Amol's point about thinking about what government spending
21 is more or less or premiums are higher or lower. I think
22 there's probably more analysis, whether through MedPAC or

1 others, that's needed there. I think in the absence of
2 that, pursuing program consistency is good. So I would
3 just underscore kind of what Greg had mentioned about a
4 multiplier like we see in Part A being used here makes a
5 lot of sense.

6 So lots of good ideas here, but I think the
7 current timely duration to me is particularly promising.
8 Thanks.

9 MS. KELLEY: Okay. I've reached the end of my
10 queue unless I've missed someone.

11 DR. NAVATHE: Thank you, Dana, and thank you,
12 Commissioners. I heard a lot of passion and excitement
13 about the work, and I think that's wonderful.

14 The enthusiasm for the next session also is very
15 palpable, as many of you couldn't wait to get there, and so
16 that's great. So we're going to have a fun time in
17 November too.

18 So a couple of things I wanted to highlight. I
19 think there may be a couple of comments that were made that
20 pointed out that -- and I just wanted to kind of echo or
21 underscore it, is that because we have the penalties in
22 place, it is correct to say that. If we remove the

1 penalties, we don't know what that adverse election
2 response would be. So we just have to keep that in mind,
3 and I think people said that. I just wanted to underscore
4 that.

5 The other thing I wanted to point out is that
6 MedPAC is not actively or currently considering any option
7 of an employer buying into Medicare. That is not what's at
8 all being considered or on the table right now.

9 The other thing I wanted to point out is, doing
10 the math is pretty tricky in terms of, you know, what the
11 amounts might look like, and I think we were playing around
12 getting slightly different numbers. So I would say thank
13 you, Tom, for your effort, but let us come back to you with
14 that, and so that way we can make sure that we have a
15 common fact base on that piece in the next November
16 session.

17 I also wanted to highlight -- so this is, as you
18 all know, based on Commissioner enthusiasm, this is part of
19 a workstream. So our work on enrollment decisions and
20 coverage and Medigap, et cetera, et cetera, is part of a
21 broader workstream. So we are, of course, interested in
22 what you all are interested in. So we are registering

1 that, even if we're not going to directly address that in
2 November or again in the spring. So I just wanted to point
3 that out, and we'll have opportunities to discuss kind of
4 where we go there.

5 In terms of this session, I think there was a lot
6 of support for harmonizing and symmetry. I think that was
7 very clear, as well as kind of harmonizing symmetry and
8 thinking about the special enrollment periods and
9 potentially lengthening that enrollment window. So I think
10 those were kind of areas that we heard a lot of support
11 for, and we also heard a fair amount of support for
12 shortening the duration of the penalty, some support also
13 for reducing the size of the penalty, and maybe that may be
14 in the form of what's on the tails, as opposed to what's in
15 the center of that distribution.

16 So those are some of the kind of key themes, I
17 think, that we're taking away. Obviously, some of you also
18 mentioned things like harmonizing the notifications, and so
19 we'll stay tuned.

20 Those of you at home, stay tuned. We're going to
21 get a chance to discuss that in November.

22 So thank you very much for a fantastic

1 discussion, and we will start back with our last but not
2 least session of the day at 10:35.

3 [Recess.]

4 DR. NAVATHE: All right. Thank you for your
5 patience, everyone. We are now going to start our final
6 session for the morning, and that is our work plan session
7 addressing the accuracy of the SNF and home health
8 prospective payment systems.

9 Evan, I'll turn it over to you.

10 MR. CHRISTMAN: Thank you, Amol.

11 Good morning. Next, we will walk through some
12 work on the SNF and Home Health PPS we have planned for the
13 next cycle, and as a reminder, you can access these slides
14 in an icon on the right-hand side of your screen.

15 This presentation will have three parts and then
16 a discussion by Commissioners. First, we will walk through
17 the recent changes to the two PPSs in question and the
18 current payment policies. Second, we will review the
19 motivations for examining the accuracy of these systems.
20 And, finally, the presentation will walk through our
21 planned research questions and methods.

22 First, the background. Assessing the accuracy of

1 the SNF and home health PPS is appropriate because both
2 were significantly revised in the 2020 payment year. Prior
3 to 2020, each PPS had an adjuster that tied payment to the
4 amount of therapy provided during a stay, with payments
5 increasing as the amount of therapy provided increased.

6 MedPAC and others noted that this created
7 problematic incentives, and in past reports, the Commission
8 recommended the elimination of therapy from these case-mix
9 systems.

10 Revisions implemented in the 2020 payment year
11 eliminated therapy, as we recommended, and the new systems
12 relied more heavily on patient characteristics to set
13 payment levels.

14 Now I will turn to an overview of these systems.

15 Here you can see a summary of the SNF PPS. It is
16 a per-day system with later days adjusted to reflect lower
17 resource use. There are five case-mix adjusters that set
18 payments for specific services provided during a SNF stay.
19 These case-mix adjusters are based on patient information
20 reported by SNFs through the minimum data set patient
21 assessment tool. And, finally, as noted previously, the
22 current system does not rely on therapy to set payments.

