MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 3, 2026
11:00 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[11:00 a.m.]

DR. NAVATHE: All right. Let's get started. Welcome, everyone, to our September public meeting and the start of our 2026-2027 MedPAC cycle.

I'm thrilled to be here with Greg, and this is our first public meeting as Chair and Vice Chair in our new roles. We also are delighted to have two new Commissioners, Danielle and Ben, who have joined us, as well as want to extend a thanks to all the returning Commissioners. And thank you to the staff, who have done a tremendous amount of work in preparation for this, as well as future meetings.

We have an exciting agenda today. We'll be starting, as we always do for a new cycle, with our context chapter, and then we'll be discussing Part D and then ambulatory surgery centers today, and then have a couple of additional sessions tomorrow.

We also have a hybrid format today, in that we have both in-person attendance from the public, as well as folks joining through the web format. That means that at the end of the morning and the afternoon sessions, we will

stop and make the mic available for folks who want to make comments in person, and then folks who are listening at home can still, as they have been for the past several years, submit comments to meetingcomments@medpac.gov. And, as always, we're excited to hear from all of you.

So, as we get started for this first session, the context session is very important for us because, well, it provides context for all of the work that we do, and it lays the foundation for many of the different policy priorities that we have upcoming this cycle and then and beyond.

So without further ado, I will hand it off to Rachel.

MS. BURTON: Thanks, Amol.

Welcome, everyone, to the first session in this year's MedPAC meeting cycle.

In this presentation, we'll provide some context for Medicare payment policy. This is meant to serve as a backdrop for Commissioner discussions this cycle. This information will be included in our March report to the Congress, along with our recommended updates to 2028 payment rates.

The online audience can download a copy of these slides from the webinar's control panel.

We'll start by talking about some health care spending trends, including a deep dive into the drivers of Medicare's spending growth. We'll then provide a snapshot of Medicare beneficiaries' ability to pay for their health care. Since provider consolidation continues to be a major feature of the U.S. health care landscape, we'll also provide an update on the latest literature before turning to your discussion.

In addition to this content, FYI, our draft chapter also includes our usual textbox describing beneficiaries' various enrollment options and a new table summarizing key laws that apply to health care providers as a reference.

So, first, some health care spending trends. In 2024, U.S. businesses, households and government programs spent $5.3 trillion on health care, constituting 18 percent of the country's GDP.

National health care spending as a share of GDP rises over time in this graph, since spending on health care usually grows faster than the country's GDP.

After some unusual spending trends during the COVID-19 pandemic, health care spending rebounded strongly in 2023 and 2024, growing by 7 percent per year. This was due to growth in the volume and intensity of the services and items furnished to patients, the share of the country's population with health insurance reaching an all-time high of 92 percent, the country experiencing population growth, and growth in economy-wide prices in recent years.

Medicare spending often grows a bit faster than national health care spending, including in 2023 and 2024, but because it starts from a lower base, the growth doesn't look as large in this graph.

In 2024, Medicare spending totaled $1.1 trillion and made up 3.8 percent of GDP. Over the next few years, Medicare spending is projected to grow faster than all other payers, as the Baby Boom generation continues to age into Medicare.

Enrollment in private insurance and Medicaid are both expected to decline, and the number of uninsured people is expected to rise.

As the Baby Boom generation has aged into Medicare, the average age of beneficiaries who qualify for

the program due to age has gone down, and there's been an increase in the share of beneficiaries reporting being in very good health, shown in the magenta layer at left.

The Medicare beneficiaries who survived the COVID-19 pandemic are also healthier on average than beneficiaries were before the pandemic.

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

Another important trend is the shift in the mix of services beneficiaries receive, which started before the Boomers began aging into Medicare. As we show here, since 2009, inflation-adjusted spending per beneficiary has decreased for Part A services, such as inpatient stays and post-acute care afterward. Meanwhile, inflation-adjusted spending per beneficiary has increased for Part B services, such as outpatient visits and clinician services in all settings.

These spending trends put increased pressure on Part B's main funding source, which is the U.S.

government's general revenues, such as income taxes. Meanwhile, it puts less pressure on Part A's main funding source, which is workers' and employers' Medicare payroll taxes.

I also want to talk about Part D. For most of Part D's history, there's essentially been a lack of growth in inflation-adjusted spending per beneficiary. Researchers think one of the reasons for this may be a shift over time from brand-name drugs to generic drugs, which cost less.

But, in a new development, starting in 2024, Medicare spending on Part D has begun to rapidly increase. This is partly due to the Inflation Reduction Act of 2022's Part D redesign, which shifted more of the cost of Part D from beneficiaries to Medicare.

We've also seen a recent increase in drug utilization, which may be associated with the redesign's reduced cost sharing.

Underlying pharmaceutical trends also played a role, such as increased use of high-cost drugs like GLP-1s.

If you're eager to learn more about what's going on with Part D, Shinobu and Betty will talk more about this

after lunch.

The declining inflation-adjusted spending per beneficiary on Part A couldn't have come at a better time, since the number of workers per Medicare beneficiary has been declining for decades. This demographic trend means it's only a matter of time before Medicare doesn't have enough money to pay the full cost of payments to providers for Part A services.

According to Medicare's Trustees, this will happen in seven years, while CBO projects this will happen in fourteen. At that point, Medicare will only have enough money to pay for 89 percent of Part A costs. To avoid this happening, Medicare Part A spending will need to further decrease, or the sources used to fund Part A will need to be reassessed.

The long-running increase in spending per beneficiary for Part B services has led to exponential growth in the amount the federal government spends on Part B over time. By 2025, the federal government was spending $422 billion of general revenues to help pay for Part B.

To tease out what services might be driving this spending increase, this graph shows inflation-adjusted

spending per beneficiary for different types of Medicare services. We've grayed out services that have seen little to no growth since 2009.

The teal line in the middle is for Part D and tells a similar story as an earlier graph.

The orange line near the bottom shows rapid growth in spending on Part B drugs delivered by clinicians in non-facilities like doctors' offices.

The magenta line shows that there's also been growth in outpatient hospital spending, which includes spending on Part B drugs delivered in that setting.

A takeaway we get from this graph is spending is growing unusually fast for Part B drugs, which include treatments for things like cancer, macular degeneration, and arthritis.

You may have heard about rapid growth in spending on skin substitutes in the last few years and wonder where they show up in this graph. They are in the orange line, where it suddenly bends up at a steeper slope. Medicare recently changed how it pays for these items, and spending on them is now expected to decline by 90 percent. This is something we will continue to monitor.

Before we leave the topic of Medicare spending trends, we should talk about Medicare Advantage. Currently, more than half of eligible Medicare beneficiaries are in MA plans, and the average beneficiary has 39 MA plans to choose from.

MedPAC estimates that when a beneficiary enrolls in an MA plan, it costs the program an average of 14 percent more than if the beneficiary were in traditional fee-for-service Medicare. These higher Medicare payments to MA plans are primarily due to risk adjustment inaccuracies.

The extra payments to MA plans, which totaled an estimated $76 billion this year, are used to offer supplemental benefits not available to fee-for-service beneficiaries, like non-Medicare services, such as vision, dental and hearing benefits, and gym memberships, as well as lower cost sharing and lower Part B and Part D premiums.

Tomorrow morning, Andy will say more about challenges posed by Medicare's current approach to risk-adjusting payments to MA plans.

I'll now turn things over to Alex.

DR. HARRIS: Thanks, Rachel.

Next, I'll share some statistics that give a sense of Medicare beneficiaries' ability to pay for their health care.

As we show here, fee-for-service Medicare premiums and cost sharing consume a substantial share of beneficiaries' income. Medicare beneficiaries typically do not pay premiums for Part A coverage, but annual premiums for Part B are about $2,400. The average annual cost of standalone Part D drug plan premiums is another $400. Cost-sharing liabilities for beneficiaries in fee-for-service Medicare average around $400 for Part A services and about $1,700 for Part B. Average cost sharing in Part D plans is another $400. This all adds up to an annual bill of about $5,500 for premiums and cost sharing.

Meanwhile, the median household income reported by Medicare beneficiaries is about $50,000.

Most beneficiaries in fee-for-service Medicare have private supplemental insurance, which pays for some or all of their cost sharing, but may require them to pay additional premiums. MA enrollees generally pay lower premiums and lower cost sharing. Medicaid pays for some low-income beneficiaries' premiums and for a smaller share

also covers their cost sharing.

Since we were talking about the impact that growth in Part B spending has on federal spending earlier in this presentation, I wanted to circle back and show the impact on beneficiaries' Part B premiums.

Adjusting for inflation, the annual cost of Part B premiums has increased substantially over time. Twenty years ago, these premiums cost about $1,700 per year, and now they're about $2,400.

Overall, about 7 percent of Medicare beneficiaries report problems paying a medical bill in CMS's 2023 survey.

Beneficiaries subgroups that report this at elevated rates are shown on this slide and include beneficiaries who only qualify for partial Medicaid benefits, beneficiaries with low enough incomes to qualify for the Part D low-income subsidy, beneficiaries under the age of 65 who tend to be unable to work due to disability, and beneficiaries with fee-for-service and no supplemental coverage.

When Medicare payment rates increase for health care providers, premiums and cost sharing also increase for

beneficiaries, some of whom already have a hard time affording their health care.

Next, in response to continued Commissioner interest, we're now going to discuss some of the emerging literature assessing the effect of provider consolidation on costs, quality, and access to care.

Over the last few decades, health care markets have become increasingly consolidated. Provider consolidation has primarily occurred between like types of providers, such as hospitals merging with other hospitals; providers with referral relationships, such as hospitals acquiring physician practices; and between providers and non-provider organizations, such as private insurers, corporate entities, and private equity firms.

There are several economic and operational motivations for consolidation, including but certainly not limited to higher payment rates, patient self-referrals, more efficient care delivery, and access to capital for infrastructure and technology.

In our March 2026 report, we conducted an expansive review of provider consolidation literature. In that report, we discussed that researchers have generally

found that consolidation between providers generally results in higher payments in both commercial and Medicare markets, payer-provider consolidation may lead to greater coding intensity, PE provider integration leads to higher payments, and the relationship between many types of provider consolidation and quality and access outcomes is mixed.

In the next few slides, we will provide a brief summary of literature published since our March 2026 report.

Across both commercial and Medicare markets, we continue to find evidence that consolidation between providers leads to higher payment rates.

With respect to payer-provider consolidation, recent research has assessed medical loss ratios, or MLRs, and prices. One study found that provider-owned MA plans had higher medical loss ratios, though the authors acknowledged this may not be solely due to consolidation.

Another study found varying price strategies among integrated MA plan-offering hospitals. Some charge lower prices for affiliated plans, some charge higher prices, but most charge similar prices for both affiliated

and non-affiliated plans.

Finally, new literature finds that PE provider integration is associated with higher commercial prices across multiple specialties, including gastroenterology, cardiology, and radiology.

While research generally finds evidence of higher payment rates and spending as a result of provider consolidation, there continues to be mixed but limited evidence assessing the ways in which consolidation impacts access to care.

Recent studies have found higher-intensity inpatient and non-emergency ambulatory care after hospital-physician vertical integration, which may be a result of better outpatient care management, but the increase in inpatient utilization could also be a signal of a referral-driven mechanism. Another study finds fewer prior authorization requirements for enrollees of system-affiliated MA plans; and finally, a study finds that PE provider integration may reduce emergency department and ICU staffing and increase transfers of those patients to other hospitals.

While the relationship between provider

consolidation and quality has largely been mixed, some providers may be able to improve quality. We highlight a few recent studies here.

First, one study found that patients living in markets with large increases in hospital consolidation had higher likelihood of early-stage diagnosis and improved survival compared to patients living in markets with small increases in hospital consolidation.

Another study found that clinically complex fee-for-service patients receiving care predominantly from an integrated physician had better perceptions of care coordination and quality compared to those receiving care from mostly independent physicians.

Third, a new study found that enrollees of hospital-owned MA plans had lower mortality, readmission, and post-op complication rates compared to enrollees of non-hospital-owned MA plans who received care at that same hospital.

And, finally, several studies have found higher mortality, admission, and post-operative complication rates after PE hospital consolidation, though one study did find no change.

Some have indicated that this lack of clear quality improvement across different types of provider consolidation may be because financial integration does not necessarily translate into clinical integration.

Okay. We've made it to the end. In your discussion, we'd like to know if you have any questions about the material or any other guidance for us. The draft chapter you receive for today's meeting will be updated in the winter when some updated data come out. Commissioners will have an opportunity to review that revised version in January before it is published in our March 2027 report.

I'll now turn things back to Amol.

DR. NAVATHE: Thank you, Alex, and thank you, Rachel. It always strikes me how much information, good information, is packed into this chapter, and you all update it year to year. I think a lot of sobering information as well around the kind of fiscal challenges, sustainability, and other attributes of the program, but, also, I think highlights a number of important policy areas related to work that we'll be discussing today, even, and beyond going forward.

So, with that, I will turn it over to Dana to run

the queue for our Round 1 and Round 2. Questions or comments.

MS. KELLEY: Okay. We have Gina first in Round 1.

MS. UPCHURCH: Thank you.

Thank you both so much. I love this chapter. You do a really good job of setting us up for the rest of the work sessions.

And I was a little concerned that workforce is not in here, but I understand that's going to be moved to another chapter. In the spirit of our former commissioner Betty, I had to call that forward.

So a couple of questions here for Round 1. You mentioned the physician self-referral. You outlined that as a regulation or law, and I'm just a little surprised how that fits with orthopedic surgeons owning physical therapy groups and more and more physicians owning ambulatory surgical centers. So, apparently, it doesn't create a conflict, but it seems like it should.

MS. DRUCKMAN: So the physician self-referral law has certain exceptions for the way certain things are structured. There's a specific exception for ASCs, and

there's also exceptions applicable to the arrangements for the folks who are referring to their physical therapy assistance.

MS. UPCHURCH: Okay. All right. Thank you. It seems so obvious. Thank you so much.

A couple of times, you will call out people with Medicare due to disability, and it's not really clear where people with ALS fall in these graphs or this conversation, and sometimes end-stage renal disease. So, if we could just make clear in there where they're included in those graphics, that would be terrific.

Figure 10, you mentioned drug fees of being 10 percent as part of the Affordable Care Act. My question there is, how's that related to tariffs right now? Do we know if it is related to tariffs?

MS. BURTON: I'd have to look into that and see what we can add.

MS. UPCHURCH: Okay. Because I know the tariffs are sort of going all over the place, but I didn't know if that was interacting with that.

And, lastly, I think about Medicare Part D, especially as part of the IRA, Inflation Reduction Act. I

think of three things; obviously, the major redesign, which I know we'll be talking about later today. I think of the drug price negotiation that's going on, and then I think of the inflation rebates.

When we're talking about what funds Medicare, where are the inflation rebates? I think it's about a billion dollars so far from drug manufacturer rebates. Is that in that graphic where we're showing?

MS. BURTON: Again, we can dig into that and add that information.

MS. UPCHURCH: Okay. All right. Lastly, my last question -- and this is probably beyond this, but Baby Boomers, as you mentioned, are younger and often less costly. And I think that's historically true, but I do worry as we lose Affordable Care Act cost-sharing reductions, and more and more people are losing their Medicaid when they hit 65, if they've been uninsured, I'm assuming we're going to have a hit to Medicare because people may be more costly. Do we have any research or projections on any of that?

MS. BURTON: We don't do our own independent research on that, but I think the Medicare Trustees would

probably factor that into their projections.

MS. UPCHURCH: In their projections. So I'm wondering if that trend might shift a little bit as we have sicker people come in.

But love this chapter. Great job. Thanks so much.

MR. MASI: And, Gina, if I could just jump in on your question about under the inflation rebates under Part B and Part D, where are those flows showing up, so those should be captured under the SMI Trust Fund. So Part B inflation rebate will flow to the Part B account under the SMI, and the Part D inflation rebates are supposed to flow to the Part D account under SMI.

In terms of what we've seen here, I don't know that they're going to be an offset -- they're going to be reflected in spending, but we can circle back with you on that as well to clarify.

MS. KELLEY: Gokhan.

DR. METAN: Thank you very much for this chapter. Again, it's always very informatory. I always learn something new as I read these chapters.

So I have three questions. The first one is,

what is driving the Part A spending decline, and do we know if it's a sustainable trend? I couldn't get that from the material.

MS. BURTON: There's been a secular decline in the rate of use of Part A services, like not just a slowing in the growth, but an actual decline in the rate of use of things like inpatient hospital stays. So I think just more and more stuff is being done on outpatient basis.

DR. METAN: Okay. So does it mean that like the spending on Part A is shifting more towards Part B?

MS. BURTON: I think that's what some folks think is happening.

DR. METAN: Okay. And do we know if that trend is sustainable? Any kind of indication there? The reason I'm asking this question is about would that elongate the Trust Fund resources used and is it sustainable.

MS. BURTON: Well, that graph that showed Part B and Part A diverging, they're pretty --

DR. METAN: Yeah.

MS. BURTON: -- consistent over time. So I would imagine they would keep going, but I'm not CBO.

DR. METAN: Okay. My second question is about --

actually, somewhat touching to Gina's question about the Baby Boomers. And Slide 5 actually called the aging of Baby Boomers and that mixed shift. But I was wondering, Figure 10 on page 27 in the report, does that -- is that dynamic reflected in those projections? Do we know?

MS. BURTON: Okay. I'm looking at Figure 10. Say again your question?

DR. METAN: So, on that graph, do we know if that age mix shift of the Baby Boomers getting older, is that reflected on the projections? Do we know?

MS. BURTON: I would assume it is, but we can double- check that with the Trustees.

MR. MASI: Yes. And just to chime in, I agree with Rachel. I think, in general, both the Trustees and the Congressional Budget Office reflect both changes in the number of population, but also the demographic mix.

DR. METAN: Okay. Thank you.

And my last question is, the negotiated Part B drug prices, they will be kind of starting June -- sorry -- January 2028. Are we planning in the March 2027 report to reflect the impact of these into this material, this chapter?

MS. BURTON: I don't know the answer to that question, but it's a good question.

MR. MASI: Yeah. We are planning a dedicated block of work this cycle to Part B drugs, utilization and spending, and so, you know, happy to dig deeper into that over the course of the cycle.

DR. METAN: Okay. Thank you.

MS. KELLEY: I have a Round 1 question from Tom Diller.

He says this is an excellent summary, which is very much appreciated.

On page 8, the third paragraph is attempting to explain some of the reasons for the increase in health care spending. The statement is "Population growth and growth in medical prices due to economy-wide price growth, as opposed to excess medical inflation, also drove spending in these years." Can you further explain the difference between growth in medical prices versus medical inflation?

MS. BURTON: I think what is meant to be conveyed there is that this is due to economy-wide inflation, like lots of -- like the salad at Sweetgreen has gone up. It's that type of price inflation, not something that's confined

to the medical industry. So, in other periods, we might see pretty stable inflation, but like medical prices are kind of increasing more than you'd expect. So that's not what's happening or has been happening in the last few years.

MS. KELLEY: Thanks. Tamara, did you have a Round 1 question?

DR. KONETZKA: Yeah. Thank you.

Thanks for this work. My question is also about the hospital spending trends on Slide 13. This was one of the grayed-out ones you didn't talk about, but there seems to be this recent uptick in hospital fee-for-service spending that's sort of in contrast to the decline. Is that a price issue or utilization issue, or what do you think that is?

MS. BURTON: I think that's a post-pandemic rebound. I think the paper -- like Trustees expect that to kind of level out at like in 2028 or 2029, that it's in the paper, but I'm forgetting the specific year.

MR. MASI: And maybe pulling Tamara and Gokhan's questions together. Gokhan, you had asked about, you know, what does this trend look like in the future? And I think

you've kind of both put your finger on a really key piece of uncertainty here.

Projecting is hard as a general rule. But, in particular, when there's been a long, slow secular decline, as Rachel pointed to, and then a recent uptick, trying to project what those two pieces of information together mean for the future is challenging and uncertain and one reason why we'll do this session again next year.

DR. NAVATHE: Yeah. And the other thing I would add is that I think many of you probably noted the difference in the estimate between the Trustees' report on when they expect the Trust Fund to become insolvent, which is 2033 versus CBO is 2040, I think that's just highlighting that there's different assumptions baked in about that. And there's clearly a lot of sensitivity to that because that seven-year spread reflects that piece.

MS. KELLEY: That's all I have for Round 1, unless I've missed anyone. So we can go to Round 2, and Stacie is first.

DR. DUSETZINA: Great. Thank you so much, Alex and Rachel. This is excellent work, and like others, I feel like it does set the stage for how important the work

that we all are doing here is for thinking about access and affordability.

So I just had a couple of things. One is the details about the low or the dropping number of people qualifying by disability. That was very new to me, and it seems like such a large drop in the number of people, that it feels like more work needs to be done. I don't know if that's more work by us or more work by other researchers, but it struck me as a little bit hard to believe that that could just be because employers are making more accommodations for people. I worry about people's access in this particular case, because it takes a long time to qualify for Medicare due to disability. So I think that it just strikes me as that is a concerning drop.

And I guess from a -- could we look into it? One of the things I was wondering is, what are the conditions for which people are qualifying by disability? Has that changed where we feel like really it does seem that people are getting more accommodations or maybe our treatments are better or there have been innovations that are helping people a lot more? But that felt really new to me and also pretty alarming. Even though that ends up being a small

percentage of our Medicare beneficiaries, I think it's a really vulnerable group.

I really appreciated the note on skin substitutes and that that's getting fixed. As soon as you read that, you're like, oh my God. And then you're like, oh, okay, it's going to go down. But I wondered if you could add to the chapter, any kind of simplistic, why is that going to go down, what's the fix. Because I think when I read it, I thought, oh, wait, is that the WISeR model, but then I think that that one's facing some headwinds around whether or not there's funding for it. So I was like, okay, is it really going to go down? So a little bit of detail there would help to know for sure. Like, what are they doing to correct that?

Going maybe to some of Tamara and Gokhan's comments about Figure 6 in the chapter and kind of like where are we spending, one of the things that struck me when I was looking at that was that there are some very high-cost services that -- you know, like there's a financial incentive to move to the outpatient side. So CAR-T therapy is a really good example of a very expensive, not super-frequently used service, but one where hospitals

have a huge incentive to try to use outpatient delivery instead of inpatient delivery. And so it did just make me wonder and want more details. I sort of feel like we're all saying this a little bit in different ways of like, what is driving each of those lines?

And then I also think that -- and maybe this goes to Gina's point about where are the inflation rebates fitting in. We're just getting into drug price negotiation. So that Part B drug and Part D side, it's like that lower spending components, those are kind of newer. So we might be in a blip maybe, hopefully, and then things will settle down. But I think it's worth kind of thinking through. Is there a little bit more context there for some of those that look like they have just kind of these extreme outliers or rising more rapid than we think.

Okay. Premiums. I really liked the graph on premiums. I did wonder about like the income-adjusted premium and if it would be possible to like say something about like kind of the range of premiums that people might pay, because I think often I'm looking at that kind of lower number, and that still seems really high to me. But then if it's higher than that, it's like that would be

helpful for people to understand.

Okay. Your Figure 13 in the chapter where you show how people receive their coverage, I think is super helpful. I don't know if you can do this, but if you were able to break out the MA group to show employer-sponsored MA and dual MA as separate little wedges kind of to mirror what is shown in fee-for-service, that would be fantastic.

And then one last kudos on providing the context for the stats on the income for Medicare beneficiaries and the percent that were reporting food insecurity. I think it is really helpful to come back to that and remind people of like the very different situation that a lot of people are in when they're aging into Medicare and in the program and why we should be so concerned about spending and access and affordability.

So thank you for the fantastic work.

MS. KELLEY: Gina.

MS. UPCHURCH: Yeah. Thanks again for this great work.

On page 26, this is just a stunning thing where we talk about the interest payments, the federal government is paying, you know, nearly a trillion dollars, and that's

about what we spend on Medicare, not even counting intra-governmental loans. I just find that shocking. You know, we have no control over that. We don't have control over Social Security, but we are trying to contain Medicare spending and spend it well, but it was just shocking to me as something new.

Page 34, we mentioned that 99 percent of people have Medicare Part A. I think we probably need to keep an eye on that to see if it's going down and if that's a pro or a con, but as people continue to work past 65 and have high-deductible health plans with HSAs, many of them are not going to begin their Medicare A. So it will just be interesting for us to keep an eye on that, I imagine, and I don't know if that's a positive or negative in terms of funding Medicare having more income than expenses, but just to keep an eye on that.

One of the things we mentioned is when people have to make choices about plans. We mentioned their extra benefits with Medicare Advantage. We mentioned, you know, having open networks for fee-for-service, but one of the things when we're practically helping people -- and senior pharmacists, the agency I'm with, is a SHIP coordinating

site -- is we start it by entering their meds. So I think we need to add in there that medication coverage is a big thing in terms of steering people to one side or the other oftentimes. And that's left, you know, a lot of people moving to Medicare Advantage because it's an imbalanced Part D benefit right now.