1 And here is a similar overview of the home health
2 PPS. The home health PPS has a 30-day unit of payment with
3 second and subsequent 30-day periods adjusted downward
4 because they typically have fewer visits. It has a single
5 case-mix system for adjusting patient acuity and also has
6 an outlier payment for cases with unusually high costs.
7 This case-mix system uses patient assessment information
8 from the OASIS assessment tool to collect clinical and
9 functional status to assign beneficiaries to case-mix
10 groups. And, as I mentioned before, the system does not
11 use therapy to set payments after the 2020 revisions.

12 Now we turn to the specific motivations for the
13 work Carol will be describing.

14 In the planned work, we focus on payment accuracy
15 of the case-mix adjusted payments made in the SNF and home
16 health PPSs, which account for about \$47 billion a year in
17 fee-for-service payments. Accurate payments are critical
18 because of the incentives they create for the appropriate
19 delivery of care.

20 When payments reflect expected costs at the case
21 level, providers have no incentive to select some patients
22 over others.

1 In contrast, inaccurate payments can cause
2 providers to favor or avoid patients based on financial
3 incentives, which may lead to access to care problems for
4 some beneficiaries when their conditions are underpaid and
5 potential incentives for low-value care to be
6 overprovisioned if Medicare's prices are too high.

7 In addition, payments can become distorted when
8 the cases are coded in ways that do not reflect patient
9 complexity, and this can result in case-level payments that
10 do not reflect patient acuity and increase aggregate
11 payments to unnecessary levels.

12 Finally, the payments in these PPSs influence the
13 incentives and payment levels for alternative payment
14 models and are a factor in setting the MA payment
15 benchmarks. Any misalignment in the PPSs could reduce the
16 efficiency or effectiveness of other Medicare policies.

17 This work complements other analyses by the
18 Commission. Every year, the Commission examines the
19 aggregate level of payments and costs in these two PPSs.

20 In the 2026 March report to Congress, we
21 concluded that payment levels are high relative to cost and
22 aggregate and that access to care was adequate in both

1 sectors but may vary from market to market. As the payment
2 adequacy analysis focuses on aggregate levels, this project
3 will build on that work by examining whether payments are
4 accurate at the case level.

5 It is an opportune time to evaluate these new
6 systems. We now have several years of data to assess the
7 changes. Providers have had time to adjust to the
8 policies, and separately, the disruptions of the PHE have
9 moderated, and the most recent years of utilization data
10 should reflect typical care for the post-COVID environment.

11 Now, I will turn it over to Carol, who will take
12 you through the planned research.

13 DR. CARTER: Our analyses will focus on whether
14 payments are accurate and two possible provider responses
15 to the PPSs, patient selection and coding practices.

16 Regarding accuracy, we'll examine whether the SNF
17 and home health PPSs accurately account for differences in
18 patient costs. For patient selection, we will look to see
19 if there's evidence that providers select certain types of
20 cases over others.

21 Regarding coding practices, we'll assess if
22 providers' coding practices appear to have raised payments

1 without commensurate changes in patient complexity.

2 Our work will examine the SNF and home health
3 PPSs separately, but we'll use common analytic approaches
4 when feasible. Both sets of analyses will use claims,
5 patient assessment data, Medicare cost reports, and
6 beneficiary enrollment files. We will use similar
7 reporting formats for the SNF and home health results and
8 display our results by case-mix groups, by beneficiary
9 characteristics such as dual eligibility and by provider
10 groups such as ownership and freestanding versus hospital-
11 based providers. We will examine results for each year
12 between 2021 and 2025.

13 However, because the SNFs have distinct designs,
14 the analysis will be tailored to each. Specifically,
15 because the SNF PPS has five case-mix components, we will
16 assess the accuracy of each component and for the entire
17 stay. The home health PPS has only one case mix
18 classification and pays for 30-day periods. We'll assess
19 the accuracy of the case-mix groups and for the 30-day
20 periods, as well as for the entire stay.

21 We will use three analytic approaches to examine
22 payment accuracy. First, we will measure what share of the

1 variation in payments is explained by cost using regression
2 analysis. Cost should explain a reasonable share of the
3 variation in payments.

4 We plan to conduct regressions with payments as
5 the dependent variable and costs as the independent
6 variable, and consider models with and without provider-
7 fixed effects and provider-level controls. In general,
8 regression models such as these, costs explain less than
9 half of the variation in payments, given the large
10 differences in patients and the cost to treat them.

11 Our second set of analysis will examine whether
12 higher cost cases have higher case-mix weights and lower
13 cost cases have lower weights, so that payments remain
14 proportional to costs. We plan to use regression analysis
15 to examine the relationship between costs, which will be
16 the dependent variable, and the case mix index, which will
17 be the independent variable. We will look at whether these
18 relationships have changed over time.

19 A third set of analysis will look at whether
20 case-mix groups are similarly profitable. Case-mix groups
21 should be similarly profitable to reduce incentives for
22 selection. We will calculate the ratio of payment to cost

1 for each case-mix group. A ratio of one will mean that the
2 payments are equal to costs, and there would be no
3 financial advantage to admitting one type of case over
4 another.

5 From our payment adequacy work, we know that
6 these ratios will not center on one. Given the high level
7 of payments relative to cost, the average PCR will be
8 higher than one.

9 Our question is, how much does profitability vary
10 across case-mix groups? For providers, it would be an
11 advantage to admit highly profitable groups and to avoid
12 those that are not.

13 In addition to our descriptive work, we plan to
14 conduct progression analysis to assess the relationship
15 between the payment-to-cost ratios as the dependent
16 variable and beneficiary characteristics as independent
17 variables.

18 Our second block of analysis will look for
19 evidence of selection. If providers can identify prior to
20 admission which cases are likely to be profitable or not,
21 they can selectively admit some patients over others. To
22 examine selection, we'll look at whether relatively high-

1 profit and relatively low-profit case-mix groups are evenly
2 distributed across providers. While concentration of high-
3 profit groups in certain providers could indicate
4 selection, we will have to be careful in interpreting these
5 results. Uneven distributions could reflect other factors,
6 such as differences in provider capabilities or market
7 characteristics.

8 We will also look to see if there appears to be
9 selection within case types. Here, we will focus on
10 relatively high-profit and relatively low-profit case types
11 and examine the mix of providers and patient
12 characteristics.

13 For example, within a relatively unprofitable
14 case type, there may be a disproportionate mix of patients
15 with behavioral problems or certain clinical conditions.
16 We'll examine patterns over time to see if the indicators
17 of patient selection have gotten more or less prominent
18 since the PPSs were implemented.

19 Our third block of analysis will investigate
20 whether there is evidence of coding practices that raise
21 payments without commensurate changes in patient
22 complexity. As a reminder, providers' recording of patient

1 assessment information is used to assign patients to case-
2 mix groups that determine payments. Changes in coding
3 could represent changes in patient complexity, but they
4 could also reflect shifts in documentation that raise
5 payments without an underlying change in complexity.

6 To try to sort this out, for cases with a prior
7 hospital stay, we will compare SNF and home health coding
8 patterns with the coding of the same cases during their
9 preceding hospitalization.

10 For all cases, we will compare recorded changes
11 in patient complexity with changes in costs. If complexity
12 has increased, we would expect costs to increase.

13 Last, we will compare how coding has changed for
14 patient assessment items that are used to establish
15 payments with changes in assessment items that are not used
16 for payment. There may be alternative explanations for why
17 the prevalence of some items have changed more than others,
18 but the differences could indicate changes in coding
19 practices.

20 Here, we're glad to answer your questions about
21 what we've presented and would like to get your feedback on
22 the planned analyses. In terms of time frame, we are just

1 beginning this work. There is considerable work involved
2 in costing each day and creating the analytic files. We
3 plan to begin to report our results in the fall of 2027.

4 And with that, I'll turn things back to Amol.

5 DR. NAVATHE: Thank you, Evan and Carol, for a
6 very nice presentation.

7 Dana, I'll turn it over to you.

8 MS. KELLEY: Okay. I have Danielle with a Round
9 1 question.

10 DR. PIEROTTI: Thank you. I think we're going to
11 spend some good quality time together on this topic, and
12 I'm looking forward to it.

13 Two questions about this. The first one is in
14 the entry; there's quite a bit of discussion about the
15 historical payment for therapy. I would appreciate it if
16 we could clarify the use of the word "therapy" in that
17 sense, because it could be read really broad as everything
18 we do for a patient. But, in this situation, I believe it
19 was intended to target physical or occupational therapy.
20 So that's just a request for clarity in the use of that
21 phrase if we can do that.

22 My question is cost. So cost is a key variable

1 here. How is cost being determined?

2 DR. CARTER: For that, we take the charges on
3 each claim, and we use cost to charge ratios from the cost
4 reports, and those are department-specific. So, if you see
5 on a claim that there's a therapy charge, we will apply the
6 cost to charge ratio from the cost report for the therapy
7 services and convert that charge to a cost, and then we sum
8 the cost for the different elements of care. So we cost
9 each day for each patient.

10 MR. CHRISTMAN: And, you know, we each have our
11 own answer. But, yeah, for, you know, generically
12 speaking, there's one source of cost information for both
13 sectors, the cost report. And Carol walked through how
14 they do it on the SNF side, and on the home health side,
15 you end up using the cost per visit that's on the home
16 health claim -- excuse me -- on the cost report. And then
17 for non-therapy ancillaries, there's a similar exercise
18 where cost-to-charge ratio is computed from the cost
19 report, if I'm recalling correctly, and then that's applied
20 to the claim that has the charges for the NTA.

21 DR. PIEROTTI: Thank you.

22 MS. KELLEY: Gina.

1 MS. UPCHURCH: Yeah, thank you so much for this.

2 You talked about the analysis would have three
3 aspects of payment accuracy, and you mentioned one of them.
4 Is there evidence that providers select types of cases over
5 others? I understand that for home health, you get it.
6 You're wondering whether you're going to be their home
7 health agency or not.

8 But, if you're a SNF, how is that decided? I
9 mean, do you take data? I mean, I know with traditional
10 Medicare, you have to have three midnights, you know, for
11 rehab, be covering and skill. So do you take the
12 information that you gather, that the hospital shares with
13 you, or are you sending somebody over from the SNF to go
14 evaluate? How does the SNF decide?

15 DR. CARTER: There is communication between the
16 hospital discharge planning team and either a specific SNF,
17 or they could send out through a portal to multiple SNFs to
18 see if somebody -- if a SNF is willing to accept the
19 patient. So, unlike, say, hospital admissions, there's no
20 requirement that SNFs admit a patient.