And we talk about the VA program versus TRICARE. I feel like we need to just articulate that a little bit. The VA has its own coverage, but TRICARE is secondary coverage to Medicare. So they're not the same. VA doesn't interact with Medicare, and, you know, there's some -- I'm sure we'll talk about this later, but I had a lot of veterans have a Medicare Advantage plan and get all the perks from it. And those plans are being paid, but they're not really actually using Medicare A and B benefits when they're in the VA system, not necessarily. So I think calling a distinction between the VA coverage being totally separate and TRICARE being a secondary coverage to Medicare would be important.

And, lastly, to get at what Stacie just said a little bit, I really appreciate on Slide 18 or page 33 in our reading how you call out the groups that are struggling

financially with Medicare, and we see it all the time. So you've got dual eligibles, 25 percent who are struggling to pay for the health care, 17 percent of people less than 65, 13 percent who have low-income subsidy, and 11 percent who don't have some sort of secondary coverage that are in fee-for-service. So this is my plea again for us to consider late enrollment penalties.

We just heard that there's going to be $4 late enrollment penalty per month for Part D. We just heard that earlier when we heard the base premium's going to be $41. That means a 4 percent, $4 per month late enrollment penalty.

There are people that for 20 years have been using an FQHC pharmacy, a free pharmacy, saving us lots of money, but as the manufacturers are being squeezed with 340B, with other tariffs, with the balloon -- and so we're seeing more and more people that have used those safety-net pharmacies need to join Part D, but the late enrollment penalty is a barrier. And these are the same people who are food insecure.

So I feel like we need to have a waive or a late enrollment penalty, special enrollment period for people

who've used those safety-net pharmacies but now need to join Part D, because they are struggling mightily with our economy right now and certainly even to afford the food that they need to stay healthy, and really appreciate you pulling that out in this chapter.

Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you so much for this chapter. Lots of great information in here that I think many parties will find very useful.

So, no surprise, I was really pleased to see the discussion on health care consolidation, and I think keeping attention in this space is really important, because there are so many changes going on in the underlying health care market structure that have impacts, either for good or for less good, and so really trying to tease out what's happening in that space is really critically important, and then thinking about what levers the Medicare program has to try to reduce some of those negative effects and the pivot to greater consolidation and less competition in the marketplace, which -- I mean, I think the vast literature shows that competition not only

helps reduce prices that consumers pay.

And, to me, this whole chapter is really a strong signal around health care affordability, and so I think competition is really at the heart of helping move us in that direction.

You know, as you note, there's limited information on the impacts of quality, and obviously, you'll continue to monitor that. That has really been a challenging space to study, and I would say the evidence is really thin in terms of any improvements in the quality space.

Clearly, we need better data to be able to track who owns who and how the market structure is changing, but I think overall, you know, we're spending more. We're not necessarily getting better quality, and so that really makes me question the value proposition here.

And I think there's really little to no evidence that consolidation has improved efficiency. Now, maybe it exists and we just haven't uncovered that evidence, but so far, we haven't seen that evidence.

My second point -- and this is more future-looking, and I suspect it's on your radar -- is all of the

changes that are going to happen as a function of H.R. 1 and thinking about what the implications are related to greater uncompensated care, greater demand in emergency rooms for care, and what the effects are going to be for hospitals.

My third point relates to all of the statistics that you've provided around increased utilization, both volume and intensity. I think that's really important, and it's interesting looking at the slide because it seems like the Part B spending really ratcheted up post the Affordable Care Act, which had a lot of reforms related to moving people out of hospitals and into ambulatory settings. And, you know, whether that's ACOs, total cost of care contracts, it's really put a lot of pressure on that Part B space.

And this greater volume and intensity, I think we have to kind of think about this in the context of, I think, what Gina was mentioning, which is the workforce issue, because on the ground, health care systems are really struggling to meet this increased demand. They have labor shortages. They have labor issues related to burnout, and so I think putting some context around that

could be helpful.

As I noted, really this is a chapter about affordability, front and center, the significant pressure on Part B premiums. I liked Stacie's comment about trying to help people see sort of the range of total expenses that they face. So I think that would be great, and I think we need to think hard about what we can do in the Part B space to try to moderate that spending growth.

So kind of our North Star is how do we restrain growth in Medicare spending to try to improve affordability, and what happens in Medicare has spillover effects to the other sectors. And so I fully support a lot of the past work that MedPAC has done about trying to work to reduce incentives for consolidation, which can lead to providers shifting the site of service to more expensive settings, trying to increase competition, price negotiations for drugs, requiring coverage with evidence, you know, for new therapies, drugs that come to market, and really focusing heavily on the overpayments to Medicare Advantage plans. As that has consumed a greater share of the Medicare population, it's putting such pressure on Medicare financing writ large, and so I think we really

have to continue to identify ways to improve how the Medicare Advantage program functions, revisiting benchmarks, which I know is on the agenda, continuing to call out issues related to the star ratings program that determine rebates and quality bonus payments, and adjusting for upcoding.

Thank you.

MS. KELLEY: Gokhan.

DR. METAN: I have four suggestions and comments about the chapter and improving the chapter further. The first one is more around getting the general revenue problem is all metric. What I mean by that is Part A installments debate is vital. When I read the chapter and it says by 2033 you will run out of money, it really kind of emphasizes the importance. I don't feel the same message on the general revenue problem, with the Part B and Part D growth.

So I think it really deserves its own memorable way of calling the urgency of that, because when you see the trend, it is going really up. I don't know what would work better to kind of really push the right buttons in our brains about the urgency. But I really think that adding

some kind of a metric, in a way similar to the Part A, would really kind of help emphasize the importance of the problem there.

The second suggestion I have is on page 33, when I look at the affordability data, they are mostly static and from 2023. And especially given the Part B work that we are doing and with the premium increases and the cliffs that they are expecting, I think a sentence tying this work with the work that we will be doing for the March 2027 publication would be important to contribute to the impact of the work.

My third comment is around the consolidation around the commercial market. Evidence is mostly on the commercial market, and I'm wondering if it would be possible to triangulate and come up with even some rough estimate about the magnitude of that provider consolidation and its impact on the Medicare program specifically.

And then the last comment I had is, again, we closed the ownership data gap since 2021 of this chapter. Is there an appetite, or would it be possible even to kind of figure out some data around this? Again, that part of the chapter feels more literature review-ish to me, and is

it possible to get some data around that gap, I think that would really help to improve the chapter from that perspective, as well. Thank you.

DR. HARRIS: Just to clarify that last point. Were you talking about ownership data? Is that what you were saying?

DR. METAN: Yes.

DR. HARRIS: Thank you.

MS. KELLEY: Okay. I have a Round 2 comment from Tom Diller. He says again that this is an excellent summary. On page 24, there is a discussion of why MA plans are more costly than fee-for-service, and a reason given is that MA plans tend to enroll less costly beneficiaries. Tom believes the issue is that MA plans can focusing on coding and documentation so that the capitated payments to MA plans are higher than they would be if the beneficiary remained in fee-for-service. He says this is implied in the paper but not as clear as it might be.

Pages 29 through 33 discuss beneficiary premium and premiums and cost sharing. The Medicare program currently in place is designed for significant beneficiary cost sharing. In several locations in this section there

appears to be some presentation of opinion that this cost sharing may be excessive. That may be true. However, this section provides very little comparison for contextual analysis.

For example, within commercial markets there are significant pressures on premiums and cost sharing as well as due to general medical inflation. It may be helpful to review some of the language used, and more importantly to provide comparative references to what is going on relative to the commercial health care market. Examples include pages 29 to 30 that show Part B premiums to be up 67 percent over 10 years while Social Security is up 56 percent over 10 years. It's described as a rapid increase, but the question is what might be reasonable.

Overall, health care inflation has increased more than 67 percent. Thus, an argument might also be made that CMS has managed the premium escalation relatively well over the last 10 years. It might be helpful to provide more context to how the premium escalation for Medicare compares to overall health care inflation and premium increases in the commercial market for more context.

Additionally, it's important to understand

whether those beneficiaries that are more vulnerable are adequately protected and able to obtain appropriate health care. On pages 32 and 33 there is a discussion regarding median household income, food insecurity, subsidies, et cetera. A deeper analysis of whether those most vulnerable are being protected by current policies might be helpful in this section. While this statistics are important to understand, the question is whether or not existing policies are adequate or not to protect these very vulnerable populations.

Finally, on page 35, it might be helpful to show the premiums for higher income versus lower income beneficiaries. A more detailed discussion of subsidies for lower income beneficiaries might be helpful here.

Okay, that's all from Tom. I have Brian next.

DR. MILLER: Thank you. I have a couple of thoughts. One is the financing pressures on general revenue. Gina and a couple of others commented on the -- Gina and I think Stacie commented on the range of premiums. We might want to put a little bit in about IRMAA, a little blurb. Over one million Americans on Medicare are making over half a million annually. So we celebrate their

economic success and congratulations to them. I probably will not be part of that crowd myself, but, you know, again, I'm happy for their success. IRMAA doesn't fully account for this, and I think highlighting sort of the range of incomes and the sort of subsidy that folks who are at higher income retirees are getting and the pressure that that puts on Part B is probably a pragmatic thing that we could add.

On Medicare Advantage I agree that there is definitely MA overpayment. There was a Health Affairs study recently from Humana researchers demonstrating a favorable selection factor that is half of what we found. Take it for what it is. It is from industry, and industry has a bias. I do think that showing some range or doing some sensitivity analysis of our MA overpayment might be helpful. I know we already do distributing amongst coding intensity for plans, for example, so there's definitely overpayment. And I would like to joke that we could beat CBO and have dynamic scoring ahead of them.

The provider consolidation section, I thought that was great. Theodore Roosevelt would be very proud of us. The evidence, sort of building on Cheryl's comments

that efficiencies like economics, economies of scale, better adherence to clinical guidelines, alignment of value-based care and EHR interoperability are actually often not realized from mergers. We have 30 years of FTC merger cases which are pretty instructive and show that most of the provider merger-driven consolidation is really about market power and market pricing over health plans, which includes, of course, Medicaid managed care orgs, Medicare Advantage plans, commercial insurance plans, state health plans, noting that I am on the board of a state health plan.

So the monopolization is inherently anti-consumer, anti-provider, and frankly, anti-taxpayer, and that same consolidation I recognize can happen on the payer side too. I do think we should differentiate that from organic growth, from health systems that are building and improving operations on their own as opposed to buying their competitor to increase market power.

The BLS labor productivity data for hospitals has been flat for 30 years. I keep saying this every year, and it's still flat, or just about flat, suggesting that we don't have labor productivity growth. That's a product of

consolidation, of monopoly, and overregulation.

And then my last comment is on that table, which was added, on laws and regulations. That might be my favorite MedPAC table ever. I have many favorite MedPAC tables, because we are all very nerdy.

Two things that I wanted to highlight from there, just for us to noodle on as a group. One is certificate of need. This drives up cost and restricts entering competition. The Mercatus Center has 20 years of research in this area. Fundamentally, for those listening who don't know what a certificate of need is, applying to build a facility and then having your competitors comment on it, telling the state that it's not needed, is probably not a great process to promote competition at lower costs.

The second is Stark law, noting, of course, that I am a physician so I have a bias in that sense. But just owning that. So I wanted to think about what self-referral is, and there are problems with self-referral, big time.

Self-referral can be good, and it can also be bad. Using Gina's example of the orthopedist, if the orthopedist can offer one-stop shopping for the patient, and they come in, they get their x-ray, they see the

physical therapist who has a customized training program for that specific condition, that they work with the orthopedist and the physical therapist to create that one-stop shopping, that integrated care delivery, that's good thing. That's integrated care which is what you need.

If it's just, hey, I happen to own the MRI, I happen to own the physical therapy, just come here and I get to drive volume, that's not good.

So that good or that bad behavior can occur whether you are a large, tax-exempt health system or whether you are a physician. So thinking about it, I trained at MedStar Georgetown. I'm using them as an example because they're a wonderful hospital. I like them. I would get care there myself. They could, in theory, require self-referral for that orthopedist. They could require their orthopedic surgeon, working at MedStar Georgetown to self-refer to the MedStar physical therapy, to the MedStar MRI, to the MedStar x-ray. And, in fact, when you work in a large integrated health system they often require you to do self-referral as part of your job. It's just part of your expectation and part of your employment, actually, as a physician.

In contrast, my medical school colleague, Dan Choi, who is an independent spine surgeon, if he did all of those things for a Medicare patient that would be illegal.

So yes, there are problems with self-referral, but I don't think that my medical school colleague, Dan Choi, is more or less self-interested than MedStar, which is a $9 billion a year integrated health care delivery system.

So I would posit that one of the things we should think about is, one, an equal playing field. Because certificate of need, that's driving consolidation. Stark law has actually eliminated independent practice and small business competition in the marketplace. If we actually want to address self-referral as problematic, how are we going to do that? It is hard to sit here, and we can't realistically write a list of what all the conditions and right things are. We would end up with a 3,000-page regulation. And actually, if you go and look at Stark law, self-referral law and rules, it's over 900 pages. I read it and it was exhausting. I read it by the pool on vacation. I need new hobbies, as my wife tells me.

So one of the things that we could think about if

we wanted to think about competition and promoting provider competition is a Stark exception in the managed care setting, whether it's managed Medicare, managed Medicaid, someone is doing utilization review, someone is looking over your shoulder, someone is saying no. They might not be saying no efficiently. They might be mean about it. But that is an area where we could potentially remove that break, allow for that physician competition, and then maintain that break in a fee-for-service setting.

So great chapter. Thank you.

MS. KELLEY: Greg.

MR. POULSEN: Yeah, thank you very much. I also really, really liked this chapter. I think we've learned a lot from it.

I guess I'd like to hit three points that others have mentioned but do it really quickly since others have mentioned it effectively and efficiently. The 14 percent more for MA than fee-for-service I think is really, really noteworthy. And I think that we are starting to feel like we're getting our arms around why that's the case and what we can do about it, and I'm looking forward to our discussion tomorrow on coding, which I think is going to be

even more insightful to help us understand that.

I think the consolidation piece was particularly well done in the paper -- it often lends itself to simplification, inappropriate simplification, where consolidation is good or consolidation is bad. And I think what we see here is that we've got examples where consolidation leads to higher value, and we've got examples where it leads to lower value, and causality and where it comes from is meaningful on this. I think that you pointed that out nicely, where in many instances provider-led vertical integration has shown increased value, whereas if it goes the other direction or it starts in insurers and goes towards providers the indications seem to be far more mixed and even negative. So I think understanding those dynamics is really, really helpful, and I think we're starting to get some increased coordination there and some increased insights there. So thank you for doing that and not going to a simple or simple-minded solution on that.

On the Baby Boom thing, this is really going back to something that Gokhan said, where I think that the sense of urgency really is kind of interesting. It's easy for me even to become a little bit jaded. If you go back and look

at the prognostications in terms of where the trust fund is going, in 1970 we thought the trust fund would be broke in 1972. We did. In 1993, we thought it would be 1999. And in 2019, we thought we'd be out this year, 2026. It's easy to look at that and say, well, you know, it's like nuclear fusion. It's always X years away, but we never get there.

But you guys did a really good job, I think, showing that the demographics are really starting to make this a very, very difficult nut to crack. We're having more and more people getting into the use years and fewer and fewer people paying for the bills. And that's true not only -- and Gokhan, again, to your point, that's true not only for Part A but it's equally true for the impact on taxpayers in Parts B, C, and D. So we need to think about all of those things, and I think that's really useful.

And just one other thing that I think is really interesting. If you look at the Baby Boomers, of which I am one, we certainly, when we moved into that and started to move into that, as you all talked about, we had an increase in the younger people in the Medicare demographic, that that bolus is now moving into the high-use years. We're starting to see the big chunk of the Baby Boomers

moving into the mid-70s, and that's a much, much more expensive cohort than it is in the mid-60s in age.

So I think we do definitely have every reason to feel challenged in terms of the work that we do, because we've got some important things that need to be done in order to keep Medicare affordable for the population, irrespective of what the trust fund numbers appear to be at the moment.

So thanks very much for some great work.

MS. KELLEY: Scott.

DR. SARRAN: Okay. Rachel and Alex. It's so difficult to take such a huge topic and tease out and then coherently speak to important themes, so great job.

There are two comments, both in the consolidation space, and it builds somewhat off of Greg's key point about not all consolidation is good and not all consolidation is bad.

One small point is I don't think I saw, and I apologize if I missed, in terms of calling out potential negatives of consolidation, the potential negative when there is vertical consolidation involving payers and providers, for that to create opacity via transfer price

arrangements around MLR and true medical costs. And we all know that is a substantive concern. So if we didn't call it out, let's do that.

And then my last comment is just to emphasize the concern about what I would describe as the troubling but not surprising to date findings around the intersection of private equity-driven consolidation and some downstream negative effects on beneficiary health and outcomes. And you did a great job commenting on the key provider implications for staffing and transfers to PE hospital, around mortality -- I mean, let's digest that for a moment -- and post-op complications, and admissions. And by the way, that should have been around one question. I don't know if we meant to say readmissions or admissions in that one.

But when I think about the quality journey writ large over the last many decades has been in fits and stops but overall a positive journey. Quality has gotten better. And now we are seeing some evidence that there is a market phenomenon of private equity-field consolidation that is at least associated, to some extent, right, with worse markers of quality. That should be, to us all, I think, very

troubling.

It's also, if we take a half step back, it's not surprising, right. Private equity finds strong short-term levers to improve revenue and cost management. That's what they do. They're not ashamed to say that's what they do, and in many other industries that's perfectly fine.

But think about those levers. Improving revenue in a fee-for-service world or fee-for-service dominated world becomes significantly around coding, volume and intensity of services. It's not in any way, shape, or form directly connected to improved outcomes.

And improving cost in health care delivery is not about back office efficiency. It's about people, and it's about people on the front line. You talk to any hospital or somebody running a hospital, somebody running a large medical practice, where are their costs? It's people, and it's people involved in patient care.

So I just think just emphasizing it's very troubling. And I think the take-home I have from that is that we just do not have, at this point in time, sufficient safeguards needed to protect beneficiaries. And let's just assume that all these private equity players, let's just

assume that they are all playing by all the relevant rules. So saying that, though, it tells us we do not have sufficient guardrails to protect beneficiaries writ large from the impact of for-profit, particularly private equity driven consolidation, and that's a thread, I think, worth continuing to pull on.

DR. HARRIS: And just to clarify on that readmissions/admission, I'm quite sure it is admission, but I can clarify.

MS. KELLEY: Robert.

DR. CHERRY: First and foremost, I really like this chapter because I think it's really well done. Many of us are just giving additional context around the context, so you can utilize that to hopefully make it a richer and even more balanced chapter.

The heavy emphasis here in terms of health care spending is around consolidation and pharmaceutical costs, for example. We also have discussed in the past around coding intensity as well.

I think it's also a little more complicated than that, because there are a lot of costs that are rising in health care that are uncontrollable, particularly from the

perspective of hospital executives that are managing both inpatient and outpatient services. So I thought I'd mention that because that's also increasing the spend, as well.

You did mention about the growing numbers of people on Medicare. And while that's true in terms of driving up the costs, this generation of Medicare patients is going to be experiencing health care much differently than in previous generations. And by that, they are living much, much longer, and particularly much longer than when Medicare first started. And with that, of course, you would expect an increase in chronic conditions driving up the costs of care, but it's not just the chronic conditions.

It's the constellation of conditions that are coming together around each unique patient. So the patient with diabetes has this chronic kidney disease that also needs their blood pressure managed, is really increasing the complexities in ways that we may not have fully anticipated. And these patients also need increased access to services, emergency services, dialysis, home health, et cetera. And with that comes increased utilization of post-

acute care in terms of skilled nursing facilities, rehab, LTCHs, and hospice care circumstances.

Technology is also getting better but also more expensive, imaging studies, whether CT scans, MRI. There is more personalized care, particularly with genomic testing, and there's pharmacogenetics with particularly cancer care. We have patients now where cancer, in certain selected situations, is becoming more of a chronic condition than anything else. They're not necessarily cured, they're not necessarily terminal, but people are living with it because of advancements in care.

I also wanted to add to the labor costs too, because that is problematic. And labor and pharmaceuticals for the majority of hospital systems is the majority of the budget. And while AI might help with some back office operations, I'm a bit skeptical that it's going to solve the labor issue, because health care is highly dependent on human interaction.

So I think we'll still have labor pressures going forward, and it's going to be harder to recruit, for various types of professionals in health care, whether it's nutritionists, nurses, physicians, et cetera, because the

educational pipeline is somewhat constricted. It's more costly to go to colleges and universities. There are now caps on loans. There are shortages of professors and instructors. And all of that is making it very difficult to try to keep up with the expansive labor needs that are necessary.

There is also additional investments that health systems are making in real estate. Because of the Baby Boom generation you have to expand services, the constricted space. You have to involve new construction and expand both inpatient and outpatient services alike.

There are other hidden costs that go on, as well. Just over the last week, for example, Boston Scientific and McKesson underwent cyberattacks, that's causing a looming national crisis over the next several weeks. Stryker had one recently, as well. And then you have these natural disasters, like Baxter recently, where these become a national crisis. And it's costly for those companies, but it's also costly for providers and those on the health care delivery side.

There is more insured, as you mentioned, but there's also more underinsured, and that includes the

Medicare population, particularly when they are hospitalized, because in many areas the costs of taking care of inpatient Medicare patients, that doesn't keep up with those costs.

And then there are all these looming regulatory threats too, whether it's 340(b), like neutrality, H.R.1, et cetera. And these constellations of threats, particularly in 2027, for very large health systems could mean hundreds of millions of dollars in lost revenue, therefore adding on other pressures in terms of keeping up with the costs, as well.

So it's kind of a chicken and egg thing, is all of these uncontrollable costs producing consolidation. It's hard to tell. But I think one thing I'd like to see, that's difficult to do, is try to differentiate consolidation, which tends to have a bad connotation associated with it, from true clinical integration, which actually does improve efficiencies, reduce costs, and improve clinical outcomes.

But I did want to mention that there are all of these costs that are just beyond one's control, that's increasing health care spending, and will be for the

foreseeable future. Thanks.

DR. HARRIS: And I do want to emphasize that our use of the term "consolidation" in this chapter and in our work does not have a value judgment associated with it, from our perspective.

DR. CHERRY: Understood. Thank you.

MS. KELLEY: Paul.

DR. CASALE: I'm also adding my gratitude for a great chapter, really terrific. I really love many parts of it.

A lot of things have already been said and I support, so I'm just gonna make two brief comments.

One is around the premium information, which again was terrific. I just wanted to plus-one Tom's comment about if you could provide some comparison to what's going on in the commercial market.

Even just yesterday, there was an article in The New York Times about employer health costs skyrocketing and how much of that is gonna then roll down to the employee. So, if that could be added for context, that would be great.

And to Brian's comment about IRMAA, which, again,

it's less than 10 percent, but as Gina's pointed out before, some people end up paying IRMAA who didn't really expect because of their businesses, et cetera. So keeping an eye where things are going there, I think would be helpful.

And then just piling on on the consolidation, because I really do -- that's terrific work. I'm wondering if there's potential to do a little more work or more information around the private equity specialty integration, that some has been going on for some time in things like GI and ophthalmology. And there's growing integration or consolidation with other specialties like cardiology and others.

And, in fact, things like GI has been going on so long that some private equity groups have sold that to another private equity, so how that affects care, as has been pointed out by others around, particularly quality, access, and cost. As Scott said, they do have a playbook, and again, around specialists, it's usually moving care to ASCs, increasing procedure volume, reducing the labor costs for the practices. And how that all impacts, again, particularly quality, I think is really important to try to

keep an eye on, which I'm sure you're doing, but I just wanted to call out that in particular.

So thanks again.

MS. KELLEY: Tamara.

DR. KONETZKA: There are a couple of things I really appreciated about this chapter. Specifically, one, I really like the explicit reminders to everybody about how the recommendations we make or the things that get actually changed about payment translate into premiums and cost sharing for beneficiaries, because I think sometimes our discussions about payment veer into sort of fairness and things about providers, and we sort of lose sight of that. And so I really love that very explicit emphasis in this chapter.

The other thing I really appreciated was the inclusion of the consolidation piece, you know, echo everybody else's excitement about that.

I have couple of more specific suggestions about the consolidation part of it. I think following a lot of the literature, perhaps, some of the text focuses in a lot on hospital consolidation, on hospitals and physicians, and then a little bit into plans now too. I mean, there's a

little bit more in there. But I think one of the things that strikes us over and over again in our conversations is how -- it's almost overwhelming how much consolidation there is across the health care spectrum.

So we talk about sort of there's lots of action in post-acute care with private equity buying or taking ownership of nursing homes, of home health agencies, for example. We talk about it in when we talk about dialysis and only two major firms running all of these dialysis facilities. So I'd love to see some of the discussion expanded.

And, if possible, I realize this is easier to suggest than to do, but I would even love to see like a table or a figure that kind of goes through sector by sector and says whatever descriptive information you can dig out of the literature, you know, like X percent of these facilities are now owned by private equity, right, dialysis, there's just two major suppliers, you know, like so that one can see, you know, from the perspective of the entire health care system, just how ubiquitous increasing consolidation is. So something, you know, a table or something that makes that a little bit more obvious would

be great.