21 MS. UPCHURCH: There's none for SNFs.

22 MR. CHRISTMAN: There's no, right.

1 MS. UPCHURCH: Gotcha. Thank you so much.

2 MS. KELLEY: Ben.

3 DR. IPPOLITO: I was just curious. Is there any
4 ex-ante theory or sort of question that's being tested
5 here, or is this purely exploratory in nature? Are there,
6 like, concerns about selection effects stemming from
7 payment policies?

8 DR. CARTER: I'll speak for SNF. There is some
9 discussion about upcoding of certain characteristics that
10 are used to boost payments in the classification system. I
11 think, in general, we periodically try to evaluate whether
12 a payment system is accurate in the past payment system.
13 In SNFs, we looked at it three times over 10 years.

14 So, in some ways, it's sort of the bread and
15 butter of what we do. But there, I think, have been
16 concerns about -- and in some of our interviews and other
17 work, we are hearing about stickiness on admissions for
18 certain types of cases

19 DR. IPPOLITO: Could you just explain what that
20 means?

21 DR. CARTER: That SNFs are reluctant to admit
22 certain types of patients with high costs.

1 MR. CHRISTMAN: So I would say for home health,
2 you know, similar to Carol, we would look at the accuracy
3 of the system from time to time just to make sure the
4 incentives are where we want them to be.

5 In terms of -- I think this work is exploratory,
6 but, you know, there have been concerns about patient
7 selection in home health. I guess I would note that when
8 we looked at home health utilization in the last cycle, we
9 found that the -- you know, the odds of someone going to
10 home health hadn't changed significantly in 2023 relative
11 to 2019.

12 I think one thing we'll be watching for is -- not
13 that we've -- I don't know that we've necessarily seen this
14 in the data, but there have been concerns that some
15 stakeholders believe that the system favors sort of post-
16 hospital patients over community-admitted patients. So
17 that's definitely something we'll test in this.

18 DR. NAVATHE: Dana, if I can jump in for a
19 second.

20 So, Ben, remember that there was a relatively,
21 like, substantive shift in the way that the payment model
22 is functioning or was implemented. So that shift basically

1 is changing from a system that was a little bit more
2 activity-based to one that is more assessment-based in a
3 sense, and there's MedPAC prior work around that kind of
4 the integrity of that assessment data as well. So this is
5 kind of part of our ongoing work to track what's happening
6 as payment systems change to ensure that we're keeping
7 track of the different dynamics, post those system changes
8 also.

9 Brian?

10 DR. MILLER: Quick thing. There is a reason why
11 some patients don't go to some SNFs versus others, and
12 like, for example, if a SNF has on-site dialysis
13 facilities, that's a reason for them to take more dialysis
14 patients. And other SNFs often in that region, for
15 example, might know that because -- you know, they would
16 know because of discharge planning. And so there are
17 sometimes very valid reasons why patients will go to one
18 set of facilities or another.

19 So, when we do talk about selection, it's not
20 always a bad thing, and sometimes it's appropriate to get
21 the beneficiary the right care.

22 DR. CARTER: Yeah. Obesity patients would be

1 another example. Yeah.

2 DR. MILLER: The bariatric lifts and whatnot.

3 MS. KELLEY: Okay. I think that's all we had for
4 Round 1 questions.

5 So, going to Round 2, we had Stacie first.

6 DR. DUSETZINA: Great. Thank you so much.

7 I really like this workstream, and I like the
8 analytic plans that you've laid out.

9 I wanted to have a special request associated
10 with the case selection and thinking about who has access,
11 and this partly stems from some work that a collaborator of
12 mine has been doing related to access for people who have
13 cancer and high-cost drug use.

14 Specifically, what he's seeing in preliminary
15 data is like much lower use of SNF, even for similar
16 reasons for hospitalization as a control group, and not
17 completely being offset by home health. So I know that
18 there could be many choice-related reasons that a person
19 with, you know, maybe more immunocompromised condition
20 might want to avoid being in a SNF.

21 But I think that looking more into it, there is a
22 lot of messiness around consolidated billing versus

1 separately payable for the drugs, and my understanding is
2 that even as something as -- like if you have chemotherapy,
3 older drugs, those would be counted as separately payable.
4 But maybe newer therapies, like targeted therapies and
5 immunotherapies, are not because of the way that the law is
6 written.

7 So it creates a huge financial disincentive for a
8 place to take someone needing a high-cost drug that I think
9 could result in kind of more of a blanket -- you know, if
10 you have this condition, I want to avoid you.

11 So I would put in a special plug for people using
12 high-cost therapies and especially newer therapies that
13 aren't specifically mentioned as separately payable, and
14 maybe that's in the analytic work. Maybe that's also
15 talking to discharge coordinators, because I think they
16 could give insight into this patient preference part of it,
17 which I think also plays in here and complicates it.

18 But I do worry that if places are legitimately
19 underpaid relative to the amount that it costs to take care
20 of a patient, it makes sense that they would try to avoid
21 those patients, but it's not good for our beneficiaries.
22 So a special plug for digging a little bit deeper into that

1 access part of this.

2 MS. KELLEY: Danielle.

3 DR. PIEROTTI: So I fully support it's time to
4 evaluate the changes that came in for both of these
5 settings of care a couple of years back. It's really
6 meaningful to evaluate the impact of these very significant
7 changes on these industries.

8 I also appreciate that your design plan includes
9 organizational characteristics in each of the analysis
10 components.

11 What I didn't see in there was an analysis of
12 payer MA versus fee-for-service, and I bring that up
13 because of our discussion from last month where we saw a
14 distinct difference in MA patients staying longer in
15 hospitals. And I'd like to request that be at least
16 considered in this analysis, and wonder if MA versus fee-
17 for-service is impacting some of the selection that is out
18 there in the ether, and a conversation about who's
19 selecting what patients and admitting them where.

20 I do want to remind everyone that there are
21 distinct differences in these two settings of care, that
22 home care does statutorily need to provide services to

1 restore and maintain and delay decline, which is uniquely
2 different than the SNF setting, which is really about
3 restore. And in the SNF setting that issue that Brian
4 mentioned about particular specialty care being available
5 in particular places.

6 I don't know how to control for all of this, but
7 I do just want to keep bringing it to everyone's attention,
8 particularly when some of the home health analysis will
9 include those low utilization payments group of visits.
10 Those are a specific and distinct set of patients. It
11 doesn't necessarily mean anyone is doing anything wrong.
12 It could actually mean people are doing something right by
13 ensuring that there is one visit a month to refill med
14 pills. So I just want us to be aware of when we look at
15 the numbers of these nuances.

16 I think I saw geography as one of the
17 characteristics that would be included. If I didn't, I do
18 think that is a really important component when we start to
19 talk about rural care. Patients are traveling 100 miles to
20 get to the hospital. How far is their family going to go
21 for the SNF? How far does the home health travel to get to
22 their house will influence how many visits they can have

1 and where the choices of the patient and family are.

2 Finally, I want to just point out one of the
3 analysis points in this is about comparing hospital
4 assessments versus, I'm assuming, the admission assessments
5 to the two levels of care. And again, I want to caution us
6 about assuming that they should be the same. When a nurse
7 is standing in the hospital room making an assessment of a
8 patient's capacity they are most often watching a patient
9 try to get two steps to the chair or six steps to the
10 bathroom. In the home environment, now they have to get 20
11 steps to the kitchen, 30 steps to the bathroom, and maybe
12 up a flight of stairs. So the capacities and the
13 assessment modalities are different, in addition to the
14 differences in the psychology and emotionality of being in
15 the hospital versus being in your own home.

16 Though I agree it is worth comparing, I will
17 caution us against accepting, well, there must be a problem
18 because the assessment at noon on Tuesday from the hospital
19 looks different than noon on Wednesday from either the SNF
20 or the home health. For many patients, just the transfer
21 from one place to another can be exhausting and change the
22 way that they interact in those assessments.

1 DR. CARTER: Can I respond to a couple of things?
2 First, this is an analysis of the fee-for-service
3 component.

4 DR. PIEROTTI: Just fee-for-service.

5 DR. CARTER: Yes. It is a building block for MA.
6 MA plans tend to benchmark their payments off of the fee-
7 for-service, so it's really important that we know whether
8 this is accurate.

9 But some of the questions that you raise are
10 going to be addressed in the other work, where we're
11 comparing PAC use between MA and fee-for-service. And we
12 have been doing interviews, hearing about selection in
13 types of patients. So we will address that.

14 DR. PIEROTTI: Thank you.

15 DR. CARTER: When we're comparing hospital and
16 post-acute assessment, there I think we'll really be
17 focusing on diagnosis, because we don't have comparable
18 functional status and cognitive status information at the
19 hospital. So we'll be looking at things like the coding of
20 depression, or difficulty swallowing, because those are
21 things that change the payments under the SNF payment
22 system, and some of those symptoms might be consistent

1 between hospital and SNF and home health, and some of them
2 won't. So we'll be looking at characteristics that you
3 would expect to be true in the hospital, should be true in
4 the SNF, and is the coding the same. But we will, I think,
5 be focusing on diagnostic coding there.

6 DR. PIEROTTI: Thank you for that clarification,
7 Carol. I missed the part where this is fee-for-service
8 only, and I'm glad it's going to get caught somewhere else.
9 I do need to point out that that is one of the challenges,
10 because both of these environments do include the
11 assessment of the patient. From a nursing a therapist
12 point of view that includes that functionality, which we
13 don't see clearly because it's captured in different ways
14 in hospitals. So it's just a limitation. Thank you for
15 pointing those out. I appreciate it.

16 MS. KELLEY: Brian, did you have something on
17 this point?

18 DR. MILLER: Yeah, a quick thing. Carol, you
19 mentioned sort of anchoring on the fee-for-service
20 experience. I don't think we should anchor on the fee-for-
21 service or the MA experience as the right one, because in
22 the fee-for-service there's different incentives, and in MA

1 there are different incentives, and those incentives sort
2 of circle around what the right clinical answer is for the
3 patient.

4 If you remember in our prior sort of post-acute
5 discussions, while I'm obviously very sympathetic to people
6 getting stuck in the hospital waiting to get to post-acute
7 access, I personally might not think that's always the best
8 choice, but sometimes the result being if that person gets
9 an extra day in the hospital and then they don't have to go
10 to a SNF, they have to go to home health, like you could
11 make the argument the plan is doing the right thing.

12 I realize it's very hard to parse that, but I
13 don't think cognitively we should anchor on either the fee-
14 for-service post-acute care experience or the MA post-acute
15 care experience being the right answer.