The other thing I'd love to see be a little bit more explicit -- and this is in there in different ways, but I'd love to see like a section on it, which is, you know, this is the broader health care context, right? But there are certain aspects of consolidation that Medicare policy specifically might contribute to or encourage or discourage, right? And so a section that says, you know, the fact that we don't have site-neutral payment may be contributing to consolidation in this sector or whatever it is that's sort of in there in different places right now, so just a sense to give the reader a sense that there is all this consolidation. Some of it may be good, some of it may be bad, but there's a limited extent to which Medicare payment policy can affect that.

On the other hand, Medicare spending will be affected by it inevitably. But, anyway, an explicit discussion of sort of Medicare's role in all of this would be really helpful.

So those are my main suggestions. Great chapter. Thank you.

MS. KELLEY: Kenny.

MR. KAN: Excellent summary.

I like the chapter section on consolidation. Regarding consolidation, the chapter suggests that provider consolidation increases both payment rates and spending. The paper also discusses the 7 percent Medicare spending growth in 2023 and 2024, identifying price, volume, and mix intensity as key drivers.

Can we do the same for provider consolidation? More specifically, can we decompose the spending effect into higher prices, volume, and intensity?

As a nerdy actuary who likes to measure things, the composition is important as the appropriate policy response could vary depending on the result. For example, a few years ago, BCBSA, Blue Cross Blue Shield Association, performed a study suggesting 20 percent of hospital price increases are due to coding intensity.

I believe we're in the second inning of AI-driven revenue cycle management. Hospital coding intensity will get worse with the larger hospitals using their balance sheets to consolidate over time. As we tease out the historical composition, I'd like us to consider how does the future change and how policy responses need to flex

appropriately. What guardrails can Medicare do to mitigate this?

Thank you.

MS. KELLEY: Ben.

DR. IPPOLITO: Well, I'll try to be brief. And I suppose maybe my first comment may sound a little bit more sort of orthogonal to what some folks have been saying.

But there's a tremendous amount of ink that has been spilled summarizing the effects of consolidation in the health care space and categorizing it and documenting it, think tank reports, testimonies, congressional testimonies, policy papers.

I don't know that there's a tremendous value in you spending your sort of incremental time doing another summary. I think there's a bigger value in really emphasizing I think something Tamara was mentioning, which is what does this matter for Medicare, and what is Medicare doing to contribute to this phenomenon and really hammering on that angle, because that really does seem to be sort of the relative value-add this group has.

And to that extent, one thing that I don't think I saw was it does affect, for example, pass-through when we

have programs like MA, where when we pay plans, if we think there's greater competition between those plans, we think a larger share of the marginal dollar gets passed to the benefits than if there's less competition. That's the kind of thing where I think there's probably more incremental value than doing sort of a full additional synthesis of what do we know about consolidation. But that's just my suggestion.

I also like the enrollee finances piece. I do think that people talked about this with respect to sort of cost trends. I'd suggest roughly the same thing for comparing these results to non-Medicare results, so what does sort of affordability and access challenges look like outside of the Medicare program, just to give some baseline for like, is this high or is this low?

I'd also suggest there's a lot of subgroup analysis presented in here -- analyses. Those always suffer from the same criticism, which is that there's an overall population average. We've gone out and we found the subgroups where this number is bigger than the average. But what does, of course, that imply? There's other groups where it's lower. And so really hammering, why are we

focusing on these subgroups?

And I think the argument -- you've kind of implicitly said it -- is we're trying to identify places where we're concerned that there might be access challenges and so on, and just be really explicit about that. It's not sort of a -- we're not sort of hunting for the biggest result, but rather we're using this to try and identify populations where we might be worried about access.

And then, finally, this is a very nitty-gritty point, but on Figure 7, it shows spending over about 15 years across all sorts of different spending categories. First, I agree with, I think, what Stacie opened with. I think the most important thing to understand is what is driving the Part B increase.

But it also includes kind of average spending growth over a 15-year period, where some of those trends are highly, highly nonlinear. I would suggest just ditching those and talking about the trends in sort of words, rather than saying that Part D spending has increased 2 percent per year over 15 years, because, of course, the last two years, it's gone up by dramatically higher rates than that. And so that's really sort of a

nit, but I think that might lead people to take the wrong thing away.

But thanks.

MS. KELLEY: Danielle.

DR. PIEROTTI: Thank you so much for whoever included food insecurity in this chapter. That was an amazing way to bring the dollars back to the reality of humans, and I'm so grateful for it.

I am a little bit surprised by the surprise in the use of Part B versus Part A. We've been trying to do this for 20 years, move people out of the hospitals. That was always the goal, and we're doing it.

Currently, the only reason to be admitted to the hospital is truly if you need to be watched by a nurse, because everything else you can come and go for. And if you can, see your physician and go home, you will. If you can get your X-ray, your surgical procedure, and then go home, you will. The only reason to stay in the hospital is because you need someone to administer continuing treatment, usually a nurse, or you need someone to be watching you in case something goes bad that you can't do at home. This is what we've been aiming for, for a really

long time.

And I point back to the comments about what we thought, the Medicare Trust Fund was going to be gone for the last 30 years. Well, this is what we've been doing.

It will be interesting, and I look forward to getting into more of the workforce aspects of that, because we are on an interesting precipice. A few people mentioned earlier about, well, what's going to happen now with emergency room backups and holdovers and kinds of things. I'm going to try and stay off of my apocalypse belief system for this right now, but I just want to point out that we've achieved what we set out to achieve, draw down hospital stays.

There is a fascinating and I think under-discussed point in here that there's some data about MA patients staying longer in hospitals, and I think we'll get more into it in the post-acute chapter, but boy, we ought to spend some time on that one.

And this idea of favorable selection potentially being related to those outcomes, well, maybe they're just staying longer in the hospital and having more favorable outcomes. Maybe we pushed too far to get people out too

fast.

I am curious, and I don't know if either of these things are something that we can get any data on. But we talk about the extra payment to the MA plans that is tied up in this idea of the supplemental services, glasses and hearing aids. Is there any way to capture the financial and/or quality impact of those supplemental benefits? I think it's interesting to talk about how much more payment is going there.

I'd really like to understand how much money are we spending on actually getting the supplemental benefits. How many pairs of glasses? How many hearing aids? How many gym memberships? What is the impact of those supplemental benefits? Are they worth this investment?

The other piece that jumps out at me around this idea in the MA versus fee-for-service and the relationship of favorable selection that is coming up here, as well as the age relationship that was referred to a few times with more of the younger Medicare beneficiary being on the MAs and that that sees a trend of change as we move into the older of the patient population, my question is, are people moving? Are we moving from a Medicare Advantage plan?

When I'm motivated at maybe 65 because I want the supplemental services and I'm willing to manage or not be too impaired by the utilization review and the prior authorization standards that are happening in those plans, and then I move to the fee-for-service as I grow older, as I am less motivated by the glasses because I now have them, and I'm more motivated by easier access to more providers with fewer of the utilization management, I think understanding what is happening with that will offer us a lot of insight into what we can plan for, because if this is just, well, I enrolled at 65, I'm 85 now, so I was in fee-for-service at the beginning and I didn't change, that's a very different pattern than people who are moving from an MA plan into fee-for-service as they grow older. And I think that it would be really helpful to be able to think about that.

I also just want to bring up a caution that as we talk about issues like coding intensity and our first instinct, mine as well, is to say, ooh, that must be bad, is to pause for a minute, because it's possible -- and we haven't ruled it out -- that coding intensity is an effect of better capture of the critical thinking that's happening

in the patient care environment, and that it may be entirely plausible that particularly as we now have AI who is listening in the patient care room and capturing the critical thinking of the provider or of the nurse or the therapist, and they are talking through how they are considering multiple aspects of a whole person, that AI is capturing things that when they were documenting by hand, they didn't remember to document.

So I don't want to rule out the possibility that coding intensity is a better reflection and that our relationship with it to payment may need to change. I just don't know that we understand it very well, and I would point to a little historical experience.

Many moons ago -- here I go, being that old lady, but many moons ago, CMS invented Never Events, and one of the first ones was late-stage hospital-acquired pressure ulcers, and boy, let me tell you, we did a great job with those. We almost eradicated late-stage hospital-acquired pressure ulcers, and I believe Brian is laughing because he knows where I'm going in that here's the little dirty little secret. We didn't. What we did was we learned how to document them on admission.

So the documentation part is meaningful, and it's meaningful to understand what it's really saying and what it's really telling us about patient experience. That knowledge was first applauded because, yay, no more late-stage hospital-acquired pressure ulcers. It is not because people weren't having them.

It did increase the awareness of how to avoid them, of the science behind their development, around how we talk to family caregivers, about a lot of other things that happen downstream, even though it really wasn't about changing the existence of late-stage pressure ulcers. The whole trend was helpful.

So, when I think about this issue of coding intensity, is it good? Is it bad? I don't know. Right now, it's just a thing, and I think it deserves more varied thought because some of these things are both good and bad. They're not a choice between this or that. It's both things simultaneously, and we referred to some of that in our conversation about consolidation. Sometimes consolidation really is improving care efficiency and effectiveness and care communication, and sometimes it's really a money grab. It's not one or the other.

So I ask that we consider that in some of our other discussions as well, particularly this issue of coding intensity.

Thank you.

MS. KELLEY: I have a comment from Josh Liao.

Josh agrees with points made about avoiding simple conclusions about all consolidation being good or bad and the importance of flagging different types and funding mechanisms driving consolidation with a focus on impact on Medicare.

His other comment is about the affordability information on pages 32 and 33. First, he appreciates the work placing problems paying medical bills alongside information on beneficiary income and food insecurity. Together, he believes that these measures provide a broader picture of financial vulnerability.

If possible, the picture could be further strengthened with information about additional health-specific affordability measures, such as delayed or foregone care because of cost, medical nonadherence, medical debt, or out-of-pocket spending relative to income.

On page 32, a few clarifications might help.

First, the two groups receiving help with Part B premiums, 18 percent figures, aren't mutually exclusive. Beneficiaries receiving Medicaid help with Medicare premiums or cost sharing also qualify for the Part D low-income subsidy.

A brief note about this overlap would prevent readers from adding the percentages or treating the groups as separate. If feasible, a cross-tabulation could show the extent of the overlap.

The other clarification relates to the four example subgroups noted in the bullet points. These groups also overlap. For example, a beneficiary under age 65 may be partially eligible and receive the LIS. Describing them as selected overlapping populations would improve interpretation.

If possible, a few key comparisons might also help; for instance, partial versus full-benefit dual-eligible beneficiaries or fee-for-service beneficiaries with versus without supplemental coverage. The goal would be to show how reported affordability problems vary across levels of beneficiary protection, recognizing that interpretation is affected by other factors.

And that is all I have for Round 2.

DR. NAVATHE: Great. Thank you, Rachel, Alex, and Jennifer for great work.

Commissioners, thank you for a very robust discussion. I think a lot of wonderful comments.

So a couple of reflections. I think a lot of common themes, which is wonderful. And then, obviously, folks had some additional comments outside of those themes as well.

So one thing I wanted to reflect upon, the note that we kind of have a pithy way to describe some of the financial challenges in the Part A side, whereas we're seeing a lot of growth on the Part B side, and how can we articulate that in a way that's maybe a little bit eye-catching, I think we can think about that. If you all have suggestions, obviously, you can send that to us afterwards.

I think there was a number of comments that were, essentially, can we stratify things differently? Can we group things differently? I think we can take a look at that. I think just keeping in mind some practical realities of how much we can do and how much we want to lengthen the chapter versus keep it in a digestible form.

One thing we definitely will do is there's a number of questions that folks asked around clarifications of what's in and what's out, the numbers that we're reporting. I think that will take a little bit of work to kind of double-check and we can follow up about that. And I think that we'll certainly do.

There's also some questions about and suggestions around indexing to commercial, and we can think a little bit about that. I would say one thing that's worth remembering here is that the goal of this chapter -- actually, in some ways, I would say, listening to your comments, I would say that the context chapter is working. I think it's stimulated a lot of conversation. I think it stimulated a lot of areas where you're worried, concerned, want to do more work in terms of the policy areas.

And while, on one hand, the goal of this chapter is not to get into those policy areas and start to develop policy areas within this chapter, the goal is to provide the kind of context to say, hey, we need to do more on X, Y, or Z. And judging from your comments, at least, I would say it's working. It's working. I think it's highlighting that.

So we're going to try to keep the kind of grounding of the context chapter as context. So many of the suggestions that you all made, that I would put in the category of, you know, can we do more kind of primary work versus literature review, I think we'll probably take your suggestions and pull those into the respective policy areas, as opposed to try to do that within the context chapter itself, just, again, really mainly for practical reasons.

And I think another piece that kind of goes alongside that is we will -- again, just being very transparent with you about kind of bandwidth and workflow, I think there's aspects of what you all suggested that we'll try to pull into this coming March chapter versus some of your suggestions probably will just carry over into future refinements that we'll take -- that we'll try to make, I should say, over time.

But thank you. I think really, really well-thought-out, thoughtful suggestions.

Oh, actually, the last thing I wanted to touch on is many of you mentioned consolidation, and obviously, it was a featured aspect of the chapter itself or the paper

itself. So I think I definitely agree with the way Alex described it in general, which is in general throughout the context chapter, we're trying to be dispassionate. We're trying to report out kind of what we see as the trends. We're not trying to make value judgments.

Now, there's literature that we're reviewing and we're pointing out. So there where the literature exists, we're going to say, you know, it's mixed or it's this or it's that. I think that that touches on other aspects that we've heard about in terms of what's happening in MA and otherwise. I think that the goal in this context chapter is not to make any, quote/unquote, "judgments" per se, but just to report out.

One of the challenging parts around consolidation also is I think has been mentioned by a couple of folks, including Tamara, that the payment policy levers that Medicare has around consolidation, as well as the effects of how consolidation impacts Medicare, it can be quite variable depending on the type of consolidation and who's involved. And, you know, if we think about traditional hospital, you know, horizontal integration in a setting where Medicare doesn't have negotiated prices in the way

commercials -- the commercial prices are negotiated, that context and that sort of pathway to impacting the program, certainly not saying that it doesn't impact the program, but it's just different than it would impact commercial prices and perhaps is a longer pathway.

So very, very much appreciate the feedback around that, and I think we will sort of, I would say, try to do what we can within the context of these limitations that I'm also highlighting.

But I think the discussion was great, and again, I'll just come back to the point that the discussion and the backdrop that it sets for all the work that we do, I think, from the discussion that you all had, I was very reassured that we're hitting some of the right themes in the chapter, and we'll continue to work on that and refine that.

So, with that, Paul, is there anything else that you would like to add?

MR. MASI: Great start.

DR. NAVATHE: Okay. Excellent.

So, in that case, we will begin our wrap-up process for this session. We do have the opportunity for

folks who would like to make any comments in person here at the mic, where Rachel and Alex were sitting. So, if anybody does want to make a comment, please go ahead and come up to the microphone. In general, the in-person comments should be limited to three minutes, and we will have a timer for those. And please certainly identify yourself and if you would like your organization as well.

[No response.]

DR. NAVATHE: Okay. Seeing no in-person public comments.

I will also remind folks that we can also -- especially those listening at home, we want to hear from you. We love to hear comments and feedback, and you can submit written comments to us at meetingcomments@medpac.gov.

I think with that, we can wrap up this morning's session. Thank you.

[Whereupon, at 12:45 p.m., the meeting was recessed, to reconvene at 2:30 p.m. this same day.]

AFTERNOON SESSION

[2:30 p.m.]

DR. NAVATHE: Welcome back, everyone, to our afternoon session today of our September public meeting. We'll be discussing issues and potential policy directions in Part D, and I think Betty is going to start us off.

DR. FOUT: Thank you. Good afternoon. In this session we will present on emerging issues in Part D and potential policy directions. As a reminder, the audience can download these slides by clicking on the document icon in the upper right-hand corner of the screen.

Before start, I wanted to acknowledge and thank our colleagues, Tara Hayes and Renuka Diwan, for their contributions to the Part D work.

This presentation will cover background information; the Part D benefit redesign and its effects; spending trends using newly available data and drivers of the spending growth we observed. We will then discuss potential policy directions and have our discussion.

We begin with background on the Part D program.

Part D relies on private plans competing to provide prescription drug coverage. Plans may be

standalone prescription drug plans, or PDPs, which are available to fee-for-service beneficiaries, or they may be part of a MA plan that offers both medical and prescription drug coverage, called MAPDs.

Plans bear financial risk for enrollee spending, incentivizing them to manage benefits. Medicare does share in that risk through reinsurance payments and risk corridors that limit plan losses and profits. Payments to plans are also risk-adjusted to account for variation in spending due to health status.

Plans and their pharmacy benefit managers negotiate with both pharmacies and manufacturers. These negotiations determine networks, payment rates, and formulary placement and rebates.

Medicare, beneficiaries, and manufacturers each finance different parts of the Part D benefit. Medicare's payments to plans cover a substantial portion of basic benefit costs. Enrollees pay their share of the premiums plus any cost sharing, and manufacturers must pay a portion through discounts on brand-name drugs.

Part D has worked well in multiple dimensions. Enrollment is high, with about 80 percent of Medicare

beneficiaries, or 56 million people, enrolled in a Part D plan. The program has also consistently achieved high levels of beneficiary satisfaction, as documented in surveys and focus groups.

Plan availability is good, with more than 5,000 plans offered nationwide, and beneficiaries have multiple plan choices. However, the number of standalone prescription drug plans has declined in recent years.

Plans have achieved high generic utilization -- generics account for about 90 percent of prescriptions. This helps constrain prices, reduce benefit costs, and moderate premium growth.

The Part D benefit redesign substantially improved affordability and enrollees' accessibility to medications by eliminating the coverage gap and capping their out-of-pocket spending. At the same time, the shifts in benefit financing and spending growth have increased Part D benefit costs. Premiums would normally rise with higher benefit costs, but temporary policies have maintained lower premiums, increasing federal spending.

After the temporary policies phase out, enrollee premiums could increase substantially if the growth in

spending and benefit costs are not addressed. Higher benefit costs and premiums may affect the long-term stability of the Part D market, especially for PDPs.

We now move on to some of the changes made to the Part D benefit by the redesign. These analyses are discussed in greater detail in our March 2026 Report to the Congress.

The IRA's redesign of the Part D benefits includes key elements of the Commission's 2020 recommendations, which sought to address weakened plan incentives to manage spending, since Medicare payments were increasingly cost based, as well as address access barriers for enrollees who need high-priced medications.

The Commission recommended increasing plan liability as well as strengthening financial protections for beneficiaries. Consistent with these recommendations, the redesign increased the role of the capitated direct subsidy and reduced reinsurance. It also eliminated the coverage gap and enhanced financial protection for enrollees with high spending.

The IRA introduced major changes to the Part D benefit, and we'll talk through the ones that are most

relevant to today's topic.

Starting with the bottom right, in 2025, the redesign changed benefit financing by increasing the role of Medicare's direct subsidy payments and reducing cost-based reinsurance payments, which had previous covered most of the costs for high-spending enrollees.

Moving to the top two bullets that are bolded, the redesign introduced an out-of-pocket cap in 2024, and lowered it substantially in 2025. This significantly reduced costs for high-spending enrollees.

Finally, moving to the bottom left, since the benefit redesign was expected to increase benefit costs, a temporary policy was implemented in 2024 to mitigate premium growth. As we'll discuss in a later slide, capping premium growth shifted more costs to Medicare's direct subsidy.

This graph illustrates how Part D spending is financed and how this changed following the redesign. Starting with the top bar, before the redesign in 2023, the largest share of spending was financed through Medicare's reinsurance payments, as shown by the 38 percent in the dark blue part of the bar. This means that most payments

were cost based. Enrollee cost sharing made up about a third, as shown in the dark orange on the far left. Plan liability, the portion of spending for which plans bear insurance risk, represented only 11 percent of spending. This is financed by Medicare's direct subsidy payments and enrollee premiums. Since plan liability financed a relatively small share prior to the redesign, plans had relatively limited incentives to manage spending.

Moving down to 2026, the distribution changes substantially. Plan liability grew to 57 percent of spending while the Medicare reinsurance fell to 15 percent. The redesign shifted more spending to be financed by plan insurance liability, which better incentivize plans to manage spending and aligns with the Commission's recommendations, as we discussed. The far left of the bar shows how enrollee cost sharing fell to 14 percent of total spending, reflecting the introduction of an out-of-pocket cap and its subsequent reduction.

Enrollees without the low-income subsidy, or LIS, were particularly affected by the introduction of an out-of-pocket cap, since, by law, cost sharing for LIS enrollees is mostly covered by Medicare. The bars on this

chart show that inflation-adjusted average out-of-pocket spending for non-LIS enrollees, including both cost sharing and premiums paid out-of-pocket has fallen by nearly 25 percent from $830 in 2023 to $630 in 2026. Average cost sharing declined by 30 percent, and the premium portion declined by 16 percent over this time.

The decline is particularly notable among high spenders, defined as those in the top 10 percent of total gross Part D spending in each year. As the purple line shows, among these enrollees average out-of-pocket spending per enrollee declined by 50 percent. That is, the redesign was effective in reducing financial exposure among beneficiaries with the greatest drug spending needs.

However, it comes at a higher cost for Medicare program spending. Over this same time, Medicare spending per enrollee rose by 30 percent, highlighting a central tradeoff in Part D.

We now take a closer look at the increase in plan liability that followed the redesign. This is the part of spending financed by Medicare's direct subsidy payments and enrollee premiums. Part D plans submit bids that reflect their expected share of enrollees' drug spending, or their

expected plan liability. The average bid amounts shown in this chart are not risk adjusted, so they reflect the actual spending projections plans use to develop their bids.

We decomposed the increases in the average bid from 2024 to 2026 using information provided in plans' bid submissions. For 2025, we found that most of the increase in bids, the 82 percent shown in dark orange, was attributable to the redesign of Part D benefit financing. These shifts were intended and expected. By 2026, however, most of the increase, the 72 percent shown in peach, reflected higher expected drug spending. In both years, higher bids may also be due to uncertainty about how the redesign would impact drug use, prices, and spending.

Higher bids and basic benefit costs put outward pressure on enrollee premiums. Basic benefit costs equal the sum of the national average bid in Medicare's reinsurance payments. This chart shows how expected benefit costs changed from 2024 to 2027. The 2027 bid amounts have been recently announced. The two gray parts of the bars together represent the national average bid, and the teal bottom parts of the bars show expected

reinsurance payments. Although the role of reinsurance declined under the redesign, higher bids have more than offset that reduction, and as a result, expected costs increased in all years through 2027.

The growth in basic benefit cost reflects several factors. First, lower cost sharing under the redesigned benefit increases the generosity and therefore the costs of the benefit. Second, the lower out-of-pocket cap is expected to increase utilization and spending through induced demand. And finally, broader trends in the rising use of high-cost drugs continue to put upward pressure on benefit costs.

Higher benefit costs would also have increased enrollee premiums. Historically, average basic premiums covered 25.5 percent of basic benefit costs, as shown in the top portion of the bars. Therefore, as basic benefits rise, enrollee premiums would have risen proportionally. Under this historical policy, the average basic premium would have reached about $94 per month in 2027.

However, Medicare program spending increased to maintain lower enrollee premiums in two ways. First, beginning in 2024, the IRA capped annual growth in the base

beneficiary premium at 6 percent. The cap reduced the enrollee share of basic benefit costs and shifted a larger share of costs to Medicare's direct subsidy. As a result, Medicare's direct subsidy costs increased by $33 billion between 2024 and 2026. Because the cap is applied each year to the prior year's capped amount, the costs compound over time, requiring larger subsidies each year to maintain the cap.

Second, in response to large increases and variation among PDP bids, CMS implemented the Part D Premium Stabilization Demonstration, which further reduced premiums for PDPs. We estimated this demonstration raised Medicare's direct subsidy costs by $10.7 billion in 2025 and 2026.

Summing these amounts together yields an estimated $44 billion in additional Medicare direct subsidy spending over the last 3 years. The net effect on federal spending would be smaller because other program components would also adjust with higher premiums. For example, Medicare's low-income premium subsidy would increase, offsetting part of the change in the direct subsidy. Changes in premiums would also affect other components of

Medicare spending that are not captured here.

But these policies substantially reduced premiums, but they are likely to rise significantly once the policies expires. The 6 percent cap ends after 2029, and the premium stabilization demo ends this year.

This chart shows the base beneficiary premium if it were set to the historical 25.5 percent of cost, the gray bars, next to the actual base beneficiary premium, the orange bars. You can see the gap between the historically set and actual premium widens substantially over time, due to the 6 percent growth cap. In 2027, the actual base beneficiary premium of $41 is only 11 percent of expected basic benefit costs, and is nearly 60 percent lower than historically set amount of $94.

As the dotted portion of the bar shows for 2027, if the premium were set to be 20 percent of costs, as is in statute for 2030, it would be substantially higher.

We now switch to talk about gross Part D spending trends using the recently available 2025 data.

In 2025, gross spending rose to $351 billion, a 22 percent increase from 2024. Beneficiary out-of-pocket spending, show in the very bottom portion of the bars,

declined, accounting for 5 percent of spending in 2025. In contrast, the catastrophic phase spending accounted for 66 percent of spending, up from 43 percent in past years. The redesigned benefit was expected to increase spending in this phase, so this does mean that the majority of spending in 2025 was not subject to any cost sharing.