16 DR. CARTER: yeah, I think we talked about that
17 last month, and we agree with neither is the gold standard.
18 That's right.

19 DR. NAVATHE: Yeah, and just to jump in, if I
20 understand what Carol was saying I think she was saying
21 from a payment mechanism perspective that fee-for-service
22 payment mechanism is one that MA typically follows,

1 although to your point, Brian, there can be very different
2 patterns, as we saw last month.

3 MS. KELLEY: Tamara.

4 DR. KONETZKA: Thank you, Carol and Evan, for
5 this great work. I'm very excited about it. I think, big
6 picture, these are sort of the right questions and a
7 reasonable approach. We sort of look at these payment
8 systems, and now it seems like a good next step to sort of
9 look at some of the heterogeneity and some of the potential
10 selection effects.

11 You know, because payment rates here are
12 generally high, we're just looking at the distributional
13 aspect of this, and payment rates across all of these case
14 mix groups, probably, in Medicare fee-for-service are high
15 relative to other payers. I'm not sure we're going to find
16 a ton of selection, because they'd rather take a sort of
17 slightly less profitable Medicare fee-for-service patient
18 than somebody with a payer that is less generous. But
19 that's what the data will tell us. I won't be shocked if
20 we don't find huge effects, but I think well worth
21 investigating.

22 Also, this conversation we were just having sort

1 of brings up sort of this issue. I think you framed the
2 analysis as an extension of the analysis of the PDGM and
3 PDPM, right, which are fee-for-service payment mechanisms,
4 and so, therefore, sort of focusing on the fee-for-service.
5 But it's clear that this isn't -- and I think this is
6 correct -- it's clear that this isn't a causal analysis of
7 what happens to case mix because of the change in a payment
8 system. We're really looking at sort of trends over time
9 and what's happening over time to the different case mix
10 groups and the relationship to cost.

11 So I think it's important to think about or maybe
12 write in some of this context, as well. I think it's
13 important to do not just because the SNF payment system
14 changed, but because we see sort of tightening supply of
15 SNFs over the past 15 years, and people are starting to
16 worry about access because of exit of nursing homes from
17 the industry and then even in the existing nursing homes
18 sometimes the number of available beds is reduced because
19 of staffing problems. Similarly in home health, you don't
20 have the same kind of access, but you have the same kind of
21 workforce pressures.

22 So it's really a mixture of these payment system

1 changes and the overall context that makes people worry
2 about case mix. So it might be worth clarifying the
3 framing of that, because it may be because of the payment
4 system or it may not. But all would be important to sort
5 of discover.

6 About the MA part of it, I was thinking of it in
7 a much more simple way. I fully support that we look at,
8 first of all, patient characteristics, as you said in the
9 chapter, dual status, other characteristics of
10 beneficiaries, and whether this has affected them
11 differently. But also provider characteristics. And I was
12 thinking in the MA context one of the provider
13 characteristics we could look at is the percent MA, because
14 if a SNF is really dominated, or if a home health agency is
15 really dominated by fee-for-service you might see a little
16 bit more selection effects. Or it could be if they are
17 dominated by MA they have more financial pressures. I know
18 we're not really finding that maybe in other work. Anyway,
19 that could affect how the home health agencies and the SNFs
20 react to the pressures under the new payment system.

21 Another suggestion about the analytics is I would
22 love it if we could look at the variation in costs within

1 case mix groups, as well, not just the average. Because I
2 think providers will consider what the certainty is or what
3 the probability is that they're going to get the average
4 payment that covers their cost and not just what that
5 average payment is. So just a simple sort of adding it to
6 the descriptives of not only what's the average cost in
7 each payment group relative to payment but what's the
8 variation within case mix groups in the payment-to-cost
9 ratios.

10 Back to the context issue around SNF exit, that
11 is causing a lot of concern right now. I would really like
12 it if we could model these cost-to-payment ratios in terms
13 of whether they are associated with SNF exits. So if we
14 look at the beginning of the panel that we have and see if
15 these changes in the payment system are contributing, or
16 potentially contributing, to associated with which SNFs go
17 out of business, that would be helpful.

18 And then finally, because Evan expects me to say
19 this every single time, I really love the fact that you
20 said you're going to pay particular attention to the
21 community-initiated versus the post-acute and the home
22 health. I think that's built into the case mix groups

1 anyway, but I would really appreciate it if you sort of
2 call that out and take a particularly detailed look at
3 that.

4 So those are my comments. I'm very excited about
5 this line of work, and I think the analytic plan sounds
6 totally reasonable. Thank you.

7 MS. KELLEY: Scott.

8 DR. SARRAN: Yeah, excellent work. I am really
9 impressed by your proposed approach to the analytics. The
10 only things I'd add to that is a plus-one on Tamara's point
11 and other points as well about parsing the results by fee-
12 for-service versus MA. I think for a variety of reasons
13 that would be helpful.

14 And the only other thing I'd add to the
15 analytics, not just the analytics but the work, is that
16 some interviews with hospital discharge planners,
17 particularly as we get into the issues around differential
18 patient types and ensuring that beneficiaries across all
19 clinical types and needs have access, that will be an
20 important piece.

21 I would just make a brief editorial comment,
22 based on decades of experience in the provider and payer

1 side, working in these spaces. I think it's fair to say
2 that particularly as these spaces, and those two most
3 especially, nursing facilities, have become increasingly
4 for-profit in a variety of Byzantine ownership
5 arrangements, and many of them characterized by private
6 equity injected somewhere in the mix, we see more and more
7 that the care responds to the incentives. You can say
8 that's not necessarily a bad thing, but it's out there.
9 And that there has been historic and continued concern
10 around variability in coding accuracy. So I think that
11 just underlines the importance of this work.

12 And at the same time, big picture view, we are
13 getting better and better, as a medical profession, in
14 taking people through really historically incurable
15 illnesses, unimagined procedures. And a common
16 characteristics is that beneficiaries need rehab
17 afterwards. So the ability for us to be sure that net of
18 concerns about workforce adequacy, et cetera, that
19 beneficiaries truly have that access across all communities
20 by patient type is so important.

21 So for all those reasons, I'm very excited by
22 this work. Thanks.

1 MS. KELLEY: Kenny.

2 MR. KAN: Carol and Evan, I'm very excited about
3 this chapter. I strongly support ensuring that Medicare
4 payments accurately reflect patient complexity and protect
5 taxpayer dollars. As you noted, while the analysis was
6 focused on fee-for-service, many MA plans benchmark the SNF
7 and home health payment rates to fee-for-service.

8 I worry that many health systems and providers
9 are way ahead of health plans in using AI to augment
10 inappropriate coding intensity or reported patient
11 complexity to optimize revenue cycle management. This is
12 likely inflationary for overall cost of health care long-
13 term.

14 That said, as we evaluate potential coding
15 distortions and payment inaccuracies, I encourage us to
16 prioritize solutions that use existing claims and
17 assessment data to better calibrate payments rather than
18 imposing additional documentation, reporting, or compliance
19 burdens on providers.

20 I look forward to future analysis on the issue.
21 Thank you.

22 MS. KELLEY: Robert.

1 DR. CHERRY: Yeah, thank you for this work. I
2 think the analytic plan is actually quite solid. Just some
3 minor feedback on Slide 17. It's mentioned that you're
4 going to explore whether or not high-profit versus low-
5 profit cases are evenly distributed.

6 You know, even within a facility they may not
7 necessarily be evenly distributed because, for example, if
8 a low-profit case has a low length of stay but a higher
9 volume, the net margin between the low-profit versus the
10 high-profit are going to be equivalent. So it's good to
11 take a look at the length of stay, as well, to see if
12 there's kind of an equivalency there.

13 But other than that, this really looks really
14 good, and I'm looking forward to the work and having more
15 discussion on this.

16 DR. CARTER: So just to be clear, when we're
17 looking at the distributions -- I'm going to make this up -
18 - let's say high-cost cases make up 5 percent, on average,
19 of a single provider's mix of cases. We're going to look
20 to see how much that 5 percent varies from provider to
21 provider. We're not looking at it to see whether within a
22 provider there's an even percentage share of cases in a

1 particular provider. We're looking to see whether
2 unprofitable cases are sprinkled everywhere, and high-cost
3 cases are sprinkled everywhere, or whether they seem to
4 concentrate. And as we talked about before, there will be
5 good reasons why there's some concentration of some cases.
6 So we'll need to be careful of the nuance there.

7 DR. CHERRY: Yeah, no, thanks for clarifying.
8 And I agree, if there's a way of kind of capturing whether
9 or not certain SNFs and home health agencies have specialty
10 areas that can account for that type of uneven
11 distribution, that would be great. Sometimes it's
12 possible, sometimes it's not.

13 MR. CHRISTMAN: I think we'll be thinking -- and
14 Brian raised that issue -- I think we'll be thinking about
15 the issue kind of two ways. The point that some facilities
16 have unique capabilities and should get those patients is
17 certainly something that could happen. If those
18 arrangements are happening because there is an agreement
19 among the providers in your community that that facility is
20 going to do those cases, because those cases are always
21 financial losers, and they have the reserves to take it.
22 In the latter case, if it's being driven by payment policy,

1 that's what this work is kind of more aimed at getting at.

2 So definitely take the point that, controlling
3 for the fact that different types of patients may sort to
4 specific facilities is going to happen. We're also trying
5 to make sure that, you know, preclude it from happening for
6 inappropriate reasons.

7 DR. CHERRY: And if I'm understanding you
8 correctly, because sometimes an acute care hospital may
9 have a carve-out. They'll buy out a certain number of
10 beds, and they may have a preference in terms of the
11 patient type that they'll utilize for that, so that may
12 skew things, as well. And you may not have good visibility
13 on what those contractual relationships are.

14 MS. KELLEY: Cheryl.

15 DR. NAVATHE: Tamara, did you want to get in
16 here?

17 DR. KONETZKA: Just on that point. To me, the
18 part of your analytic plan that sort of gets at that is
19 looking at the trends over time. I mean, that's an
20 important point, right. Because these differences in which
21 SNFs take which patients or which home health agencies take
22 which patients, obviously there's going to be huge

1 differences. Some specialize in some things and some
2 don't. Or it may be that cancer patient with high-cost
3 drugs always have trouble getting in, which would be an
4 interesting finding.

5 But to me the interesting part will be what are
6 the trends and do they seem consistent with the incentives
7 and the payment system. Same thing with the upcoding,
8 right. Like it's really all about the trends. Are there
9 trends that seem worrying and people are sort of facing
10 decreased access to care.