This table shows additional detail on trends for all Part D enrollees, and by their LIS status. Starting with the first column, average per-enrollee gross spending across all enrollees increased by 18 percent between 2024 and 2025. That increase was 26 percent for non-LIS enrollees and 10 percent for LIS enrollees.

The second column shows the share of spending above the out-of-pocket limit. In 2025, overall, spending above the out-of-pocket limit accounted for two-thirds of total spending, compared with 43 percent in 2024. This increase was larger for non-LIS enrollees than for LIS enrollees.

The last column shows the share of enrollees who reached the out-of-pocket limit, 22 percent overall compared with 8 percent in 2024. Among non-LIS enrollees, the share reaching the out-of-pocket limit was 18 percent,

up from 4 percent in 2024, while, for LIS enrollees, the share was 30 percent, up from 16 percent in 2024.

The increase in spending appears to be concentrated among non-LIS enrollees, which is consistent with LIS beneficiaries' cost sharing remaining mostly unchanged. Their cost sharing was largely subsidized before and after the redesign.

We now look at the distribution of spending. Part D spending is highly skewed with a relatively small number of enrollees accounting for a large share of spending. The dark bars in this graph show the share of total Part D enrollees by categories of spending. 29 percent of enrollees, shown in the middle bar, spent $100-$500 in the year. On the far ends, 6 percent of enrollees spent nothing, and another 6 percent spent more than $20,000 in the year.

The gray bars present the shares of total gross spending. So on the far right side, 6 percent of enrollees accounted for 60 percent of total spending. The orange line showing average spending per beneficiary. So these 6 percent of enrollees spent, on average, nearly $64,000 in the year.

On the lower end of the distribution, a large share of enrollees, more than 50 percent, spent less than $500. This means that more than half of all enrollees have spending that is less than the standard deductible amount, but, program costs, and therefore, premiums, are increasingly reflecting the spending by the 20 percent who above the out-of-pocket limit, as shown on the upper end of the distribution.

I will now hand it to Shinobu to talk about spending by therapeutic class.

MS. SUZUKI: This table shows that the increase in spending between 2024 and 2025 was broad based, with every class shown here growing by at least 10 percent. At the same time, there was wide variation across classes.

At the top, you can see that antineoplastics and diabetes drugs, particularly the injectable versions, which includes GLP-1s, accounted for the largest increases in spending, growing by 32 percent and 27 percent, respectively. Anti-obesity agents, nearly all of which are GLP-1s, shown at the bottom, experienced the fastest growth, increasing by nearly 580 percent, from just $0.3 billion to $2 billion.

This chart shows how the broad trends by therapeutic class you just saw in the previous slide played out for one class of drugs, GLP-1s. The distribution of spending above, shown in dark blue, and below the out-of-pocket limit, shown in gray, changed substantially between 2024 and 2025. As you can see, relative to 2024, in 2025, spending grew substantially and shifted into the catastrophic phase much earlier, with most spending occurring above the out-of-pocket limit by midyear. Similar patterns may emerge for other high-cost therapies, which raises questions about whether plans have sufficient opportunity to manage benefit costs and encourage the use of preferred and lower cost therapies before beneficiaries reach the out-of-pocket limit.

We now turn to the Part D specific factors, separate from broader pharmaceutical trends, that may be contributing to recent spending growth. Understanding the drivers of spending growth will be important and may help inform policy discussions about access and costs.

During this cycle, we plan to take a closer look at the underlying price and utilization trends, and how the elimination of cost sharing in the catastrophic phase may

have affected overall spending growth.

In this section, we will focus on two aspects of Part D that may be contributing to faster spending growth. The first item is the new true OOP, or TrOOP, policy. We'll talk about how counting supplemental benefits as TrOOP lowers the effective out-of-pocket limit and may contribute to higher spending.

Second item is how the lower out-of-pocket limit combined with the other features of the Part D' benefit, compresses the initial coverage phase and may limit plans' ability to use cost sharing to manage spending, which may increase spending.

We'll start with the TrOOP policy. Under the current policy, supplemental benefits count towards the out-of-pocket limit, which means enrollees may reach the catastrophic phase with out-of-pocket spending well below the out-of-pocket limit.

In 2025, median out-of-pocket cost sharing among non-LIS enrollees in enhanced plans averaged $960, compared with $2,000 out-of-pocket limit set in law. This policy may contribute to higher program costs because the benefit covers a higher share of spending in the catastrophic phase

than in the initial coverage phase.

In addition, because there is no cost sharing in the catastrophic phase, medication use may increase while, at the same time, plans have limited ability to encourage the use of lower-cost therapies. Higher basic benefit costs increases basic premiums in Medicare's reinsurance payments, and Medicare's direct subsidy costs for all plans, through their effects on national average bids.

The second item relates to the current benefit design. This figure uses 2027 benefit parameters to illustrate how the current benefit design shortens the initial coverage phase, potentially limiting plans' ability to manage utilization.

The vertical axis shows gross spending in thousands of dollars. Starting at the bottom, the figure shows the deductible, which is $700, the initial coverage phase, where enrollees pay 25 percent coinsurance, and the catastrophic phase beginning at $2,400 out-of-pocket.

Note that the deductible is just under a 1/3 of the annual out-of-pocket limit. For an individual who needs expensive drugs that cost thousands of dollars, 25 percent coinsurance could result in relatively rapid

progression through the initial coverage phase, because once beneficiaries reach the catastrophic phase plans have limited share of spending over which they can use cost sharing to influence utilization. In turn, that may limit their ability to encourage the use of lower-cost drugs and negotiate rebates from manufacturers.

We plan to conduct further analysis during this cycle to inform your discussion. For example, we plan to assess changes in utilization associated with the redesign, including comparisons between non-LIS and LIS enrollees, between basic and enhanced plan enrollees, and across therapeutic classes.

We also plan to conduct exploratory analysis and literature review to understand the drivers of spending growth, including improved adherence and shifts away from lower-cost therapies. We also plan to conduct analysis to understand the financial effects of policy changes on beneficiaries and continue our discussion with plans and actuaries to understand how the redesign is affecting the Part D market.

We next turn to potential policy directions for addressing spending growth.

In earlier slides, Betty discussed how high spending growth so far has mostly resulted in increased Medicare costs and the effects on enrollee premiums have muted due to temporary Medicare policies. Some of the high growth likely reflects broader pharmaceutical trends, but reductions in cost sharing under the redesign, which improved access to medicines, likely also played a role by limiting plans' ability to manage utilization. Because the temporary policies that have capped premium increase to 6 percent ends after 2029, continued elevated spending growth, if not addressed, is expected to lead to a substantial increase in enrollee premiums in 2030 and subsequent years.

The premium increase could pose greater challenges for PDPs, which unlike the MAPDs, do not have external funds to buy down premiums. Higher premiums, in turn, may make Part D coverage less attractive to beneficiaries with relatively low drug spending. As you saw earlier, a substantial share of Part D enrollees have spending that is less than the standard deductible.

In the next few slides we'll discuss a few policy directions that the Commission could consider.

One policy the Commission could consider is the TrOOP policy we just discussed. A policy that excluded supplemental benefits from TrOOP calculation could reduce spending growth and enhance plans. The policy would slow beneficiaries' progression to the catastrophic phase, which would increase enrollee cost sharing up to the out-of-pocket limit, lower basic costs and premiums. It may also increase supplemental benefits costs and premiums.

Increasing the share of spending in the initial coverage phase may increase plans' ability to influence utilization and spending through tiered cost sharing and reduce spending in the catastrophic phase.

The change to the TrOOP policy alone, however, is unlikely to substantially slow spending growth. The table shows the potential impact of changing the TrOOP definition. The top row shows that in 2025, under the current TrOOP definition, 35 percent of enhanced plan enrollees with spending above their plan's deductible reached the catastrophic phase. Gross spending in the catastrophic phase for these beneficiaries totaled $78 billion, accounting for about two-thirds of total gross spending.

Under an alternative TrOOP definition that did not count supplemental benefits as TrOOP, 17 percent would have reached the catastrophic phase, meaning some spending would shift to the initial coverage phase. As a result, 53 percent of total spending would be in the catastrophic phase, down from 66 percent. That is, if enrollees in enhanced plans reached the out-of-pocket limit, based solely on their own out-of-pocket spending in 2025, the share of enrollees reaching the out-of-pocket limit may fall by about half.

Although this analysis assumed no behavioral responses affecting total gross spending, it may still be useful for illustrating the potential effects of this policy. However, additional policies may be needed to meaningfully slow spending growth. This is because a substantial share of spending would remain in the catastrophic phase, with more than 50 percent still remaining above the out-of-pocket limit in the simulation analysis we just discussed.

In addition, basic plan enrollees would not be affected by the TrOOP change, and as you may recall from the earlier slide, catastrophic spending for basic plan

enrollees also accounted for about two-thirds of spending.

Another policy the Commission could consider is extending the initial coverage phase. By that we are referring to the amount of spending that would be subject to cost sharing tool in the initial coverage phase. As depicted on the right, benefit parameters could be modified to extend the initial coverage phase, for example, by lowering the deductible or coinsurance, increasing the out-of-pocket limit, or a combination of these.

A greater share of spending in the initial coverage phase may allow plans to more effectively manage spending and negotiate higher rebates, which in turn would lower costs and premiums.

Finally, the Commission could consider giving plans more management tools and additional formulary flexibility to manage spending in the catastrophic phase. For example, allowing plans to use fixed-dollar copays for certain prescriptions filled in the catastrophic phase, while maintaining a hard out-of-pocket cap for other drugs could encourage enrollees to choose preferred or lower-cost therapies.

The Commission also has standing recommendations

from June 2020, which included giving plans greater flexibility to manage the use of drugs in protected classes and establishing a higher copayment for nonpreferred or nonformulary drugs under Part D's low income subsidy program. There may be other flexibilities the Commission may wish to consider.

We will now turn to next steps and Commissioner discussion. We would welcome your feedback on our analytical plan, interest in policy options discussed today, and any additional approaches the Commission may wish to consider.

That concludes our presentation, and we turn it back to Amol.

DR. NAVATHE: Thank you, Shinobu and Betty, for, as always, a very articulate presentation and very informative new analyses, so thank you for sharing those with us.

I think we can turn it over to the queue, Dana.

MS. KELLEY: All right. I have Greg first in Round 1.

MR. POULSEN: Thank you.

And to reiterate what Amol just said, great

presentation, really clear, well done, nice work. I did have just one clarifying question. Do we have -- I didn't notice it in the chapter. We mentioned that 90 percent of scripts being filled are generic, but at least the data that I'm aware of suggests that's only about 13 percent of spend. Do we have that in there, and did I miss it? If not, I would suggest that we probably put that in, because we might look at that and say, wow, this is great. We have achieved success because we know that we have good prices for generic drugs, but if it's a very small percentage of the total spend, then it's less impactful.

MS. SUZUKI: We can definitely add that information. I think the most recent data we've looked at had 17 to 18 percent accounted for by generic drugs.

MS. KELLEY: Ben?

DR. IPPOLITO: Thanks.

On Slide 24, you report that in 2025, median out-of-pocket cost sharing was $960. In the context of talking about the out-of-pocket limit for enhanced plans, is that conditional on reaching the cap? Is the correct interpretation that of people who reached the cap, they were reaching it with $960 in spending, or their total for

the year was $960?

DR. FOUT: It was among those who reached the cap. Their median out-of-pocket spending was $960.

DR. IPPOLITO: Wow. Okay, thanks.

MS. KELLEY: Gokhan?

DR. METAN: I have one question, clarification question. If you could go back to Slide 15. So Slide 14 calls out that the premium impact is going to be quite substantial, and I think on Slide 15 for 2030, there's some kind of a projection, but I couldn't quite get if that's kind of a do-nothing scenario, what the premium increase is going to be observed. Could we go back to Slide 15 and maybe explain that piece of it?

DR. FOUT: It's not a projection. It's just using 2027 information, which we have, what it would look like if the base beneficiary premium were set to be 20 percent of basic benefit costs, what the increase would look like. But it's not what it would look like in 2020 -- in 2030. That would require knowing what the 2028 and 2029 expected benefit costs would look like.

DR. METAN: So how should I interpret that dotted line, that box? Because it says in 2030.

DR. FOUT: It was just what it would look like if we had applied what the 2030 rule is in 2027.

DR. METAN: Okay. So how should I think about, if we do nothing, what would be the total impact on the premiums, beneficiary premiums, that we would expect to see? Do we have a sense around it in the analysis so far?

MS. SUZUKI: So I think this is sort of illustrating what the impact will be in 2027, and that's sort of your lower bound of what may happen in 2030. As the 6 percent cap continues to bind, that delta in the dotted part is expected to grow. We just don't have the projection for what would happen in '29 and 2030. But with 6 percent cap expected to bind each year, that means that difference is going to be a bigger amount, as well as the spending that's used to set the base beneficiary premium would also grow, in which case you would have bigger dollar amounts.

DR. METAN: Okay. It would be super helpful if we could maybe in iterations have some kind of a projection of what we are looking into in terms of the premium impact if we do nothing. So that would at least create some base scenario, but thank you for the answer.

MR. MASI: Yeah. And thanks for servicing this, Gokhan, and I can claim some blame for the presentation of it.

And I hear you, that I think a really policy-relevant question is, in 2030, what's going to be the expected premium change. We were a little reluctant -- and by that, I mean mostly me -- for MedPAC to -- ourselves get into the business of making projections, but we will give some more thought into how we can express the potential effects of what may happen in 2030.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. On slide -- I think it is 19 where we talk about how 6 percent of the beneficiaries drive 60 percent of the cost. Do we have the underlying diagnoses for those 6 percent? I think that would be informative.

Thanks.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks, guys, so much for this work. It's actually kind of shocking, the information that you shared today.

If I recall, the Inflation Reduction Act, for the

first time, drug manufacturers' discount was going to help people who had low-income subsidy. It hadn't helped them before. So that would make me think that some of our spending would go down because the drug manufacturers' discounts were counting to help people with low-income subsidy. But I know that's being phased in over time. So when does that -- has it already started? Remind me the timing of it.

MS. SUZUKI: That's a good question, and I do think it has started. We'll get you the exact percentage that's being phased in over time. It should be completed in a few years, but we'll double-check.

MS. UPCHURCH: So that's counter to some of the other trends we're seeing with costs going up. The drug manufacturers' contribution, at least to people with low-income subsidy, will be more and more over time. So I just wanted to make sure that we included that as something important.

And the other thing, on Slide 20, we talk about, you know, the anti-obesity medications. But, of course, Medicare doesn't cover anti-obesity agencies yet. Where are we getting that data from? What is that?

MS. SUZUKI: So they can cover these anti-obesity medications when those medications have other conditions that are covered under Part D. So it could be cardiovascular conditions that are --

MS. UPCHURCH: Oh, okay. S, that's the GLP-1s, then, down there?

MS. SUZUKI: That would be my understanding how Part D plans would cover these medications.

MS. UPCHURCH: Okay, okay. That's not for that indication as primary, but it's a secondary. Okay. Got it. Thanks so much. Great job.

MS. KELLEY: Okay. That's all I had for Round 1, unless I've missed someone. So we'll go to Round 2, Amol? All right. And I have Stacie first.

DR. DUSETZINA: Great. Thank you so much. This chapter is excellent, as usual, and I really appreciate the additional analytics in the presentation.

I've got a couple of big pictures. So, if this does move forward to a chapter, one of the things I feel like is kind of missing is prices, and that it feels a lot like we kind of dive into a little bit of the picking on the things that are not working as well as we had hoped

they might work or not working as well on average. But there are a lot of things to celebrate, too, about access, and I think you show some of those here.

But I think that prices are a lever we should mention, and we should also speak to the issue of the drug price negotiation just starting in January of this year.

So 2024 and 2025, especially 2025, look rough, right? So we're worried about that, but we don't see any of those savings yet from 2026. We have more drugs coming in 2027. So I think it might just be worth kind of a little bit more in the context and setup to say we're going to focus on this part, but there's also these other components of the law that are contributing to this in different ways. And they might be smaller than the overall demand and spending parts.

Slightly related to that, I think if there's any possibility of adding a tiny bit of analysis on the people who move from partial to full subsidies, because I think just being able to kind of say, you know, we did -- the law did actually expand access to a group of patients who were very financially vulnerable and might not have been using medications as much as they needed. That's maybe a side

question, so not mission critical, but I think would be a really nice contextual bit of information.

A couple of things that I just -- sort of stronger reactions to different parts of the ways to think about fixing some of the things that have happened. I like the idea of slowing the progression to the cap, but not by raising the out-of-pocket maximum. I feel like, you know, that is already going up. So it's going to continue to rise, and it reminds me a lot of every time I have to google, like, what is the ACA out-of-pocket max for an exchange plan? And I see it, and I'm like, that is really expensive now. So, you know, it goes from like $6,350 when it first passed to over $12,000 for an individual now.

So, like, in a few years, it's already going to sound like the out-of-pocket maximum is quite high. So I wouldn't -- I don't like the idea of saying let's bump it up to $3,000 or $4,000 or whatever.

I do like the idea of the other ways of slowing progression, and I think those are reducing or getting rid of deductibles. It doesn't make sense to me why you have as high of a deductible as we have on Part D. Again, it's that annual growth part that is in the standard benefit

that now I think is too high and doesn't make a lot of sense for a lot of people on the benefit.

And, also, you know, if a plan is currently offering a lower deductible, then all those enhanced benefits count towards the out-of-pocket max. So I would very much like to figure out how do we stop doing that.

I think what has accidentally happened is that plans have now made the benefit design look much closer to the standard benefit. So, on average, the average person from your lovely graph showing, like, the distribution of people and how much they spend, like, they're not feeling that this has done very much positive for them, probably. It probably feels like they're paying a little bit more. So I think anything we can do to figure out how to undo that TrOOP calculation so that you get to the cap based on what you actually spend would be great.

I am worried about over the cap, like, not having any cost sharing at all. So I would love to think about, is there a nominal copayment that, like, could be potentially applied after you hit the cap? Because going from, you know, something to zero, zero is not a great price for things that, you know, have value.

And you could think about ways. You mentioned, like, flexibility for plans. It's like, well, maybe plans could have preferred drugs, preferred brands, preferred generics as zero after the cap, and then non-preferred drugs have a copay. Nothing -- you know, maybe it's, like, within the LIS limits of brand and generic copays, but something that basically tries to at least indicate which drugs are preferred and which are not preferred. So I would really be interested in thinking about something like that.

I think, in general, plan flexibility is tough. You know, like, prior authorization and stuff like that is not very popular, and there are limited things that plans can do for the most expensive drugs and the protected classes. So I think that, again, goes back to prices are a real problem.

And I think that a couple of components from your analysis, both that oncology was, like, the highest growth category, and then you have the 6 percent of people who are spending a ton of money, I would not be shocked if most of those people are using oncology drugs -- or many of them. And those are places where we have no leverage over price.

And, in fact, with recent changes through H.R. 1, a lot of drugs that are coming to the market, very expensive, might never be candidates for negotiation, no matter how much their blockbuster status is there. So I think those are, like, contextually the things that I worry about.

I am really excited about this work plan, obviously, but I think trying to focus on kind of repairing the TrOOP calculation, I think that will help for the average beneficiary. And then, contextually, trying to tease out a little bit more about anything we can learn once we have 2026 data about, is there a slowing of that growth for the negotiated drugs in a way that might give us some hope that, you know, 2025 is not -- you know, the trend won't keep going, you know, as fast as it has been.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. Great, great work.

You actually enabled me to understand the whole TrOOP and supplemental benefits, and I thought I would never understand it.

Two brief -- two comments. First on substance, and the second is on the story and how it fits, pieces fit together.

So, on the substance, I just wonder if part of where we should also go in terms of policy options, et cetera, is looking, in particular, the depth at biosimilars. I just have a sense from everything I've read and people I talk to, we're not achieving the net savings we could or should be achieving via biosimilars across both Parts B and D at this point in time. So I think that may be worth some deep diving into.

The story stuff, it's possible to read what you've written, which is extremely well written, again, and basically conclude that the story is that the IRA changes on top of high unit price launches and price increases have created a problem. And that's all true, but I think we should also include some more about how it represents some successes.

And we do -- we sort of touch on this, page 22 in the write-up, where you say, we plan to explore whether increased spending reflects improved adherence to clinically appropriate therapies. I mean, there's a story that there's been historic -- and Stacie's published much of this, right? -- historic -- a ton of documentation about how high out-of-pocket costs result in low adherence to

lifesaving therapies, right, and how by putting an out-of-pocket cap on that, we may be remedying that.

And we all know that part of the story also here is that -- and this applies, of course, to Part B as well -- is that we've really revolutionized the care of many serious chronic diseases and either improved dramatically the quality of life or we've made a formerly set of fatal illnesses, many of them cancers, into chronic illnesses.

And so, you know, I think since the story is important to policyholders, I think that's just worth sort of, you know, inserting into the write-up.

Thanks.

MS. KELLEY: Greg.

MR. POULSEN: I confess that in four years here, this is the -- I approach what I'm about to say with the greatest nervousness. I'm really serious about that, because I think that Stacie paved the way a little bit.

We've spent some really good analysis, and Betty and Shinobu, you guys have done a wonderful job. I agree with everything Scott said. It's clear. It's helpful. And I also agree that there are successes in terms of getting people access to really wonderful drugs that do

really wonderful things for people. Those are wonderful things.

But we're spending an awful lot of money, and we're spending a disproportionate amount of money compared to everybody else in the world for the same thing. I'm very concerned that we are spending a lot of focus -- not inappropriately -- about how we distribute the money that we spend between Medicare, the plans, and the beneficiaries, and trying to use that to help align incentives in ways that help people to use things in a wise fashion.

But the fact of the matter is, we're still spending a lot. We're approaching 30 percent of total Medicare spend on these drugs. That's more than we spend for any other category except inpatient hospital. It's now substantially more than we spend for professional fees. It's substantially more than we spend for outpatient hospital or surgery centers or anything and everything else.

But I think we have assumed, because at the time that the PDPs were created, that Part D was created, that we created the non-interference clause as part of that,

that I think we've kind of chosen as a society to leave our hands off. And when we've started to approach it, we've done it pretty tenderly.

To give us an example, we put on a handful of drugs. They have to be aged drugs. They have to have been in the marketplace for years. So the newest and most expensive -- we talked about cancer drugs -- they're off the table for a discussion for a period of time, irrespective of the fact that that's now often a quarter of a million bucks for a course of treatment. And I think that that's -- at least to me, that's something that we should either -- we could approach that, but we should do it very consciously and make it a decision that we say, okay, we know what we're doing here, because the data is fairly consistent.

And I've spent enough time with folks that I know that we're not exaggerating when we say that we spend 3.2 times as much for branded drugs as other wealthy countries. We're not talking about unwealthy countries. We're talking about European and major other places.

Anyway, so as we continue to think about this, I think that one of the questions that we need to do -- and

I'm going straight to the discussion where it says other approaches and asking -- do we want to contemplate something that is broader? Because imagine what would happen if Medicare were given the charge to look for fair and appropriate pricing for medications, just what we spend 80 percent of our time doing for doctors, hospitals, home health agencies, ground ambulances. Imagine what we could do there and how much difference that would make to the future affordability of Medicare, and imagine if we were talking about all of the things that are in this wonderful document, but on a basis that was dramatically different in terms of its total spend and affordability. We'd be able to think of things differently.

Right now, we contemplate medications as something that we need to be careful to ration. Imagine if things, some of them which could be affordable enough, that we looked for ways to maximize the benefit to everybody who could use them effectively. I think that's a different and vastly more exciting future. I know it's unrealistic to go from where we are to that in one step, and that's not what I'm suggesting at all, but I do think that we as a group need to ask, is it in our purview to look for something

that is more controversial, but more substantive than the really good work that we already have before us?

So sorry for that. Like I said, I approached this with a lot of fear and trepidation, but I just think that the numbers are so big, that the other things that we spend loads of time on, and appropriately so, to try and get right are dwarfed by the magnitude of what we're looking at in this group.

So, again, thanks, guys, for the wonderful work, and sorry for the detraction.

MS. KELLEY: Ben.

DR. IPPOLITO: Well, I'll mostly not talk about drug prices, I guess.

[Laughter.]

DR. IPPOLITO: Although I will say I'm not dismissing it, but rather, just it strikes me as something that where there's a mechanical relationship to the challenge at hand, if the drug prices go up, the financing challenge gets larger. If they go down, it gets a little smaller. There are tradeoffs involved with those decisions. That's well sort of trodden territory. So I'll mostly step aside.

Although I will say I think there is a policy argument for a relatively systematic kind of step-by-step approach, just in the sense that, for better or for worse, we are by far the biggest purchaser of these products, and so what we do has this incredibly outsized effect. But, anyway, I'll step aside from that for a second.

First, I want to talk about I do think there's no getting around the 2030 cliff and trying to give people some sense of how big is this premium shot going to be, although I'm sensitive to perhaps not wanting to put your sort of name behind a particular number. I will say the Trustees have put out in their latest Trustee Report some numbers that I believe imply about a 50 percent premium increase in 2030. I have some work that's going to come out soon. I think that seems a little conservative to me. I think it's very easy to come up with scenarios where the premium increases required to keep benefits the same are, in fact, much higher than 50 percent. That translates very, very easily into like nine figures worth of federal spending or a budget window. So these are very large numbers. But I understand if you don't want to pursue that in the chapter.

One of the questions that I think comes up with this a lot -- and Stacie sort of touched on it here and elsewhere, I think, but two things are happening. There is a notable change in the underlying trajectory of drug spending due to GLP-1s and all sorts of other things, and then the IRA is also happening. And trying to get some sense of magnitude of those two things seems like an important baseline setting exercise.

And I wonder -- and maybe this is sort of an open question to people -- do we think that perhaps the LIS population provides a ballpark, first-order sense for what we think drug spending might have done absent the IRA? They're mostly spared from the big IRA changes. And so the report, I think, quotes a 10 percent increase from '25 to '26 for the LIS enrollees and a 26 percent increase in gross spending, but an approximation of spending for non-LIS. Does that delta give us some ballpark to think about in terms of what the IRA effect versus the underlying trend effect is?

The one thing that I think is missing from this, but I think you've already done work on, is I think it's very important to put the current state of premiums in the

Part D market into context. So Part D premiums, inclusive of all the temporary federal subsidies today, are at historic lows, despite quite generous plans, which, of course, may change in 2030. I think that's important.

Inflation-adjusted premiums for PDPs were averaging north of $50 a month through the entirety of the 2010s. We're way below that today, and so one of the things that I do think Congress is going to have to think about, in addition to many other things, is how do you balance financing responsibilities between beneficiaries and the taxpayer? And that strikes me as a very, very important input into that decision.

Then I guess I'll say in terms of -- I'll just switch to the policy option. So I generally support the change to the TrOOP calculation. That seems like something that's probably necessary.

I'll also mention one thing that didn't come up, which is not a policy per se, but is a feature of a policy, which is transitions. We are talking about very, very large shifts in federal financing. One of the things that that does is that creates tons of uncertainties to actuaries and plans about selection and enrollment that is

not constructive on its own, right? And so just thinking about whatever we come up with, are there ways to think about phasing changes in federal financing in, to sort of smooth those transitions to at least eliminate some of those, perhaps, unnecessary bumps in the road?

There's no way to get around, I think, anyway, adding some financial exposure in what is now -- well, in the catastrophic phase essentially. I think there's essentially two ways to do it. I think the first way is to think about something like what Stacie mentioned, is using something like LIS copays as an allowable modest copayment, no coinsurance, but a copayment for a broad set of drugs just to provide some financial incentive to enrollees.

But I actually think we should consider much more aggressive cost sharing in specific cases where we have brand drugs for which there are generics or biosimilars or preferred brands available and those preferred products have zero or very low cost sharing.

I don't see a reason why we should be averse to allowing a plan to actually charge quite high cost sharing for the non-preferred brand in that case, and that seems like a very strong argument where we're targeting

specifically drugs where we really think there is a substitute that is much cheaper and trying to sort of use cost sharing I think where we think gets most effective and probably most productive.

And so I'll conclude maybe with my least popular idea, but I really do think we need to sort of think about or -- think about the idea that maybe premiums do need to slowly, gradually return to something that looks a little more historically normal as part of this process. I understand there's not going to be many people who love that idea, but that strikes me as quite important.

MS. KELLEY: Brian.

DR. MILLER: Hey, there's one guy here who likes that idea besides you, and that's me. Even though sometimes you have to make unpopular decisions, you have to make an unpopular decision. Obviously, you don't want to have price shocks for beneficiaries, but artificially holding prices down and then being surprised when that balloon explodes in our face is -- we should not be surprised.

So a couple thoughts. One is, I fully agree with Scott about biosimilars. I think it would be interesting -

- and I apologize for not mentioning this in Round 1; he triggered the thought, so kudos to Scott -- of modeling biologic drug spending if biosimilars had similar discounts to generics, right? So we know what the average generics are across therapeutic areas. What would the biosimilar -- what would biologic markets for which there are biosimilar competition -- what would that price decrement look like, and what would that savings be to Part D? And then what would be the -- from that savings to Part D, what would be that effect on premium? Because that would give us an actionable thing to think about.

Which gets to Ben's comments about benefit design, which is we need to lean in assertively to benefit design, right? We need to make selective choices and give plans tools to do things.

So where's this -- the way I think about Part D is sort of the way I think about other markets. And to quote my friend who's a North Carolina treasurer, we need lower costs, right? So when we talk about drugs having six-figure costs, the average house in the U.S. -- I looked this up while I was listening to people's comments -- $418,610, and there are plenty of drugs that cost that

much. And that is okay, because a lot of drugs have a lot of high clinical value.

But we need to be realistic in that if you have a chronic disease, if you have heart failure, if you have rheumatoid arthritis, if you have lupus, if you have Crohn's, if you have diabetes, there should be -- it's reasonable to expect because there are lots of products on the market -- there should be a reasonably cheap bucket of drugs that you can use to get sort of basic therapy.

And so when I think about what the Part D programs, one of the core responsibilities of Part D, that is one of the core responsibilities of Part D. In addition to facilitating access to the $418,000 drugs that cost as much as your house, it also needs to ensure you have that basic benefit.

So we're being like Mr. Potato Head and taking this apart. There are sort of three components. And I think about this way at the state health plan, too, which is there's the taxpayer, right, who's footing the bill, there's the member of the beneficiary, and then there's the provider or the supplier. In this case, it's the pharmaceutical companies.

So taxpayers have already paid a lot, and they're going to continue to pay a lot. And that's okay, right? That's an expectation.

And consumers, I think, is sort of what we're getting into, and all of the -- we're dancing around this with our various suggestions. But, fundamentally, we're saying that consumers should pay more, right? They should either pay a bit more via an expanded initial coverage phase. We could modulate deductibles, co-pays, co-insurance. We are, you know, talking about premiums going up. We are, to some degree, saying consumers should pay a bit more, but that that should not be a price shock, that that should be a gentle elevator over time, because price shocks will disrupt access. And I think that's a reasonable principle for us to think about.

One other principle for us to think about, putting on my IRMAA hat from Aunt IRMAA, you know, Aunt IRMAA in Part D has not been updated in a long time. So there are lots of, you know, very wealthy retirees who have done a great job. Again, I celebrate their economic success, but we probably do not need to subsidize them as much. That's another way. So updating IRMAA and

modernizing IRMAA is another way that we can sort of improve the Part D financing on the consumer financing side in sort of a more fair fashion or what might be perceived as more fair.

And then the third one is sort of what we were also -- I think Greg was getting into, which is the pharmaceutical industry, right? Great innovation, great product innovation. Lots of diseases are boring, clinically, right? It's great to have diseases that go from a death sentence or disabling to being boring, hepatitis C, HIV, right? You know, a lot of those can be treated by infectious disease docs who -- those become almost like primary care for the infectious disease doc, which is a great scientific and clinical transformation.

But -- and the bug is -- we can't continue to always have high unit costs in every therapeutic area that's not sustainable, and so several of my colleagues have mentioned price regulation and administrative pricing. I think, you know, there are other big levers that we could use, which is Medicare does not pay for value right now.

It sounds sort of silly when you say it. Like, if you're buying a house, buying a car, going on vacation,

booking a plane flight, people make trade-offs. Health insurers need to make trade-offs, and the Medicare program is not making trade-offs on the basis of, you know, sort of clinical value. And I think it's reasonable, given how insane the spending is growing, and we're, you know, talking about, again, worrying about taxpayer financing. We're thinking about ways to increase consumer cost sharing. It's also reasonable for us to go to the pharmaceutical industry and say we have three legs of the stool. We have the taxpayers, we have the consumers, and we have the provider supplier. And everyone needs to, you know, put some more skin in the to make this work.

So what could that look like on the provider supplier side? Because you don't want to destroy innovation. You want to continue to support innovation. You want a dynamic market. There's sort of, you know, three things that I sort of think about. One is for super high cost, you know, high six-figure, low seven-figure drugs, you could do mortgage-like payments, right? Instead of having a one-time, you know, the drug is $700,000 or $200,000 or whatever it is, you'd have a mortgage-like payment, right? Because that smooths out payment over

time. You could come up with standardized contracts. Those could be portable with the bene. So that's one creative thing.

Another creative thing, which I wrote about with the former MedPAC chair, Gail Wilensky, seven years ago, was about accelerated approval drugs. Big fan of accelerated approval, facilitating access to innovation. Lots of folks have expressed concerns about PMRs or post-market requirement trials not being done in a timely fashion. We could say until your PMR is done, we are only paying the reference price, right? That could be another way that we could save lots of money.

Scott has mentioned biosimilars. I have also talked about biosimilars. I believe there's a standing recommendation in Part B, not in Part D, but reference pricing, right, with biosimilars. That's another way to introduce price competition.

And then the fourth one, which, again, I'm recognizing, just like Ben has suggested, controversial things. I am going to suggest something controversial also, which will probably be resoundingly unpopular, but I think is a reasonable thing to think about, which is

protected classes. Protected classes are there for a reason, right? We want people who have cancer to have access to therapy. We don't want to inhibit it.

But I would just ask the question, why are we statutorily prohibiting price competition in markets that have multiple products? That doesn't really seem policy-smart, and it certainly is not physically responsible for us managing a plan or looking out for the plan member in which, you know, the Medicare bene.

And then sort of the last thing I'd say is the community pharmacists, we have 119,000 of them, maybe 139,000. I don't remember the exact number. We need to make medication therapy management real, right, dose titration, growing the role of the pharmacist, all of these things. Pharmacists could help a lot.

So, in summary, taxpayers are paying a lot. They'll pay more. That is okay. Consumers are probably going to have to pay more in some formulation or another. And then I think the providers, suppliers also need to come to the table.

MS. KELLEY: Kenny.

MR. KAN: Betty and Shinobu, I am very

enthusiastic about this outstanding chapter and will try to speak 10 seconds less than Stacie and Greg combined.

[Laughter.]

MR. KAN: Over five years, the Part D monthly bid amount increased 8x from $38 in 2022 pre-IRA to $296 in 2027. This is clearly unsustainable in a country struggling with 40 trillion national debt.

Given this, I support the paper's diagnosis that TrOOP rules, lower out-of-pocket exposure, and rapid entry into the catastrophic phase are creating challenges for the Part D cost spiral. The proposed TrOOP and initial coverage reforms are actually sound and worth pursuing.

Excluding supplemental benefits from TrOOP directly addresses situations where enhanced plan enrollees can reach catastrophic coverage with relatively little out-of-pocket spending. The paper's example suggests roughly a 12 percent reduction in basic benefit costs.

Extending the initial coverage phase could also restore some plan-ability to influence utilization.

However, I view these two solutions primarily as benefit design patches rather than a complete response to the underlying cost growth.

The larger challenge increasingly appears to be high-cost specialty drugs, including GLP-1s and oncology therapies with the IRAs, lower cost sharing, potentially amplifying utilization.

For future work, I would encourage four analyses of which the first three were previously noted with some tweaks on page 26 of the deck.

Number one, decompose the spending growth. So separate price volume and mix intensity and, where feasible, distinguish clinically appropriate growth from potentially low-value utilization. This helps to design policies that reduce unnecessary spending without discouraging appropriate adherence.

Number two, model the behavioral responses. If the initial coverage phase is extended, how much utilization changes, and is the effect concentrated in high- or low-value therapies?

Number three, examine the distributional effects. Who bears the cost of all these changes? Particular enhanced plan and PDP enrollees who lack Part C rebates to offset the impact?

And I echo Greg's call. Let's be bold. Should

we look at a separate catastrophic strategy for ultra high-cost drugs, including GLP-1s, oncology drugs, gene therapies, and other specialty products? Increasingly, this cost may be difficult to address sufficiently through deductible coinsurance and TrOOP changes alone.

I like staff's willingness to consult Part D actuaries on practical implementation suggestions and to minimize operational burden.

Finally, while I suggested several additional analyses, I am also a practical actuary who would be receptive to a two-phase outcome, phase one, a short-term. two-solution patch, given that beneficiaries' basic benefit costs will roughly double from 11 percent in 2027 to 20 percent in 2030, and phase two, a longer-term fix.

Thank you.

MS. KELLEY: Gokhan.

DR. METAN: First of all, thank you for this great work. Really, really appreciate the analytical rigor.

I share the same sentiments as Greg. This is a deeply concerning area for me, and whenever I hear Greg, I triple or quadruple in my concerns.

I share many of the comments Kenny just shared.

I would like to call out a couple of things. First of all, what kind of substantial changes happened in the PDP market since 2024? I think it would be really helpful to understand the plan's response to the changing environment.

I've been researching this. I have seen a lot of PDP plans sunset. I think the total number of plans went down from 700-ish number to 300-ish. I think it would be really helpful to understand that dynamic to help us understand any policy recommendation we make, what kind of additional impact that could potentially make in the market. So it would be really helpful to understand and enrich the work from that perspective.

The second comment I would like to make is, again, I'm in the camp of definitely making the initial coverage phase reasonably set, because that's where the plans really have the leverage to manage. I think the current redesign stripped the plans out of this utilization management zone substantially. So I'm also in agreement with Stacie in terms of the deductible, eliminating even maybe the deductible phase to elongate that area. I'm not

really supportive of increasing the out-of-pocket too much, especially for the vulnerable population.

I really enjoyed Stacie's idea, again, in terms of in the catastrophic phase, some kind of a cost sharing and building some skin in the game in a reasonable manner might make sense. We need to be careful, of course, in that zone that we are not doing something that would unintentionally hurt the vulnerable population, and having some guardrails to protect those populations would make sense.

But I'm totally in the camp of giving plans more flexibility in terms of managing the utilization, whether in the -- again, between initial coverage stage or in the catastrophic phase. So any kind of analysis to understand what those options might look like would be super helpful.

And then the other commentary I have, the third one I have, is in the, hopefully, unlikely event that we have a really hard landing, comes 2027 and 2030, with all these changes, what would be the -- how do we see the viability of the PDP market? What I mean by that is, if the PDP affordability becomes really kind of problematic, would we expect to see a lot of people moving from fee-for-

service Medicare to MA-PD plans or any kind of dynamic that would, you know, originate from the first wave of the impact of the tsunami? So what would that look like?

And tying that into my next comment, especially in the MA-PD market, MA-PD plans subsidizes the cost increase through the rebates. Again, what's the impact that we maybe don't see as like the unseen part of the iceberg there? And how would that make the MA-PD plans more attractive to the population who may not necessarily kind of absorb any kind of exorbitant premium increase that might happen in that hopefully unlikely event? I think those are really important areas that we should really try to understand more in the further next steps of this work.

And then the last thing that I would like to understand better -- and I have been doing some research, but really can't say that I really understand better. But the benefit parameters are updated every year by CMS, but using certain formulas that I'm trying to get my head around, like the deductible and the out-of-pocket. How do those mechanically work? If we can enrich the chapter to educate us a little bit better on that sense, I think that would be really, really helpful, especially how the direct

prices, gross basis versus net basis, and how those dynamics come into play. I think that could help us understand the dynamics of how those benefit parameters are going to change in the future and maybe even some make recommendations around those lines as well for the sustainability of whatever policy changes we recommend.

Thank you.

MR. MASI: Dana, can I jump in for just a second here?

So a couple things. One, we are slated for this session to go to 3:55, but there's still a number of Commissioners who want to comment, and it's a really important topic that we know there's a lot of interest in. So we're going to allow the session to run over. So the goal is that all the Commissioners who are in queue should be able to make their comments fulsomely, not to cut anybody off. So that's the first thing.

Second thing, to some extent for the purposes of efficiency, you're staring at a slide that kind of highlights some of the policy ideations or options that have been explored. A number of the Commissioners have already commented on those, and so I think just for

efficiency's sake, as part of your comments, if you could give us your sense of whether the idea of supporting something around changing the TrOOP for the enhanced plans is something that you would support, I think that would be helpful.

I think the other piece that a number of Commissioners have mentioned is around the initial coverage phase and increasing the gross drug spend exposure. What that would mean is potentially a mix of things, right? We've heard some heterogeneity from folks, and that's okay. One piece of it could be lowering the deductible or lowering the coinsurance, co-pay piece of this, or raising the out-of-pocket max. So all three of these parameters would be potentially at play, and we don't need to know all the specifics in terms of what you would support or not support right now. But I think just understanding that ICP piece, if that's something worth exploring, I think that would be helpful.

The other thing that a number of folks have mentioned is putting some structure, if you will, into the catastrophic phase where it doesn't exist now. Again, we don't need details per se. You're welcome to share the

details that you want to share, but just knowing notionally, is that something that you think makes sense from your perspective, that will help us as we kind of pick up this work and go forward.

So I figured I'd just put it out there as we've heard these comments, so that way people can weave them in, and we can perhaps save a little bit of going back at the end of the session, given that we're a little time-constrained.

Thanks, Dana.

MS. KELLEY: Cheryl.

DR. DAMBERG: Okay. I will keep it short.

So I think this is channeling something that Stacie mentioned, which is we're really at the early stages of the IRA implementation. So this work is really informative, kind of as a first look, but we realize this storyline is going to play out, so looking forward to future installments.

I agree with the recommendations in terms of the future research directions, support revising the TrOOP, in terms of removing the supplemental benefits, but obviously, as you showed us on that one slide, it sort of has some

effects, but it's not solving the larger problem.

I also support modifying the standard benefit design, both to change up, you know, such that more spending occurs in the initial coverage phase, but I was really intrigued with this notion of adding cost sharing in the catastrophic phase and sort of plus-one-ing on Ben's comment about trying to tailor that based on to what extent cheaper alternatives are available.

And I think as you proceed with these analyses, it would be interesting to both see what types of beneficiaries are affected in terms of not only duals versus non-duals, but also people with different kinds of conditions, because I think to Stacie's point, it's that 6 percent, you know, who represents 60 percent of spending. And I think some of the changes that we're talking about still aren't going to touch those people much, but that really isn't going to solve the problem.

And so, you know, we still have to deal with, you know, prices being paid, and I don't know whether it's what prices other people are paying in other countries, but trying to think through what some of those solutions might be.

And I guess I should go back and think about the work. We're talking about multiple solutions, and so I don't know whether as part of your modeling, you can model multiple things happening at the same time to sort of see what the total downward pressure might be.

And then, lastly -- and again, I think this speaks to Ben's comment about premiums increasing over time and getting back to sort of historical trends -- I think as the Medicare program transitions to higher out-of-pocket costs for consumers, probably primarily in the form of premiums, I think there needs to be a lot of consumer education, because I think the average beneficiary on the street does not understand the extent to which taxpayers are subsidizing their coverage currently.

MS. KELLEY: Tamara.

DR. KONETZKA: Okay. I'll try to be brief. A lot of my comments kind of double down on what a few other people have said -- Stacie, Ben, Scott, Greg -- but I might be saying them in a slightly different way.

Let me start with the specific proposals. I think refining the TrOOP is kind of a no-brainer. It's just kind of oddly distortionary and probably not what

anybody intended. So I'm very much in support of that.

I'm also in support of refining the sort of beneficiary skin in the game part of it. I like I think what Stacie suggested of maybe sort of converting some of the deductible into a longer period of copays. Because, you know, the deductible may discourage high-value care if you have to pay the entire thing out-of-pocket, right at the start. And the sort of sort of copays all along could give plans sort of a longer time to manage that utilization without sticking people with the whole cost. So that makes a lot of sense to me.

I guess I temper my enthusiasm about those. I think they're necessary and sort of not fixing them doesn't make a lot of sense to me, because I think they're just kind of distortionary.

I want to temper my expectations about how much that's going to change things, and it comes back to this 6 percent of the people with 60 percent of the spend. That, to me, is sort of an underlying real challenge here. Because a lot of the people who are not in that 6 percent, they are already using some generics, and they already have some cost sharing, and they're not accumulating a lot of

drug costs, by definition.

So I don't know how much more high-value utilization and cost savings we are going to get out of those people. So I'm just really interested in the 6 percent. And I think there have been a lot of people talking about maybe introducing cost sharing in the catastrophic. I think those are probably all really good ideas. I just want to know a lot more before we go there. So I want to know a lot more about that 6 percent.

I want to know, for example, as Scott asked earlier, what are their diagnoses? I mean, are we just talking about cancer patients or is there really a wider mix? I mean, looking at it by therapeutic classes, the prices, was a good start, but I want to know more about those people with the high drug spend, what are their diagnoses, what are their comorbidities, which drugs are they taking. Is it mostly one really expensive thing that puts them in that class, and other things they may be taking just because they've already met their deductible and basically they're facing zero price? Or are they just really sick people on a lot of expensive drugs?

So whatever analysis we can do to get at that 6

percent, and who they are, I think will lead us to some potential policy solutions, like, oh, should we impose more cost sharing on them, or is it just going to make these cancer patients more financially impaired, strapped, because they have to have these drugs and no, it's not going to change their behavior at all.

Building on something Ben said earlier, it would also be interesting to see if who is in that 6 percent changes year to year, depending on whether drugs are going off brand, et cetera. Also, a deeper dive at what they are actually taking. Are the most common drugs among those 6 percenters ones that there is an alternative for or not an alternative for, and that could lead into a great policy where we encourage the use of a generic or a lower-cost alternative. But I think we need to know first whether that is actually happening.

So that's my main priority here. And then I agree, it may turn out that these are all just like cancer patients who are facing really expensive drug costs, and it just comes back to prices. It comes back to how we price our drugs.

So I really appreciate, Greg, that you said what

you said, because it's hard to have this conversation without that elephant in the room, of that might just be the problem. It's a bigger problem to solve.

Finally, the last thing I would like to repeat. I think a couple of people mentioned this. But I do think in this body of work we need to keep an eye on the PDP market and how all of these policies and the potential changes we might suggest will affect the sort of sustainability of that market, because that seems really important to maintain. Thanks.

MS. KELLEY: Gina.

MS. UPCHURCH: Great. Thanks. I appreciate so many of the comments from fellow Commissioners, and I'll try not to repeat all of them, but a couple of things.

I have major concerns about people just above low-income subsidy eligibility. It's what my agency helps, but people between 150 percent, 200 percent, 300 percent of the poverty guidelines. Thirty percent of people 65 and older have incomes at or below 200 percent of the federal poverty guidelines. So imagine, $2,660 is your monthly income. Thirty percent of people 65 and older, that's what they are dealing with. Okay, so just to level the

playing field there.

So it's really bad timing for them to have more shifted over to them, because of inflation. So when we make these policies we just have to watch for the disproportionate impact on people with very limited incomes. And don't get me going on how assets keep them about. About 25 percent of people that could get some help with Medicare, within the Medicare savings programs and Part D are not eligible because of the assets test, because they have a little nest egg.

I really want us to lower the deductible. It's becoming a game changer for people, especially in the standalone Part D market, not being able to afford to that deductible. I know we have the Prescription Payment Plan, but you really should just do that if you take more expensive medicines, to spread it over the year. But it's getting out of hand. Seven hundred dollars is a lot.

And it doesn't make sense for people to think, "I need to pay a monthly premium but I just take generics, and I've got a $700 deductible. I'm not getting anything from it." I'm worried they are going to drop out of the market, because that doesn't make sense to people. So I think we

have to keep the deductible lower so they'll continue to contribute. That's how insurance works, all the people contributing.

We are in a bad cycle where we believe they were overpaying Medicare Advantage, 14 percent plans. They buy down the drug benefit. Yes, Gokhan, they're already leaving standalone drug plans to go to Medicare Advantage plans. That's a major driver of that. And then everybody's premiums go up, because they're paying more for Medicare Advantage plans.

So it's this cycle of premiums being jacked up for other people because of this movement. That's one of the reasons people move to Medicare Advantage plans.

Understanding the base premium that is only supposed to be 6 percent. You know, that cap is going away in a few years. A lot of people just assumed that was the entire premium. That's just the base premium. So a lot of premiums with enhanced plans go up way more than 6 percent. So this may be making that point, because people misunderstand that. They're like, "What? My premium went up more than 6 percent." I was like, there are two parts to your premium. It's very confusing to people.

I'm very much supportive of getting rid of this enhanced benefit counting towards TrOOP. It doesn't make any sense that we let people take more expensive medicines and pay less throughout the year than somebody taking less expensive medicines. That doesn't make any sense. So I appreciate that recommendation.

Yes, we're talking about drugs costing three times as much. I want to endorse what Greg said, and others have joined in. Yes, we pay three times as much for drugs. But guess what? We pay a lot more for our medical care too, you know, our hospitalizations, our providers. We pay them more. So it's not just the medications.

I'm not a huge defending of drug prices at all, but I do feel drug manufacturers are being squeezed in many different ways right now. Just as some examples, they are helping with low-income subsidy assistance right now, which they have not done before. 340(b) has blown up, and we know they are pushing that back. The tariffs that are coming down the pile. I do think it's like a balloon. It's being squeezed, and we're seeing it pop out.