11 MS. KELLEY: Cheryl.

12 DR. DAMBERG: Okay. I'm really excited about
13 this work. I think you've laid out a robust analytic
14 strategy. So I'm pleased to see that.

15 One of the things -- and I think you are going
16 down this path when you do some of these comparisons, is
17 comparing the for-profit entities with the not-for-profit
18 entities, because I think we've seen in past work, some
19 pretty significant differences between those two types of
20 provider entities.

21 And to kind of move into the space Tamara was
22 referencing about context, yes, these analyses are not

1 causal in nature, but I think helping provide some
2 information around the context, because you know, I think
3 if I'm remembering some of the earlier data we've seen in
4 this space, that the margins are larger for for-profit
5 entities historically. So we, I think, already know
6 there's been some selection going on prior to this payment
7 change. So I think that would be helpful to identify.

8 And I appreciated Brian's point about different
9 facilities may have different expertise and focus. Again,
10 that's an important contextual item.

11 MS. KELLEY: That is all I have in the queue,
12 unless I've missed anyone.

13 DR. NAVATHE: Thank you, Dana, and thank you,
14 Commissioners, for your feedback.

15 So this is part of our general effort to try to
16 get work in front of you early and often, so that way we
17 can get input as we're developing some of the analytic
18 strategies, in addition to other types of feedback.

19 So I did want to just quickly underscore Tamara's
20 point, because I think it's really helpful to think about,
21 is that obviously you all know that SNFs and home health
22 are not suddenly appearing now in the context of this

1 payment model. There's been a pre-existed, there's a bunch
2 of patterns, there's a bunch of selection, there's a bunch
3 of things that are predating the new payment models. And
4 so we're really focused here on trends. And as Carol and
5 Evan have nicely pointed out, these are trends that were
6 not, at least in the way that -- in what we discussed
7 today, we're not talking about any kind of quasi-
8 experimental analysis, and we're not trying to get to
9 causal estimates. We're trying to understand what the
10 trends are, and so we need to be appropriately nuanced when
11 we interpret that.

12 And we will be sure to remind you all of that in
13 fall of 2027, when we get to discuss this topic next. But,
14 nonetheless, thank you so much for the feedback.

15 So, with that, I think that brings the session to
16 a close, and before we completely wrap up, I wanted to see
17 if there's anybody who's attending in person who would like
18 to make a public comment at the microphone.

19 Great. Please come forward. Yes, new set up.
20 So please identify yourself and your affiliation, and
21 you'll have three minutes to complete your comments.

22 MS. GREWAL: Thank you.

1 Esmé Grewal. I'm CEO of Senior Care Pharmacy
2 Coalition. It's the national trade association for long-
3 term care pharmacies. We serve all sorts of long-term care
4 facilities, including skilled nursing facilities, assisted
5 living facilities, intermediate care facilities for
6 individuals with developmental disabilities, substance
7 abuse, treatment centers, behavioral health, PACE, et
8 cetera. So anywhere that you can think about long-term
9 care is where our folks are serving.

10 Long-term care pharmacy is an incredible service
11 that I hope that many of you are already familiar with, but
12 these are hardworking pharmacists and pharmacies that every
13 day are providing specialized packaging and great clinical
14 care throughout the country and delivering multiple times a
15 day to these facilities up to three to four hours.

16 Some of our greatest examples are during natural
17 disasters when they still deliver these medications to the
18 mostly Medicare population that require them, so incredible
19 members of society and just a wonderful service.

20 I wanted to just mention, because I didn't have
21 the opportunity at the September meeting to weigh into the
22 public session, but I really appreciated that there was

1 discussion around the Part D redesign. And there were a
2 couple of Commissioners who mentioned that the Inflation
3 Reduction Act's changes to drug pricing should also be
4 considered with the maximum fair price changes.

5 I wanted to note that there continue to be more
6 and more independent research journals that come out to
7 show that there were significant impacts to long-term care
8 pharmacies, because that legislation and many other drug
9 pricing proposals often look at the drug manufacturer and
10 then the resulting pricing to the patient, but they miss
11 sometimes along the way that there's an entire drug supply
12 chain that includes pharmacies. So I appreciated that
13 there was discussion as well about including pharmacists
14 and pharmacies more in these discussions, and I really hope
15 that that reporting looks more at long-term care pharmacies
16 specifically who are extremely focused in on the Medicare
17 population.

18 And I also would flag that it's been about 20
19 years since MedPAC looked at long-term care pharmacies, and
20 there's a lot to consider and a lot of changes and
21 particularly with the growth in the aging population. But
22 I'd also note with the incredible outcomes that long-term

1 care pharmacies deliver, I think it's well worth time to
2 look at how the program can benefit by utilizing a lot of
3 the techniques that long-term care pharmacies provide.

4 I apologize. I went over a few seconds, but
5 thank you so much and really appreciate the discussions
6 today.

7 DR. NAVATHE: Great. Thank you so much for your
8 comment.

9 So while we appreciate in-person comments, for
10 those who are listening through the web stream, we would
11 like to hear from you as well, and you can submit written
12 comments at meetingcomments@medpac.gov.

13 And so, with that, that brings our October public
14 meeting to a close. Thank you.

15 [Whereupon, at 11:28 a.m., the meeting was
16 adjourned.]

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