So what I'd like us to also, in addition to the expense of the drug, I really want us to look at the

middlemen and women that are involved. The vertical consolidation of the pharmacist benefit manager, the drug distributors, who are not adding value to the health care system. They are adding expense, in many, many ways. We have the incredible consolidation of the DRP. If you listen to Mark Cuban talk about the drug distributors and the three main ones, and how that is raising all of our costs for medications. That's not going to the manufacturer. It's going to the distributors. It's going to the pharmacy benefits managers, their offshore accounts, that are just charging fees to drug manufacturers. So I hope we are going to dive into all of that vertical integration.

And lastly, I appreciate Brian's comment. I think pharmacists are in a great position to understanding medication appropriateness, cost, formularies. They understand it. They could help. But they are not going to do it for free. And they are closing down. It's a perfect thing for them to be involved in.

I do think we need to look at drug costs, but I also want to see the other people that are drawing money out of the system and not adding value to health care, and

really think about protecting the most vulnerable as we can. Thanks.

MS. KELLEY: Robert.

DR. CHERRY: Thank you for presenting this work. It is really generating a lot of interesting conversation, so I'm thankful for that.

I just wanted to validate Greg's comments, tip-toeing into the costs of all this. And yes, it's a boatload of money, and yes, it's not sustainable.

That $42 billion in increased subsidies, between '24 and '26, I mean, if you think about that, just put it in perspective, because a lot of times we throw dollars around but don't really know what it means in context. That's nearly a third of the budget of the Department of Transportation. It's nearly a third of the budget of the Department of Homeland Security. It exceeds the budget for disaster relief that's been requested for fiscal year 2027. So it's a lot of money.

I tend to favor, given two policy choices, the first one, simply because it starts to reduce those direct subsidies that have been growing pretty aggressively over the last three years. However, similar to Cheryl's

remarks, if there is some sort of blended approach that gets us there, and even better, as you start to study this more, at that point we need to entertain other options too.

And then, finally, in terms of Scott and Tamara's comments around the studying around the 6 percent that's contributing to 60 percent of the costs around Part D spending, I would just add another data variable in there. How much of this is end-of-life care, occurring in the final three months? Because if it's end-of-life care, that's more of a quality of care issue, where the clinical criteria and appropriateness for prescribing the drugs is more the issue than anything else.

Otherwise, great work, and I'm looking forward to future discussion on this.

MS. KELLEY: Danielle.

DR. PIEROTTI: So to be as short as possible, I really appreciate this work plan, the analysis, and the policy direction, including the added discussion around looking at some structure within the catastrophic phase and some look at the IRMAA in this space.

I particularly appreciate the inclusion in this chapter of some of the aspects beyond the dollars and the

division about who is paying them. So I just really want to thank you guys for including some of the words that I don't think we've talked about yet, but are in the analysis plan. And that includes things like clinical guidelines, adherence, formularies, generics, we did talk about, but also polypharmacy and waste. And I hope that these components do play a pretty significant role in the next step of the analysis.

All of these aspects are part of the what are we paying for, that is a part of the discussion of what are we willing to pay for and how will we prioritize payment. So I really wanted you to take a second and acknowledge that they were hidden in there and they are really important, and thank you for including them.

I too just want to add a thank you, Robert. Yes, in other sections of the Medicare spend we've talked about the impact of that last year of life, and in the 6 percent spending 60 percent, in addition to all of the other fabulous variables I would really ask for is it part of that last year of life. And I would also ask for age as part of it, because this issue of the younger versus the older Medicare beneficiary has come up a few times, and I'd

like to understand that within many of the other variables already discussed.

I think the final part of this discussion, that is now my bit of trepidation, should be very bold and direct. Many of the comments have been very ginger and tender about oncology care and sort of continuing the idea that that is sacrosanct. And I have to say, are we sure? Just because there is a drug doesn't necessarily mean administering it is the right plan or the good plan. And when we are talking about some drugs that come to market with great fanfare, with a fabulous increased life expectancy of days, and bills in the hundreds of thousands of dollars, I think it is reasonable for us to pause and ask some more questions.

On the other side of that, it's really easy to look at the latest and most public entry into our drug market, the GLP-1s, and the eye-popping monthly charge for those. But much like some of the earlier questions, I think it's too early on those. because if the GLP-1 usage is doing what we think/hope it is, and the benefits are over long-term years, and that by using them earlier are we reducing longer-term costs and impact later, as in, well,

now I'm off four antihypertensives, three anti-cholesterol drugs, and 16 other things, and now I may have less health burden and thus less cost to the system, in a longer range.

So I just keep coming back to the decisions that we make around policy for cost, they really need that balance that was included in the analysis plan of the human part and the impact of the money being spent, back in the clinical adherence and questions of use and polypharmacy and waste. I love that you have those two words in there, page 23, for those of you that may have missed them. But it's really important that those aspects stay in the analysis. So thank you.

MS. KELLEY: Okay. I have a comment from Tom Diller. He says this was an excellent and detailed presentation. He agrees with Stacie, who identified that pharmaceutical pricing is a real problem. The explosion of pharmacy costs is affecting both Medicare and commercial markets. Clearly changes in benefit design over the past few years have created some unintended consequences that may be driving unnecessary costs.

The majority of the cost increase, however, is likely related to the substantial increase in very high-

cost medications that are being produced in the last few years. GLP-1s for both diabetes and obesity, medications to treat cancers, and anti-inflammatory agents are the classic examples. Increased plan management such as prior authorization and step therapy programs may help control costs.

Similarly, changes to benefit design, which would change cost sharing and shift some costs to beneficiaries might also help. Both of these approaches are appropriately identified in the chapter.

What concerns Tom more, however, is the manufacturer discount percent of 14 percent on Slide 10. The fundamental problem is not necessarily inappropriate utilization but rather the very high prices of specific medications. These medications are often very efficacious and improve outcomes. This, however, is not really discussed in this chapter. Consider calling this out, an increased focus on industry prices, as an alternative or additional policy approach might be considered as a recommendation to Congress.

And then, lastly, I have a brief comment from Josh Liao, who says he is very supportive of prioritizing

work that explores both redefining TrOOP and adjusting benefit parameters to extend ICP.

And that is the end of the queue.

DR. NAVATHE: Great. Thank you, Dana. And thanks to all of you. I mean, it is very clear how much all of you have put thought into the remarks that you made, and very comprehensive, a think very nicely touching different dimensions, short-term, long-term, incentives, prices, I think a whole litany of different issues that you all covered. So thank you so much for your comments.

A few things I'm just going to kind of recap, since we're over time, and then we're going to move straight into our next session.

I think one of the things that I think was reasonably thematic, that I think seems like a good analytic direction for us to pursue further, is understanding more about this high-spending group, the 6 percent, as we characterized it here, who are accounting for more than a majority of costs. So I think that seems like a very important analytic direction, especially if and as we were to consider doing something around the catastrophic phase, better understanding that population

would certainly inform that. So I think that was very helpful.

I think, in general, it seems like there was reasonably uniform support for exploring more on the TrOOP side. And then I think there is seemingly also relatively uniform support around the ICP, although exactly how that would play out I think obviously we're not proposing anything here, and none of these are recommendations. But we would need to put some meat on those bones and explore that a little further.

One thing I wanted to just note there is that if, hypothetically, one were to go into the direction of decreasing deductible, decrease cost sharing, sorry, coinsurance/copays, not touching out-of-pocket max, then that would be enriching the benefit and could potentially have further inflationary effects from a utilization perspective. So I'm calling that out just so everybody is on the same page and also to articulate that we recognize that. That's not something that is somehow being missed here. So as we think about this, I think we'll come back with thoughts and suggestions for you all to react to in the future.

And then the last thing, and I know I'm not covering everything that everybody said, but another thing I would say is that I heard a lot of concern, pretty uniform, about the market itself, the Part D market, the aspects of standalone market relative to MAPD market.

I'll just point out that we sort of intentionally didn't have work about that here. We're already over time, so there is lot to try to jam more in. But we do have our Part D status chapter that we'll be discussing in January, so we will be including that. So we'll have an opportunity to chew on that as that comes out. And, of course, you will see this work, as well, again. So I think multiple bites at the apple, MedPAC style. Obviously, if you have other thoughts, we're going to welcome hearing them as we go forward.

Shinobu, Betty, thank you so much for fantastic work, as usual. Commissioners, thank you for your very, very thoughtful comments. And I am enthusiastic that there is a lot of excitement to move this forward, within the context of the kind of sobering reality of what's happening on the spending and premium pieces. So thank you.

We'll close this session here and then move into

the ASCs directly. If people need a stretch break or bathroom break, please take it during the slide portion.

[Pause.]

DR. HARRIS: Today's presentation, which includes an analytic work plan, is in response to Commissioner feedback on the ambulatory surgical center, or ASC, presentation from last cycle.

For the online audience, a PDF version of the slides is available on the control panel on the right side of your screen. The topics we cover in this presentation include an overview of ASCs, a work plan for two proposed analyses, and then we will close with a discussion.

First, we provide an overview of ASCs in the context of fee-for-service Medicare. An ASC is a facility that primarily provides outpatient surgical procedures to patients who do not require an overnight stay. Fee-for-service Medicare covers more than 4,300 procedures in ASCs, though historically volume has been concentrated in a small number of procedures.

Fee-for-service Medicare generally makes two payments when services are rendered in an ASC, first, a facility payment through the ASC payment system and a

payment for clinician services through the physician fee schedule. For most ASC services, the facility payment rates through the ASC payment system are a product of a set of relative weights and a conversion factor or base amount. The ASC conversion factor is 62 percent of the outpatient prospective payment system conversion factor.

Since 2019, CMS has updated the ASC conversion factor using the same method as the outpatient prospective payment system; namely, the hospital market basket index minus a productivity adjustment.

For many years, the Commission has recommended that ASCs submit cost data, which would help inform decisions about the appropriate level of payment for ASC services.

In addition, cost data are needed to evaluate whether an alternate input price index rather than the hospital market basket would be a more appropriate proxy for ASC costs.

In 2024, about 6,400 ASCs treated more than 3.4 million fee-for-service Medicare beneficiaries. The number of ASCs has also grown considerably, roughly 12 percent increase from 2019 to 2024.

ASC concentration varies considerably across states and rurality, with roughly 94 percent of ASCs operating in urban areas.

The majority of ASCs are single specialty, of which gastroenterology and ophthalmology are the most common. However, pain management, cardiology, and orthopedic ASCs have grown the most in recent years.

Numerous factors have contributed to this sector's growth, including changes in clinical practice and the expansion of procedures performed in ASCs.

ASCs also provide some advantages over hospital outpatient departments, or HOPDs, which is the setting that is their closest competitor. For patients, ASCs can offer more convenient locations, shorter wait times, easier scheduling relative to HOPDs, and lower cost sharing. ASCs can also offer physicians more specialized staff and control over their work environment.

The volume of surgical procedures per fee-for-service beneficiary has also steadily grown by about 1 percent annually from 2019 to 2023 and by more than 3 percent in 2024.

Services that have historically contributed the

most to overall ASC volume continue to be the most common, including cataract, gastroenterology, and pain management services. For example, 18 of the most common ASC services in 2019 were among the 20 most common services in 2024.

Although not currently in the top 20 most common services, the volume of total hip, knee, and shoulder replacements is rapidly increasing. Even though the ASC payment system covers thousands of procedures, ASC volume for fee-for-service Medicare is concentrated in a small number of procedures. In 2024, 50 percent of the ASC surgical volume was concentrated in just seven procedures.

The ASC covered procedures list, or CPL, is the list of codes for surgical procedures that are covered under the ASC payment system. The CPL currently includes, as I mentioned, about 4,300 procedures. The number of procedures on this list has been rising rapidly in recent years, largely due to CMS's phase-out of the inpatient-only, or IPO list, which is the list of services that are covered only when provided in an inpatient setting.

In 2026, CMS removed 271 procedures from the IPO list and added those to the CPL. In addition, CMS added 276 procedures to the CPL that were covered under the OPPS,

but not the ASC payment system.

For 2027, CMS has proposed to remove 618 procedures from the IPO list and add them to the covered procedures list. There's a lot of change here. The effect of these changes, however, is not yet clear.

We have also been monitoring the evolution of ASC ownership. Generally speaking, most ASCs are for-profit and at least partially owned by physicians. However, corporate ownership of ASCs, whether by private payers, large health systems, or private equity firms is growing. While admittedly still a limited literature, there has been some emerging research examining the effect of ASC ownership on Medicare spending, quality, and access to care for beneficiaries. We do plan to update the published evidence assessing corporate ownership in ASC markets in our ASC status update chapter, which will be presented in January.

I will now turn the presentation over to Dan.

DR. ZABINSKI: All right. Thanks, Alex.

So, in this next and final section, we present a proposed analytic work plan for two key aspects of the ASC sector that the Commission has been monitoring.

On this slide, we highlight some of the context for this work plan. First, the number of ASCs per capita varies widely by geography and across states, and as a result, many markets don't have any ASCs. Therefore, beneficiaries in these markets may lack access to the benefits of ASCs, including lower costs and the potential for more efficient care delivery relative to HOPDs.

And, second, we note that the growth in the number of ASCs can substantially affect outpatient surgical volume. This could cause surgical procedures to shift from ASCs to hospital outpatient departments, particularly for routine and high-volume procedures. This could also increase overall outpatient surgical volume if convenience, shorter waiting times, and lower cost sharing encourage greater access to elective procedures.

Regarding the geographic differences in ASC supply, the current literature identifying the factors that are associated with ASC supply is somewhat limited and dated. As a result, we propose to conduct a two-part mixed methods analysis.

In the first part, we would conduct semi-structured interviews during site visits with ASCs across

specialties, states, and varying degrees of ASC market concentration. The goal would be to gain a better understanding of the challenges involved in opening and operating ASC and to learn more about the effect of ownership on ASC operations and patient care.

In the second part, we plan to conduct a multi-year, cross-sectional regression analysis of market characteristics that may be associated with the number of ASCs per capita in a market. For this regression analysis, we plan to use the number of ASCs per capita in a market as the dependent variable. We have considered several ways to define markets, but we are currently leaning towards modified health service areas that were developed by the National Center for Health Statistics. MedPAC has used this market definition in other work, most recently in our June 2026 report.

We plan to include several explanatory variables, and they are listed in your mailing materials. A quick rundown of these variables that we are considering includes several variables for population characteristics, a measure of the need for surgical providers in a market, a measure of outpatient surgical capacity, the concentration of

outpatient surgical procedures among ASCs and HOPDs, whether the state that the market is in has a certificate of need law, and an indicator of the state's medical liability level.

Now we turn to the second topic of our work plan, which is assessing the impact of ASC growth on outpatient fee-for-service surgical volume.

Overall, this issue has implications for Medicare spending, access to outpatient surgeries, and the distribution of outpatient surgical volume across Medicare payment systems. However, the literature on this topic is, again, somewhat limited and dated. Therefore, we plan to conduct a staggered adoption difference-in-differences approach to estimate changes in outpatient surgical volume following the entry of a new ASC into a health care market.

The proposed primary outcomes are county-level procedure volume among fee-for-service Medicare beneficiaries for four common procedures performed in both ASCs and HOPDs, including total hip arthroplasties, total knee arthroplasties, cataract removal, and diagnostic colonoscopies.

We propose the following secondary outcomes that

are high-volume procedures performed in ASCs, HOPDs, and physician offices, including cystoscopy, trigger finger release, carpal tunnel release, and epidural steroid injections. Because these procedures may be furnished in all three of these settings, they provide an opportunity to assess whether ASC entry is associated with changes in overall utilization and or shifts within these three sites of care.

So this concludes our presentation. For today's discussion, we'll address the Commissioners' questions about the material, and we'd like to hear your feedback on the work plan. We plan to include the results of our analysis in the future ASC presentation.

Thank you, and we turn back to Amol.

DR. NAVATHE: Alex, Dan, thank you so much for your presentation, which was, as always, information-packed and efficient.

So, before we jump into Round 1 and Round 2, I just want to mark a milestone here, which is that this is Dan's last presentation, public meeting for MedPAC, and he's going to be staying on and working with MedPAC still, but this marks his last presentation. So, on behalf of

MedPAC and Commissioners, past and present, we wanted to thank you, Dan, for all your service.

[Applause.]

MR. MASI: And I'll jump in mostly just to watch Dan squirm as we continue to say really nice things about him. It is an absolute privilege to thank Dan on behalf of the MedPAC staff for his many, many, many years of service. Dan has been a cornerstone of the team and has worked on such a wide range of complicated and sensitive topics.

A handful I've written down, ASCs obviously, also Part B drugs, 340B, the ambulance fee schedule which he submitted a report on just a few months ago, hospitals, the OPPS, Medicare Advantage risk adjustment, geographic differences in health care, software as a service, and I'm almost out of time. So I'm going to stop listing all the many things he's worked on. But it's really a privilege to have worked with Dan, but mostly, we'll miss his friendship and just seeing him around the office.

So, on behalf of the staff, we wanted to add our thanks.

DR. ZABINSKI: Thank you.

The only thing I'll say is that for somebody who

grew up with nine siblings, you know, any attention usually was a bad thing. So this is really -- this is new.

[Laughter.]

DR. ZABINSKI: So thank you for all that.

DR. NAVATHE: Wonderful. Thanks, Dan.

All right. Dana, should we go through the queue?

MS. KELLEY: Sure. The first comment or question is from Josh Liao, who says, recognizing potential data limitations, are you able to capture ASC size, specifically number of operating rooms, not procedural volume, or ASC specialties, for example, orthopedic versus GI?

DR. ZABINSKI: Well, yes, we can capture the number of ORs. Also, in fact, I would say we can, to some degree, capture, you know, ORs by type of specialty, so yeah.

DR. HARRIS: And I think we have plans for capturing type of specialty. Normally, in the status update chapter, we have either a table or in the text talking about breakdown by specialty of ASCs, whether they're single specialty or multi-specialty. So we should be able to leverage that work for this.

MS. KELLEY: Thanks. Scott, you had a Round 1

question.

DR. SARRAN: Yeah. I feel like I should know the answer to this, so I apologize. Is there a clear and consistent proportional relationship between what Medicare pays for the same exact procedure in an ASC as compared to an HOPD?

DR. ZABINSKI: In general, yes. The general way is, yeah, the ASC payment rates are generally a percentage of HOPD, lower by a good margin. But there's -- I don't want to get into the details, but there's some where they're predominantly provided in physician offices. The payment rate can be even lower than what the standard percentage difference is.

DR. SARRAN: Is there a ballpark number for the percent difference that you typically see between an HOPD and an ASC?

DR. ZABINSKI: We've had 61, 62 percent, something like that. Yeah. ASC 61, 62 percent of OPPS.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks.

And Dan, I'm sorry this is your last in-person meeting. I'm going to miss you.

I had a question. There's a sentence in the draft chapter that talks about the fact you can't look at this in MA due to data limitations, and I was trying to wrap my brain. What is the problem there?

DR. HARRIS: I wouldn't say a problem, per se, but I think it's part of our broader work, trying to find ways to use MA encounter data and apply it to different settings. I am not our MA guru, but I know that we have others here who are working on that. So I think it is something that we're certainly hoping to do in the future, but for now, the focus has been fee-for-service.

DR. DAMBERG: So it's a completeness kind of issue, accuracy?

DR. HARRIS: Mm-hmm.

DR. DAMBERG: Yeah. Okay. Thanks.

MS. KELLEY: Okay. That's all I have for Round 1, unless I've missed anyone. So we'll go to Round 2, and I have Stacie first.

DR. DUSETZINA: I think I've swept first Round 2 comment on all sessions today. I don't know what you guys are doing, but --

[Laughter.]

DR. DUSETZINA: So great work, you guys.

First, I want to say I think it's great that you're going to do site visits, and so I was trying to think of something that might be helpful to ask about. And I think when you were talking about thinking about future entry of these types of practices in the area, it might be something worth asking them about as these procedures list, the ones that they're now allowed to do, are changing. Are they prepared or kind of planning to offer certain services? Are they anticipating those? So I think that would be kind of a helpful looking forward thing to ask.

DR. HARRIS: You read our minds.

DR. DUSETZINA: Good.

So I think the other thing that would be helpful just for the -- like the reading materials themselves, I always have a little bit of a hard time conceptualizing what these services are. And I don't know if it's possible to put together a table of maybe the more common ones that are moving from one sector to the other, from outpatient only to ASC-approved. That would be helpful just for like kind of following. I always like to have a mental map of, you know, what that procedure might be.

For your regression model, I was trying to think through, you know, like -- and maybe you do intend to capture this. This is well outside of my area of expertise. But I was thinking about like the hospital outpatient consolidation in the area. Is there like one major market player or something like that where you could enter and try to maybe shake up things for contracting or something?

I don't know if it's possible to bring that factor in or if you plan to, but it was just something I was thinking about as might be relevant.

For the question about the shift in volume, there were a couple of things I was thinking about. One is this issue of ASCs getting the healthier patients and HOPDs keeping the less healthy patients or people with more complexity, and I wonder to what degree that can be teased out, because I think that's important. Maybe that's the thing that we would really like to have happening, but it does mean that HOPDs are -- you know, like they're really expensive, and you're trying to incentivize people moving. But then it's like they just get the sicker- and sicker-looking cases, so to whatever degree you can take that into

account or evaluate how that's happening.

And then on the patient side, one of the things I think could be really positive for patients is like shorter wait times between when they, you know, are getting worked up before they can actually get access to a surgery. So to any extent we could figure out not just are like more people getting surgeries, but like is there just shorter time so it's more about like efficiently getting people to their care.

But this is really fantastic work. I'm excited to hear about the work plan.

And, Dan, I can hardly look at you. I'm so sorry you're leaving us.

MS. KELLEY: Tamara.

DR. KONETZKA: Great work. I really enjoyed this. I have three very specific comments. One is, on page 4 of the mailing materials, there is this paragraph about aggregate fee-for-service payments to this sector, saying basically fee-for-service Medicare payments to ASCs grew at an average annual rate of 5.6 percent from 2019 through 2023, 13 percent 2023 to 2024, and then payments per fee-for-service beneficiary rose at an average annual

rate of 9.5 percent from 2019, and by 15.9 percent from 2023 to 2024. So those are just huge, right?

But given the context of some of the stuff we were talking about this morning, you know, as we shift more and more into ASCs, maybe that's a good thing, because we're getting them out of more expensive settings.

After that you say this probably reflects an increase in the conversion factor, growth in per capita volume, growth in the average relative weight or complexity, and increased spending for drugs that are separately paid under the ASC payment system. I'd love to see that decomposed and see the numbers behind each of those, if you can do that. Because like I said, it may be a good thing that this sector is growing at a really fast clip, but I think we want to kind of keep a handle on that and make sure it seems like sort of good growth for high-value services that are now being provided in a lower-cost setting, and not just sort of wasteful spending. So that was the first comment.

The other two are just geeky econometric comments. For your first regression analysis, to see where ASCs are expanding, I would just suggest or hope that --

you know, one always worries about a cross-sectional analysis because there's just this potential for omitted variables, like the HSAs that have growth in ASCs may just be very different in ways you're not capturing in those control variables, from markets that don't have that growth.

So if you could also use a few years of data and do more of a longitudinal. Like is it changes in the hospital outpatient departments or in the hospital competition? Is it changes in some of those that lead to sort of entry of ASCs? You could probably do both, because they're both informative in different ways, but I would love to see a longitudinal component of that, to get more at the entry part of it, in a way that's not so subject to omitted variables.

And then at the very end, when you're talking about sort of effects of this growth, you talked about a staggered difference-in-difference design. As you probably already know, the science behind these staggered difference-in-difference designs has really changed recently. So I think you don't want to call it that. You want to do something that's more of stacked event study.

I'm happy to talk about that more offline. But I think you want to do a slightly different design to avoid the pitfalls that people have identified in the last five years or so.

That's all. Thanks.

MS. KELLEY: Brian.

DR. MILLER: So I'm going to be like my cat and be mad that one of my favorite people is leaving. Dan, we have appreciated your not just intellectual sharpness but also your creativity. So you will be sorely missed.

I'm super excited by this work. None of these comments I'd say are going to surprise people, but I'm going to say them again.

You know I'm generally not a fan of cost reporting because I think it's like doing cost reporting on McDonald's, and that we should be moving towards a competitive system and away towards administrative pricing. That being said, I'm going to be intellectually honest and say that if we do end up with cost reporting it will likely showcase the mass inefficiency of ASCs compared to HOPDs. So while I don't like that regulatory requirement, it might actually give us good information, which we probably

already know, though.

In terms of certificate need, which I think is an important policy for us to sort of laser on as a commission, obviously it inhibits ASC entry in many states. I am curious if we find that it shows that CON is most impactful compared to areas where there isn't CON in markets that are like monopoly or highly concentrated suburban markets and urban markets, as opposed to rural markets, because if you think about where you're going to find an ASC, more likely it's either a market with a lot of people or a market that is highly concentrated. So I'm curious if the evidence shows us that.

And then just a general caution for us, based upon prior cycles. We tend to -- not everybody but some of us -- tend to get upset about ASCs, in terms of them being physician owned, for profit, and private enterprise, HCOs and a bunch of ASCs. Physicians owned a bunch of ASCs. United owns a bunch of ASCs. We can have thoughts about the specific infrastructure or business structure. It doesn't mean that ASCs themselves are a bad market. This is actually one of the few parts of the clinical delivery market where we have had massive service innovation,

clinical innovation, and reduced costs.

Scott probably remembers this, as do some of my other physician colleagues, used to get cataract surgery and colonoscopies done in the hospital, and then they moved to HOPDs, and now they have moved to ASCs. So if we want to think about how we provide service delivery innovation, ASCs are a good example. I would say there are challenges to think about that continuum, which is inpatient to HOPD to ASCs, and then also ASCs to clinic and physician offices, which actually the ophthalmologists are doing with cataract surgery.

So I would say how can we push more things into ASCs that are clinically appropriate, and what the financial incentives we can set up to do so. And then what are the financial incentives that we can push things from ASCs to like a physician office, which could be a hospital-owned office, it could be an independent physician office, it could be a private equity-owned office. Just moving things to lower cost sites of care, as is clinically appropriate. And that way we can save money for Medicare while preserving safety and increasing access for the beneficiary.

MS. KELLEY: Paul.

DR. CASALE: Thank you for this chapter. I really enjoyed it, and I think it's such an important and dynamic area, and glad we're continuing to do work on this.

As Brian just mentioned, traditionally ASCs, as you pointed out, were doing mostly colonoscopies and cataracts, relatively low-risk procedures that were very amenable to ASCs. But as you also pointed out, there are 271 codes that have moved from the inpatient only, in 2027, another 618 codes. And at least I know in cardiology that includes some higher risk procedures. They may be very appropriate for ASCs now that the technology has gotten better, but very different than a cataract procedure.

So I think, going forward, I think it will be important to understand the growth of those procedures that were inpatient only, that are now moving to ASCs.

And one of the challenges is trying to get to the quality data around all of this. It is somewhat limited, but it's so important. And even some of the very specific things around ER visits, readmissions back to the hospital in X number of days. I think that's important to keep an eye on that, particularly with this expansion of those

procedures.

A couple other comments. Understanding the case mix between ASC and HOPD, because I think physicians naturally tend to do their lowest patients in ASCs, logically, and have the backup of the hospital for the higher risk, and again, how that may or may not change with the additional procedures.

And then finally, on this geographic differences, I think there is this evolving acquisition of specialty by private equity, in particular. I think traditionally a lot of ASCs were physician-only or physician-hospital partnership kind of thing, and how private equity, again, because 94 percent are in urban areas just makes me think, I'm wondering whether that may be a factor related to private equity acquisition of specialists who then are migrating more of those procedures to ASCs. So just something to continue to look at.

Anyway, I think this is great work and a really important topic going forward. Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. First of all, we're going to miss you, Dan. I guess we'll have to figure out

how to fix Medicare all by ourselves now.

Well, just a few comments here. In terms of ASC growth, one of the factors that's also contributing to the growth that wasn't mentioned on the slide was the fact that many health systems that serve quaternary care patients are looking to offload those patients out of their main OR and get them into an ASC, because there's increased need to bring in those complex surgical procedures into the main operating rooms, very internally consistent with prior discussions we've had today around the increasing complexity of the Medicare population, as well as other payers too.

In terms of quality reporting, I guess what is supposed to incentivize these ASCs to report data is a payment reduction by 2 percent. Unfortunately, that may not be enough of an incentive, when you consider the cost of collecting, analyzing, validating, uploading the data, plus the resources that need to be invested in the performance improvement work, it may not be worthwhile for some ASCs. Perhaps the only way to really do this is just to mandate it. If you want to maintain your licensure or certification then you have to report some quality data.

That may be difficult for some. I do recognize that. So maybe the easiest way to start off with a mandate like that is to take some of the larger ASCs. If you have X number of ORs you should be mandated to report out. They may have more resources to be able to do it.

In terms of the corporate acquisition issue, that's a rather fascinating sort of trend than development. Generally it's the underlying economics that is driving some of this consolidation, and the margins on the ASC is probably drawing the attention of a lot of these corporations, and particularly with five corporate entities now controlling a larger share of the ASCs around the country.

I think this is something to watch carefully. Based on prior discussions that we've had around dialysis, for example, and the monopoly that exists there, what is the trend towards continual consolidation in the ASCs? Will that be a problem or will it not? So that will be something that ultimately may need to be studied in the future, but not now.

And then in terms of the overall value that the ASCs are providing, I think the analysis around certificate

of need is a good one. And it's not just a comparative analysis, I think, around states that have it versus states that don't have it, but also how are these certificates of need constructed so that we are getting the best quality of care from the ASCs. Do some of their certificates of need have geography, for example, or do they have minimum volume requirements? Those things would be helpful to know, and to see if they have had success based on how those certificates of need are constructed. There may be some variability in that, and if Dan wants to interject in that, feel free.

DR. ZABINSKI: Yeah. There's really a lot of differences from one state to the next. Like Nevada, it's almost like it doesn't matter, and in Vermont, it's ominous.

DR. CHERRY: Yeah, yeah. As long as you put the application in, maybe you get approved, and others, yeah, you have to have a number of check boxes. But if there's a way of actually distilling that down, great. Otherwise it could be a very difficult exercise, I acknowledge.

The other thing, too, this is a point of clarification. There is a little bit of a loophole in CMS

in terms of how ASCs are defined. Some of these are really procedural units, like, for example, for colonoscopy. But when you walk in them, they don't look like operating rooms. They look like procedure rooms set up for a certain type of service, which is different than the traditional ASC that might come to mind, where it's a traditional operating room.

So you may want to differentiate those procedural areas from actual ASCs, if it's even possible, based on the CMS criteria and how they allow ASCs to be defined, based on their criteria.

Otherwise, fascinating work, and I'm looking forward to hearing more. Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks for this great work. Just a few comments. In terms of looking at geographic variation and trying to communicate that to the reader of this chapter, I was curious whether you might be able to map that, to kind of show how that varies across the country. That might be a nice visual.

In terms of the qualitative interviews, obviously we haven't seen the discussion guide, but I'm kind of

curious, are you going to be going out and talking to rural providers to try to understand why they aren't moving into that space?

DR. HARRIS: The goal would be to have a representative sample. You know, we'll see what we can accomplish. But absolutely, I would love to talk to rural ASCs as well as urban.

DR. DAMBERG: Okay. Great. And I guess related to where these are popping up, it seems to me like volume or demand for services is a key driver. But at the same time -- and this sort of gets to trying to understand what's happening in this space -- it seems like there's been this expansion in the number of procedures being performed. So you could argue on the one hand maybe that's improved access and maybe people who have been waiting in the queue to get their colonoscopies are getting them in a more timely manner, so that's good.

But it could also imply inappropriate procedures being done. That's always a tough nut to crack, but I don't know if there's any way you have to kind of look at changes over time in terms of the age at which some of these procedures are being done, to try to sort of get an

indirect measure. But obviously that's going to vary, depending on the procedure.

I think the other thing that related to the work that you're going to do descriptively to look at some of these different factors that might be affecting the presence or non-presence of ASCs is to what extent do you need to be looking at that by procedure type, given that there may be sort of -- one of your measures is the need for surgical providers in an area. So that may vary geographically in terms of the mix of providers for different kinds of services.

So just something to think about. I'm not trying to make your work more difficult, but whether you need to unpack that a little bit.

The other thing, and I don't recall seeing this in any previous MedPAC readings, but you can point me to this otherwise. Given that there has been this shift that Brian mentioned from doing things in the hospital to the hospital outpatient department to now in these ASCs is, what has been the cost savings to the Medicare program? I mean, I think that would be a nice thing to highlight, so that like this is kind of potentially one of our wins, and

I think we're kind of silent on that.

And then the last thing related to ownership of ASCs, I do think that's an important area to keep an eye on. Obviously, it's a challenging space, data-wise, although there is one paper that I'm a co-author on that I'll be sending you once it's published, that starts to look at this space. Yeah, just keep an eye on that.

MS. KELLEY: Gina.

MS. UPCHURCH: Yeah. Thank you for this work. Dan, we'll miss your professionalism and your expertise in the data you've used to help drive decisions, and I'll miss your pickleball, because I was only winning when I was on your team.

Just thinking about ownership, as we think about site neutral payments overall, we realize -- I learned this morning that the Stark law, physician self-referral, there is a waiver or bypassing of ASCs for these purposes, but I worry about cherry-picking and ownership -- I feel like I'm defending pharmaceutical companies and hospitals today. But a question around cherry-picking. Can we look at when ASCs do have coverage, is there a difference between covering people with fee-for-service coverage and then fee-

for-service with Medigap? Is there a distinction there? Or fee-for-service versus Medicare Advantage? Or income of the people who use the services, or the age of the people that are more likely to go to ASCs versus hospitals, or the race of the people?

And is there any policy whatsoever -- and I think there probably is not -- around charity care, or hardship within ASCs. And I think that's one of the hospitals' arguments, that a lot of that stuff isn't required of them. It is required of the hospitals. So as we have these conversations just to understand those things a little bit better.

DR. HARRIS: In some states their certificate of need does require a certain percentage of charity care, but I think it does differ by states. In terms of the kind of demographic patient mix across settings, we do report normally in our status update some of the demographic information, so age, et cetera. But we can certainly consider what could be possible in terms of adding to that.

MS. UPCHURCH: Great. Thank you.

MS. KELLEY: I have a comment from Josh Liao. Josh expresses his appreciation for this information and to

Dan for a great last installment in a wonderful run of public meeting presentations.

Josh supports the overall direction of this work and is excited to see results from the work plan. He offers two suggestions that could sharpen the analytic design and ideally future policy interpretation.

In analyses looking at factors associated with ASC supply, he suggests looking beyond the total number of ASCs to distinguish facilities by their level of claims activity and their age. For example, recent entrants versus established facilities based on certification or billing patterns.

The reason for this is that the total number of ASCs per capital represents an accumulated stock reflecting many years of openings and closures. So relating it only to market conditions in a given year, using cross-sectional analysis, might inadvertently blur interpretation. Using lagged or multi-year market characteristics or separately analyzing recent entry or moving away from a cross-sectional design could be options to align the timing of potential drivers with the supply outcome.

In analyses looking at ASC entry and procedural

volume, he suggests considering more specific definitions of entry. In particular, not just looking at all entrants together but also entrants that are the first ASCs in a previously unserved market or entrants that are first specialty-specific ASCs, for example, the first facility to provide GI services where existing ASCs do not offer them.

Josh also suggests considering related but distinct analysis of expansion at existing ASCs, such as adding a specialty or meaningfully increasing operating room capacity. Entry and expansion may affect procedural volume through different mechanisms, including new access, greater competition, and additional capacity, and warrant separate consideration.

And that's all I have for Round 2.

DR. NAVATHE: Great. Thanks, Dana. So Dan and Alex, thank you for your work, and Commissioners, thanks for again all of your thoughtful comments.

I think, kind of broadly speaking, as Dan and Alex noted up front, this is kind of motivated from question s that you all have asked in part of our ASC work, but I think it's also broadly connected to our site neutral work, as well. And so I think there is a definite

precedent in recommendations, of course, for MedPAC around site neutral and directing care, when appropriate, to the lowest cost setting, and ASCs play a really important role, especially for the procedural side there. So I just wanted to note that.

A lot of analytic suggestions that you all have made, everything ranging from methodological suggestions to different characteristics to look at, focusing on things like CON law. I think we are very happy to have all the feedback that you have given, and we will start to incorporate that.

The plan for this work, just to try to tie a bow on the session a little bit, is if we're able to get through enough of the analyses, based on the suggestions today, hopefully to revisit this in January as part of the ASC status work, that will go into the status chapter.

And otherwise that brings our day to a close. We have the opportunity for public comment. Should anybody who is here in person want to make a comment, please come forward to the microphone where Dan and Alex are stepping away.

[No response.]

DR. NAVATHE: And seeing likely none. Also, for those at home, please submit comments to us at meetingcomments@MedPAC.gov. We would love to hear from you.

And with that we will adjourn for today, and we will be starting tomorrow at 9 a.m. Thank you.

[Whereupon at 5:02 p.m. the meeting was recessed, to reconvene at 9:00 a.m. on Friday, September 4, 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, September 4, 2026
9:00 a.m.

COMMISSIONERS PRESENT:

AMOL S. NAVATHE, MD, PhD, Chair
GREGORY P. POULSEN, MBA, Vice Chair
PAUL N. CASALE, MD, MPH
ROBERT A. CHERRY, MD, MS
CHERYL L. DAMBERG, PhD
THOMAS DILLER, MD, MMM
STACIE B. DUSETZINA, PhD
BENEDIC IPPOLITO, PhD
KENNY KAN, FSA, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
JOSHUA LIAO, MD, MSc
GOKHAN METAN, MSc, PhD, NACD.DC
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AGENDA PAGE

P R O C E E D I N G S

[9:00 a.m.]

DR. NAVATHE: Good morning, everyone, and welcome to our Friday session of our September public meeting. This morning, we will be discussing post-acute care services and risk adjustment in Medicare Advantage, and we will be starting with a session examining use of post-acute care services by beneficiaries in fee-for-service Medicare and Medicare Advantage.

Carol, I'll hand it to you.

DR. CARTER: Yeah, I'm going to start. Good morning, everyone.

We're going to be talking about the use of post-acute care services by fee-for-service and MA beneficiaries. As a reminder, a PDF of these slides is available on the right-hand side of your screen.

In this presentation, I'll start with some background information on PAC use. Then Betty will present the data and methods we used and the results of the descriptive analyses. Then Brian will explain our analysis of PAC pathways and outline plans for our future work.

Commissioners expressed interest in learning more

about how MA and fee-for-service beneficiaries use PAC. PAC use may differ due to the incentives inherent in fee-for-service and MA and the application of care management tools by many MA plans. Today we present descriptive analysis of PAC use by MA and fee-for-service beneficiaries. These results have not been adjusted for the characteristics of the beneficiaries enrolled in each part of the program.

In the spring, we will present results that have been adjusted for beneficiary characteristics and report on additional analysis in the interviews we're conducting with PAC providers and MA plan representatives. This work may assist policymakers in considering policies aimed at improving the provision of PAC to beneficiaries.

As a reminder, post-acute care is provided by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. All PAC providers provide rehabilitation and skilled nursing services. These services help maintain, prevent deterioration, or improve a patient's function, but the intensity of care differs across the settings, ranging from the lowest intensity in home health care to the highest

intensity in IRF and LTCHs.

Despite the label, not all post-acute care follows a hospital stay. For example, about 45 percent of home health care admissions do not have a prior hospitalization and are admitted from the community.

Differing MA and fee-for-service incentives may shape PAC use. Fee-for-service incentives and benefits may encourage unnecessary care because there are few incentives for providers or beneficiaries to select the lowest-cost setting or to limit the amount of care, as long as beneficiaries continue to meet coverage rules. Furthermore, high payment rates may encourage providers to admit the marginal fee-for-service beneficiary who could be effectively treated in a lower-cost setting. While cost sharing may dampen some PAC use, there is no cost sharing for home health care. In fee-for-service, beneficiaries can choose any participating provider.

By contrast, by being at full risk for the cost of care, MA plans have strong incentives to manage where and how much care their enrollees receive. Plans must cover PAC services, but each plan can structure its benefit differently, such as waiving the three-day hospital stay.

Plans typically use utilization management tools such as provider networks, prior authorization, and concurrent review to manage PAC. Many plans pay providers differently from fee-for-service and have their own cost sharing rules that may influence beneficiary use.

Several studies have compared fee-for-service and MA PAC use. They varied in their scope and methods. Studies included different PAC services and focused on different clinical conditions. They also varied in whether they accounted for the differences in the beneficiaries being compared. Some authors noted the problems with selection even after controlling for patient differences.

With these caveats, researchers generally have found that MA beneficiaries use less PAC, especially IRF and SNF, but were more likely to be discharged home.

Not all studies looked at quality. Those that did examined a variety of measures. Their findings were mixed. In general, studies found that MA had lower readmission rates in more days in the community, but MA beneficiaries tended to use lower quality-rated SNFs in home health agencies and higher mortality rates. Differences in functional gain were mixed.

OIG found that prior authorization could result in delayed or denied care. On appeal, relatively high overturn rates raised questions about whether beneficiaries who did not pursue an appeal would have won their appeals and gained access to care. MA plans we've spoken to have said that the prior authorization helps ensure that beneficiaries get to the right level of care and that some denials were due to incomplete information that they received.

The Commission has recently reported on the use of PAC in MA and fee-for-service.

In June 2025, we compared fee-for-service and MA home health use rates and visit volume in 2021. We found mixed differences in the probability of home health use between MA and fee-for-service. Beneficiaries with a prior hospital stay had a higher -- sorry. The beneficiaries with a prior hospital stay, the probability of use was higher for MA than fee-for-service. However, for beneficiaries without a prior hospitalization, the probability was lower. Enrollment in MA was associated with fewer visits compared to fee-for-service.

This past June, we examined the relationship

between MA and PAC providers' finances. We found no statistically significant association between growth in MA market penetration and SNF and home health all-payer margins, but there were small declines in these volume.

We also looked at IRF use and found that there was substantially lower IRF use among MA enrollees compared to fee-for-service beneficiaries.

This year's work continues our investigation of PAC use.

Before we turn to our results, we want to underscore that current service use in fee-for-service or MA may not represent best practice.

Given the fee-for-service benefit and payment incentives, higher fee-for-service use may reflect unnecessary care.

Lower MA use may indicate efficient care delivery, but it could also indicate worse beneficiary access to needed services.

Without medical record review, we cannot assess the appropriateness of care, and even then, clinicians may reasonably disagree. Therefore, we need to proceed cautiously when interpreting these differences in PAC use.

DR. FOUT: Thanks, Carol.

Now we move on to describing the data and methods we used.

Our study sample consisted of 25.6 million fee-for-service beneficiaries and 27.8 million MA enrollees in 2023. These 53 million Medicare beneficiaries accounted for about 90 percent of all Part A and B beneficiaries.

Acute and post-acute care data sources included fee-for-service claims and MA encounters as well as patient assessment data available for PAC settings.

Our study sample uses fee-for-service claims and MA encounters to identify PAC use. Similar to what we have done in the past, we compared beneficiaries with encounter records to assessment data to determine the completeness of the data. We concluded that the 2023 encounter data were reasonably complete for examining PAC use, and more information on this assessment is in your mailing materials.

The rest of this presentation will review findings from several descriptive analyses. This includes an analysis of overall beneficiary use rates of acute care hospital and PAC in 2023.

We then link stays together to examine discharge from the hospital to PAC, facility versus community admissions to PAC, and PAC pathways, which are composed of sequential settings throughout the year following index event.

The findings we show today are not adjusted for differences in beneficiary characteristics, and it's important to keep in mind that the results could change after accounting for these differences.

We now present descriptive analyses of acute care hospital and PAC beneficiary-level use rates in 2023.

We first look at the MA and fee-for-service beneficiaries in our study sample. We found that they differed on a few key characteristics.

Compared to fee-for-service beneficiaries, MA enrollees were more likely to be disabled, less likely to be 85 or older, more likely to have low incomes, and to live in an urban area.

These differences could affect hospital and PAC use, and caution is therefore needed when interpreting these unadjusted differences since they reflect, at least in part, differences in the types of beneficiaries enrolled

in each program. This applies to all of the results shown today. In a future work, we will account for these and other observed differences.

This chart shows the unadjusted use rates for acute care hospital and PAC settings. On the far left, the chart shows that 14.2 percent of fee-for-service beneficiaries had an acute care hospital stay compared with 13.2 percent of MA enrollees.

A higher share of fee-for-service beneficiaries and MA enrollees used PAC services overall and for each specific setting, but the extent of differences varied by setting.

The largest difference were for IRF services. These rates were low in both populations, but fee-for-service beneficiaries used IRF at three times the rate of MA enrollees, or 1.2 percent versus 0.4 percent.

Taking a closer look at PAC use, this chart shows use rates for subgroups of beneficiaries.

Older and lower-income beneficiaries, the bars on the far right, used PAC at higher rates in both MA and fee-for-service compared to other subgroups with use rates higher among fee-for-service beneficiaries.

Fee-for-service PAC use rates were higher than those for MA in all subgroups shown here, except among beneficiaries under age 65, where MA use rates were slightly higher, 8.1 percent versus 7.8 percent.

Differences in PAC use across these subgroups also highlight the importance of accounting for beneficiary characteristics.

This chart shows the volume of acute and post-acute care used during the year among beneficiaries who received these services. Volume is measured as the total number of days across all stays within a setting, except for home health care, which was measured as the beneficiary's total number of visit days during the year. Fee-for-service days are in black, and MA days are in orange.

As shown in the left-most bars, the median number of acute care hospital days among users were slightly higher for MA enrollees than for fee-for-service beneficiaries, six versus seven days. This is consistent with previous findings of longer hospital stays among MA enrollees.

Among home health and SNF users, fee-for-service

beneficiaries had a higher number of days of use. For SNF, the median number of days is quite a bit higher for fee-for-service users, 33 days, compared to 20 days for MA users. These patterns could reflect a number of different factors, such as the fee-for-service benefit design and MA plans' utilization management strategies, but it could also reflect differences in the clinical characteristics of beneficiaries receiving care.

Among LTCH and IRF users, MA enrollees had a higher median number of days than fee-for-service beneficiaries. Because MA enrollees were less likely to use LTCHs and IRFs overall, this pattern may suggest that those who do receive these services tend to have greater medical complexity.

Across the settings, there was large variation in how much care was used, as shown by the 10th and 90th percentile whiskers on the box plots.

We now move on to discussing acute care hospital impact stays in 2023.

In the prior slides, we presented beneficiary-level use rates, and now, to better understand how beneficiaries move across care settings, we discuss stay-

level patterns of acute care hospital impact use.

As shown on this table, accounting for the overall number of fee-for-service and MA enrollees, fee-for-service stays per beneficiary were higher than for MA across all the settings.

In the next slides, we link these stays together to assess PAC use following hospital discharge, community versus facility-admitted stays, and PAC pathways.

This chart shows PAC destinations following acute care hospital stays for MA and fee-for-service beneficiaries in 2023. Among hospital stays for fee-for-service beneficiaries, 59 percent had no PAC use in the following 30 days. This share was 65 percent for MA enrollees.

A similar share of fee-for-service and MA stays were followed by home health, but a higher share of fee-for-service stays were followed by SNF, IRF, and LTCH.

MA plans' financial incentive to shift beneficiaries to lower-cost settings of care may contribute to these findings, though, again, this figure is not adjusted for the beneficiary mix.

Discharge to PAC rates varied by the type of

hospital stay. In general, surgical stays were more likely than medical stays to be followed by PAC use among both MA and fee-for-service beneficiaries. This is not surprising given that rehabilitation and skilled clinical services may be more commonly needed after surgical procedures.

SNF use was more common after surgical hospital stays than medical stays among MA enrollees, 18 percent versus 14 percent, but notably, among fee-for-service beneficiaries, discharge to SNF rates were the same, 18 percent, for both types of hospital stays.

MA enrollees were more likely to be discharged to an IRF after a surgical hospital stay compared to a medical stay, but their rates were still notably lower for both types compared to fee-for-service.

This chart shows the length of the acute hospital stay stratified by PAC destination. Similar to our prior findings, as well as those in the literature, hospital stays tended to be longer for MA enrollees than fee-for-service beneficiaries across all PAC destinations, or no PAC, especially for IRF and LTCH.

These patterns may reflect a number of factors, such as severity of the beneficiaries who are admitted to

these settings, as well as potential delays associated with PAC prior authorization and availability of PAC providers.

We now switch gears to examine whether admission to PAC settings originated from another facility or from the community. We use the term "facility" broadly to include not only acute care hospitals, but also other institutional settings, such as IRFs, LTCHs, and SNFs.

The teal bottom part of the bars are the share of stays in each setting that were preceded by a facility stay, and the gray represents the share of community-admitted stays.

Home health care had the highest shares of community-admitted stays, with fee-for-service beneficiaries having a slightly higher share than MA enrollees, 45 percent versus 42 percent.

For the other settings, MA enrollees had higher shares of community-admitted stays. For SNFs, the difference, 4 percent versus 16 percent, likely reflects the fee-for-service requirement for a preceding three-day hospital stay to qualify for coverage, a requirement that MA plans often waive.

And now I pass the presentation to Brian to talk

about PAC pathways.

MR. KLEIN-QIU: Thanks, Betty.

Preliminary analysis of PAC pathways.

The previous slides examined individual service use or the first service after a hospital discharge. However, many beneficiaries used multiple sequential post-acute care services.

We examined the full sequence of acute and post-acute services a beneficiary used in a year, which we refer to as a "pathway." Pathways are defined as consecutive acute and post-acute care services occurring within 30 days of each other. Pathways may be initiated by either an acute care hospital stay or a post-acute care service.

We also looked at transitions. These are the number of times a beneficiary changed settings within a pathway. They represent an attempt to capture the beneficiary experience because they count the number of times a beneficiary has to adjust to a new setting, map the changes in the intensity of the care beneficiaries receive, and indicate coordination needed between providers. For example, if a beneficiary goes to a hospital and is then discharged to a SNF and is readmitted to the hospital and

then returns to the SNF, the beneficiary would experience four transitions.

The order and number of transitions within a pathway matter because they provide a broader picture of post-discharge care than comparing use of individual services alone. However, a transition does not necessarily reflect an appropriate or inappropriate level of care or utilization management.

This chart shows the most common PAC pathways following an acute care hospital index stay.

The bottom dark parts of the bars show that Medicare Advantage enrollees were much more likely to receive only home health care than fee-for-service enrollees, 56 percent versus 47 percent. Fee-for-service beneficiaries and MA enrollees had similar and relatively high rates of receiving only SNF care after the index hospitalization in orange. On the other hand, fee-for-service enrollees were more likely to have an IRF-only care, the tan bars showing 6 percent versus 2 percent.

In both fee-for-service and MA, home health often followed SNF or IRF care, the gray and green bars.

The previous slide examined pathways that began

with an acute care hospital stay.

Now, in this slide, we look at the beneficiaries who had any acute care hospital or post-acute care use and then count the number of transitions the beneficiary experiences. The chart shows the share of fee-for-service and MA pathways that include one, two, and three or more transitions, with fee-for-service in black and MA in orange. The first transition is the index stay which could be a hospital or post-acute care stay.

For example, the most common one transition sequence was an acute care hospital stay. The most common two transition sequence was an acute care hospital stay followed by home health care. The most common three transition sequence was hospital to SNF to home health.

We found that fee-for-service Medicare enrollees were more likely to have pathways with three or more transitions when compared to MA enrollees. MA enrollees were more likely to have two or fewer transitions. In addition, we found that the majority of pathways with three or more transitions belong to fee-for-service enrollees, which is not shown on this chart.

We also found a similar pattern when examining

utilization days within a pathway. Fee-for-service enrollees were more likely to have pathways with more than 30 days compared to MA enrollees. MA enrollees were likely to have pathways with 14 or fewer days.

Again, the number of utilization days in the pathway does not necessarily reflect the appropriateness of care. Not shown is the median number of utilization days for fee-for-service pathways, which was eight days, compared to a median of seven days for MA enrollees. However, fee-for-service enrollees had a much longer tail. The 90th percentile of utilization days for MA enrollees was 35 days but was 44 days for fee-for-service enrollees.

To summarize, we remind everyone that these preliminary results have not been adjusted for differences between the beneficiaries in fee-for-service and MA and must be interpreted cautiously. Levels of use reflect practice patterns in 2023 and do not necessarily indicate whether the care was appropriate.

With those caveats, our key takeaways are that MA enrollees with slightly less acute and post-acute care were less likely to receive PAC after hospitalization and were much less likely to receive IRF care.

Fee-for-service care pathways were more likely to have multiple settings and to last longer.

In the spring, we plan to present results that have been adjusted for differences in patient characteristics and to conduct additional analyses. These could include examination of PAC for subgroups of beneficiaries such as those who switched from MA to fee-for-service or vice versa from fee-for-service to MA. We could also look at the quality ratings of the providers used by MA and fee-for-service beneficiaries. We will also continue to conduct interviews with PAC providers and MA plan representatives.

We are happy to answer questions about the work presented and the additional analyses that we may conduct. We look forward to Commissioner feedback.

With that, we turn it back to Amol.

DR. NAVATHE: Carol, Betty, Brian, thank you so much for an excellent presentation. A lot of data in there, and I think also I appreciate your appropriate caution about both interpretation and assessments around appropriateness or the right levels of care, in a sense.

So we'll turn it over to the queue.

Commissioners, I just wanted to remind you again, I think Betty, Brian, and Carol already did this, but just be careful in interpreting. This is descriptive, unadjusted data. For any differences in characteristics in the plans, that will be coming in the spring. Dana?

MS. KELLEY: I have Tamara first in Round 1.

DR. KONETZKA: Thank you so much for this work. Not surprisingly, I'm really excited about this stream of research.

A couple of quick questions. I was a little bit confused in Figure 2 about the high rate of IRF use among surgical conditions in fee-for-service. I know this isn't exactly the same, but when we think of IRF use we think mostly of stroke patients or stroke, and hip fracture, which can be surgical or not, being like the most common condition. So I was a little surprised to see that the rates were so much higher among surgical conditions rather than medical conditions, because stroke is in the medical conditions, right? Do you have any thoughts about reconciling that?

DR. FOUT: That's a good observation. I can check the conditions of the IRF use following the surgical

versus medical. We didn't dig that deep right now, but that's a good point.

DR. KONETZKA: Great. Yeah, probably return to that a little bit.

Other question. In the qualitative work, which is really important so I'm glad you're doing that, but I guess you mentioned in your remarks that it's very common for MA plans to waive the three-day hospital stay rule that fee-for-service imposes. What about other aspects of the payment structure? You mentioned that MA plans are allowed, for example, to charge per visit for home health instead of doing the 30-day episodes. I imagine they have other flexibilities as well. Did you get a sense of how often those kinds of things happen, where they change the payment structure, and especially the per visit charges for home health, and did you come across, in your interviews, any instances where MA plans stopped paying SNFs per diem, for example, like some of these major differences among the sites. Did any of them just do a per stay payment, for example?

DR. CARTER: So we're just in the middle of doing that work so I don't want to get ahead of ourselves. What

we've learned so far is that MA plans use a mix of payment strategies. Some use per visit. Some use per stay. They have different cost sharing rules. Some don't apply cost sharing for home health. Some don't apply prior authorization for home health. So the prior authorization rules varied across plans.

But I think I want to wait, because we really are in the middle of doing these interview, but thanks for the question. We will report on this in the spring.

MR. KLEIN-QIU: Also, I'd like to clarify that we did not characterize MA plans waiving the three-day admission as very common, but we didn't want to imply that there was the majority of MA plans that did this.

MR. MASI: I think next up for Round 1 is Danielle.

DR. PIEROTTI: Wow, and thank you. This is very deep and meaningful, and I'm going to try and stay just on Round 1 right now. But from a strict paperwork perspective, the chart at the beginning of Table 1 that defines the different services, I need to ask that the home health definition include the maintenance and restorative aspects of the original registration. It's a very

important distinction between home health and the other settings of care.

I also got confused. The very last reference on page 40 refers to beneficiary characteristics, such as those listed in Table 3. I'm not entirely sure which Table 3 that was. I went back to Table 3 in the text, and it's encounter data, not beneficiary characteristics. I just think there's a reference that's not aligned on that one.

And then in Appendix B, with the data around stay construction, would it be possible to add date in care to these charts? This is the chart that shows beneficiaries and claims per encounter and claims encountered per use. I'm wondering if it can also include days under care in these charts.

DR. FOUT: There is a figure with the days under care in a year that is following the use rate one, Figure 1, page 27.

DR. PIEROTTI: Yeah. I just really liked these ones, where it was very, very clear in showing the claims and the encounters per user, and I'd just love to see the days --

DR. FOUT: Oh, I see what you're saying, yeah.

Yeah, we can do that.

DR. PIEROTTI: Thank you. I think that's it for Round 1. Thank you so much.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks so much for this work and I'm really happy that we're pulling together a lot of the post-acute care ideas.

First of all, on page 9 it says this: "Relative to fee-for-service, Medicare Advantage total cost sharing for beneficiaries is typically lower." And I know I've read that through the years, and I just have a hard time with it, especially for people who use lots of services and are very sick. If you have a Medigap and you're younger, you're not in your 80s but you're 65 to 75, because the maximum out-of-pocket for many Medicare Advantage plans is much higher than what a Medigap policy would be.

So my main question here is does that that statement that's made often by the MedPAC include the copays and the coinsurance that people pay with Medicare Advantage? As an example, every day in the hospital, on average, say, is 350 days for somebody with a Medicare Advantage plan. Does it include not just the premiums but

the cost sharing for the individual? And it may be typically lower because not everybody uses a lot of services, but I'm just curious.

DR. CARTER: I'll get back to you on that. I'm not sure. I would have thought so but I'm not sure.

MS. UPCHURCH: Yeah. I think we might need to caveat that. People who use a lot of services would pay a lot more if they're in Medicare Advantage, even though there's a max out-of-pocket.

DR. CARTER: Yeah.

MS. UPCHURCH: Thank you. And then a little bit later on that page it says: "The Commission has long expressed concerns over fee-for-service to increase volume that may encourage unnecessary care." Do we have a sense that there is a lot of unnecessary post-acute care being used out there? My family was fighting and screaming to go to any post-acute care after the hospital, so I'm just having a hard time believing that we think that post-acute care may be in that.

DR. CARTER: Yes.

MS. UPCHURCH: We do? Okay. Is it mainly home health?

DR. CARTER: No.

MS. UPCHURCH: Oh wow. Okay. See, you learn something new every day. Okay. Well, all right.

And then on page 14 we get to learn something else new. It talks about, on page 14 of our reading, it says, "SNF interviewees also noted the lack of bad debt policies for Medicare Advantage plans lowered the revenues for Medicare Advantage plans." Can you explain that? I just don't understand that.

DR. FOUT: Fee-for-service will pay a portion of the bad debt, 65 percent, for fee-for-service patients, and we don't know whether MA pays that. Some of the providers we talked to said that they did not pay that portion of the bad debt if the patient did not pay it.

MS. UPCHURCH: That's so interesting. Wow, okay. Because it says you don't know, and for Medicare Advantage there is a daily rate. Sometimes even Day 1 to 20 there's this fall rate. Usually it's zero. But then it goes to like fee-for-service where you have this daily rate and they're often the same as fee-for-service. Okay. Thank you.

And the last question in Round 1, this is just a

general question. I'm a big fan of the CAPABLE Model out of Johns Hopkins. When somebody is post-acute care they get a nurse in there, occupational therapy, to check out things, and a pot of money to make sure that they can make modifications to their homes to remain in their home. I'm just wondering if we think some Medicare Advantage plans -- and I'm talking very favorably about Medicare Advantage plans here -- they make home health care more possible because they do things like support the CAPABLE Model. I'm wondering if you're seeing anything like that, so that not using institutional care, using more in the home, is a potentially positive thing, because of the leniency they have.

DR. CARTER: I can see what you're saying and it's possible. But we have not heard that. We have heard things like MA plans might do a better job of ordering supplies that a beneficiary might need a home. But we haven't heard about perhaps the expansion of home care, if you know what I mean --

MS. UPCHURCH: Yes.

DR. CARTER: -- which could be more personal services as opposed to medical services. We have not heard

that in the interviews so far.

MS. UPCHURCH: Great, thanks. I was talking to a physical therapist who works with a lot of Parkinson's patients, and she said that she often tends to prefer Medicare Advantage because they do allow for a lot of flexibility with getting people things they need. So I just think we need to pay attention to that too.

Thanks so much for this great work.

MS. KELLEY: Okay. That's all I have for Round 1, unless I've missed anyone. And not seeing any hands I'll go to Round 2. Tamara is first.

DR. KONETZKA: Okay. First, just to express again my enthusiasm for this. I think that there are a couple of really exciting aspects of this body of work. One is the MA versus TM or fee-for-service comparison, which is really critical. I think so many of the sort of controversial questions, arguments about MA right now are focusing on post-acute care and access to post-acute care.

And I really appreciate how careful you were in the chapter, because I think it's so easy to think, oh my, these rates are so different. MA must be sort of skimping on care and not getting people the post-acute care that

they need. And indeed, there are lots of anecdotes out there about that.

At the same time, we have this situation where we do our payment chapters every year, and we realize the margins in fee-for-service post-acute care are incredibly high. And not only MA but every single alternative payment model out there is seeing post-acute care as a way to sort of gain efficiencies and reduce costs.

So I think that, on the one hand, it may be a huge opportunity to use these as an experiment, to try to get closer to figuring out which one of those stories is true. Like are we reducing access or are we identifying a place where we can finally solve this problem of probably overpaying in fee-for-service for a service that may not be needed. So I think the MA versus fee-for-service comparison here is just really exciting.

The other thing is I think more generally it's very exciting to look at all of these post-acute care settings together, because as is obvious from this work, they are related. People who don't go to IRF might go to SNF, et cetera. So in our payment chapters, when we just look at each sector separately, it's really limiting. Even

in the MA to fee-for-service comparison, which is very exciting, I don't want to lose sight of the fact that it's also exciting just to look at these across these sites and hopefully try to move toward sort of better answers about effectiveness and value that we're getting for that care.

I also really appreciated in the chapter that you looked at not only sort of conditional and discharge from the hospital but also the unconditional use of these sites, for two reasons. One, not all, as Danielle pointed out, not all types of this care, home health in particular, requires a hospitalization. MA doesn't always require a hospitalization even for SNF care.

And the other part of looking at it unconditional is that we know that hospitalization rates are different between MA and fee-for-service. So looking at that unconditionally as well as condition on a hospital discharge is really important, so I'm very glad you did that, and looking at the pathways.

So first of all, a couple of findings that I find really striking, that I hope we can do a deeper dive on. First of all, we've sort of discussed this before, maybe at the retreat we did, but the difference in hospital length

of stay is super important and super interesting. So seven days for MA versus 6 for fee-for-service for people going to post-acute care, that's a huge difference for hospitals. One extra day in the hospital is huge in terms of hospital finances, et cetera.

And it's important in itself because it may just be a function of MA plans and payment. As Gina was pointing out, MA beneficiaries often pay a large copay for every day in the hospital, but the MA plans are paying the hospitals per stay, so it really doesn't hurt the MA plans to have people stay in the hospital longer, right. So I think that's important in and of itself.

It's also important because it adds to the hard selection issues that we face in looking at outcomes from post-acute care. Because if you're in the hospital for an extra day or two, you may arrive to post-acute care in a healthier state, I would guess mostly in a healthier state because you've had more time in a hospital to recover already. So that just complicates some of the analysis.

So I think it's really important to keep looking at the hospital length of stay as part of this, and I'm so glad you included that.

Another thing that was really striking that you pointed out in your comments with the difference in SNF length of stay. So 20 days in MA versus 33 days in fee-for-service, unadjusted, of course, with that caveat. But that is just really huge, so I think that's an important margin to keep looking at. We don't want to look at any of these sites as sort of binary, did they use it or not. I think the length of stay piece is really critical to keep in the analysis.

Another thing that I found striking is in Table 7 the unconditional rates of PAC use among people in long-term care institutions was 45 percent in fee-for-service and 36 percent in MA. Those are just really high rates of use. And these are very sick people. They're in institutions and they're very sick people, so maybe that's okay. But I think it gets at this sort of side issue of among the sort of frailest individuals in the Medicare program what is this rehab really doing for them? Is this a good thing? And it may well be, because it helps them maintain function, et cetera.

It also could be, as one of my geriatrician collaborators refers to it, maybe we're just rehabbing

people to death because we don't know what else to do when somebody with so many issues gets discharged from the hospital. It's like, okay, put them in rehab. So I think that would be an interesting side issue to explore, but maybe it's not so central here. I'd love to look at that when we look at the institutionalized population in that stream of work and in I-SNPs, and not just look at rehospitalizations but look at their rates of use of post-acute care, as well.

Okay. So those are the things I just felt really striking and I hope we can do a deeper dive on. I have a couple of more specific suggestions.

One thing, it kind of was in there in bits and pieces, but I think it would be good to have a really clear layout of the different payment-related incentive space by PAC providers, including the different payment structures for each type of PAC.

Table 1 kind of went through the different eligibility requirements for each PAC site for fee-for-service and the beneficiary cost sharing associated with that, but I'd also love to see what are the provider incentives. It's very different, and it may be very

consistent with the story of utilization that we're seeing, very different when SNFs are paid per diem, IRFs and LTCHs are paid per episode or per stay, et cetera. And that also leads into sort of what we might be able to learn from MA.

For MA, if possible, in the continued qualitative interviews, I would love to see more detailed questions about whether and how often they deviate from the structure of the fee-for-service payment. Because I think that we really want to learn how MA plans are paying these different providers and whether that's consistent with the patterns that we're seeing and may provide the explanation for some of the differences. So things like if there are plans that choose to pay SNFs on a per-stay rate. I don't know if that ever happens, but something like that would be really fascinating.

And I think that's also in the spirit of site neutral. We kind of gave up for now because it's challenging to do these comparisons. We kind of gave up on trying to impose site neutrality across PAC sites. But part of the differences is that these places are paid in such a different way. So if we can see whether it works to sort of harmonize some of those payment mechanisms that

would be very helpful, sort of learning from the MA experiment.

Another thing I'd love to see is as you move forward with the adjusted analysis I think it might be necessary to stratify everything by duals and non-duals. Duals face very different cost sharing and they may have different utilization patterns. In my own team's research we found that having access to Medicaid home and community-based services under Medicaid really changes how beneficiaries use PACs. They tend to use fewer facility-based services, and if they do go to a SNF they have a shorter length of stay. So I think they're really just sort of a different group in a sense. There are sort of different provider incentives involved in that too.

The community-admitted home health comparison, we've talked about this before. I really love that topic, but it seems really sparse here compared to what we've done in previous home health chapters. So maybe it just needs to be expanded there. I don't want to lose that, but it seems a little peripheral here.

And so just to end on sort of the bigger picture, what I'm really most enthusiastic about pursuing, given

your options you listed at the end of the chapter, I think, to me, to put these options in perspective, I go back to what are the big questions in this sector and what are the overarching goals.

So it comes back to what I was saying at the beginning. We actually pay a lot for post-acute care in fee-for-service. We don't have a good sense of the value we're getting for that care, so it's very hard to address it and try to move toward more appropriate utilization. Because it's hard to do and the evidence is really murky. So any analysis we can do that sort of moves us in that direction to me should be sort of first order priority.

And then the second overarching question is related to that. Are there things that we can do along the way that help us move toward site neutral payment? When I say that I mean 5 years from now or 10 years from now, very much thinking this is going to take a long time, but it would be nice to start moving in that direction again.

And then the third overarching question is the very related question of the MA versus fee-for-service comparison. I think we really need to get at is MA reducing unnecessary utilization or are there access

problems that we need to address.

So in that spirit, the things I'm most enthusiastic about are, one, of course, moving ahead with the adjusted analyses for all of these. I guess specifically my suggestion would be to look at this carefully by condition, because sort of just adjusting for condition or adjusting for some things, as we know, is probably not going to be completely sufficient. So a few stratifications or looking within subgroups might be helpful, for maybe the most common conditions in PAC. Messy, but I think helpful.

After we start looking at adjustment I'd love to go down the road of looking at some outcomes, at rehospitalizations. And if we can, I know there are big data limitations, looking at function.

And then third, your suggestion of looking at removing the three-day hospital stay requirement or comparing how that works in the MA plans that do it. I think it's very useful. I always thought that was a weird, distortionary policy. I think we all have heard stories about how people sometimes get sent to an IRF because they don't have to have the three-day stay. I mean, it's a not-

great policy, and this presents an experiment to see whether relaxing that requirement and therefore sort of harmonizing payment structures a little bit more across these sites is actually effective.

So that leaves a few things that I'm a little bit less enthusiastic about. The quality part of it, even though I think I suggested that in previous meetings, it feels a little bit more second order here, partly because some literature has come out on it. So do MA beneficiaries go to lower-quality SNFs, for example? I'm doing ongoing work on that, as well. But that feels less first order here.

And then looking at switchers. It's just so fraught with endogeneity and will be so hard to do that I would also table that for a little bit.

So, overall, of course, super excited. I think that there is a long roadmap here for a lot of really useful things we can do to get at some of these big picture questions. Thanks.

MS. KELLEY: Stacie.

DR. DUSETZINA: Great. Yeah, thank you so much for this excellent work.

I'm also really excited about this work stream. I'm really glad to hear the good news. The encounter data seems like it's looking pretty solid here. That's something that I think we all like to hear.

A couple of just comments. I really appreciated the background, and Table 1 was super helpful. I agree with Tamara that having a little bit more detail about provider incentives would be good there, but it brings up a lot of questions for me like, okay, that's a high copayment. Why are these days different? How many days you get to spend before you get hit with these copayments? And then why on earth isn't there a copayment for any home health? It's a nice reminder to people about how strange the system is if you're a beneficiary, so I think it's really helpful.

I also think it was great to highlight the OIG study results about denials. Those are really concerning and especially the extent to which those appeals are overturned. So I think it's helpful for the contextual information.

I love that you're doing interviews, and one of the things that I wanted to maybe put in a special request

about is thinking about people who need high-cost services, especially thinking about -- we're doing some work around people using Part B drugs that are quite expensive and finding that there are differences in post-acute care setting where people go, and I think that that could be payment-related or concerns about having to pay for expensive drugs.

So I would just put a plug in for, as Tamara said, as you're digging into analysis, even, thinking about not just condition but -- or conditions and high drug use before the need for post-acute care services might provide some new insights about where -- you know, maybe it's not the payer that's making the decision about where you're going, but the site of care where you're trying to go deciding whether or not you can come there.

I did also have a tiny suggestion for Table 2 where you're showing the reduction of people with your inclusion/exclusion criteria, and just could you add the percentage lost in each group? I kept trying to do the math, and I was like, that would just be a nice little help.

Let's see. So the other two things, for Figure

4, I think it's great. I also really appreciated the inclusion of the No PAC group in that figure, and then combined with the number of days that it took to overturn appeals that you were reporting right there from the OIG, I kept wondering like, where are you when you're waiting for that appeal? Do people stay in the hospital while they're waiting for that appeal?

And then you mentioned this issue of being able to go from the community to PAC, and so I was like, okay, I just felt like I wasn't able to quite put those pieces together, and I think it would be helpful to just let people know.

So I kept thinking, okay, well, if I'm fee-for-service and I'm appealing the decision, and I got discharged would I still qualify? Like, is there sort of a window of time issue for me being able to qualify to go still?

And then the last just kind of small thing is for Figure 5. I had a hard time kind of thinking about the denominator that was there. This is the one that shows the share of community-admitted PAC stays for fee-for-service and MA and just breaks those up, and I think my impression

is that's a pretty small percentage of the overall group. But that might just be helpful somewhere to note, because I kept thinking, oh, that seems like a high percentage. But you're just showing us within that particular small subgroup.

Excellent work. I'm really excited to see this move forward, and thank you all for being so excellent.

MS. KELLEY: I have a comment from Scott Sarran. He says, kudos to the team for another well-thought through body of work.

Scott agrees with the suggested additional analyses and would only add to that a suggestion of including hospital discharge planners in the interviews. His bet is those interviews will help drive a recommendation to look critically at the end-to-end processes around approvals, denials, and appeals of denials of PAC by MA plans.

He'd also like to see us incorporate in the chapter a comment around how the lack of a valid and robust methodology for evaluating functional status and outcomes across all acute and post-acute settings hinders our ability to draw the needed conclusions and make

recommendations.

And then, also, regarding the high rate of post-acute care, especially SNF care, among the institutionalized long-term care beneficiary population, Scott agrees with Tamara that the issue likely reflects a mix of appropriate as well as unnecessary and preventable care, for example, by avoiding ambulatory care sensitive-hospital admits, and should be part of our continued work on that population.

And the next person in the queue is Cheryl.

DR. DAMBERG: Thank you.

Great work, you guys. And I also am very enthusiastic about this work and definitely support the direction that you've outlined in the chapter.

I also recognize the complexity of doing this work and trying to tease out some of what Tamara spotlighted in terms of are we getting more efficient, appropriate use of services versus there's potentially underutilization happening.

I want to plus-one on Tamara's comment on stratifying by duals and non-duals. I think that would be important to do as well as looking by condition.

And I also want to plus-one on Stacie's comment about what's happening to people who are waiting for the appeals process, like where are they sitting.

The other thing that I wanted to reflect on is I really liked the pathway analysis that you laid out and comparing the sequence of post-acute care events. And not to add complexity to this, but it made me think about applying state sequence analysis methods to develop clusters of different PAC sequences and then potentially exploring the association between these different pathways and outcomes, perhaps focused on selected conditions to see if there are differences and obviously all of that suggesting for differences in case mix and other factors, because ideally what we want to understand is the relationship between different patterns of PAC use and outcomes, whether that's emergency room visits, rehospitalizations.

In terms of the plan to conduct interviews, I very much support those interviews with PAC providers. However, I think it would be helpful to conduct interviews with beneficiaries or their family members who sought to obtain post-acute care, particularly SNF care and what

happened to them. And this sort of relates to this comment Stacie made about what happens when they were denied care. Was it not approved? What was that timeline for approval?

And I don't know if there's anything you can add to the chapter, if there's like a standard process that Medicare Advantage plans have to follow, but my understanding, sort of rough understanding, is that the beneficiary has to file the appeal pretty quickly upon the denial. I think it's something like 48 hours. But then the plan can take several weeks to get back to that person in terms of whether that care is now approved.

So there's a fair amount of time that's going on between that denial and the person possibly getting access to care, and trying to understand what's happening in that space I think would be helpful and, relatedly, as you're having those conversations, what additional burden that places on families and caregivers, to the extent that that's possible.

I also support the comment about including discharge planners as a source of information. They really are at the intersection between the request for some type of post-acute care and sort of playing out the process in

terms of working with the health plans on appropriateness and placement.

In terms of the quality analyses, I was interested in -- and maybe this is work that you've done previously, and I'm just not remembering it -- in terms of the providers who are in these MA networks and what the overall quality is of the providers that they're working with.

I think as you go down the path of looking at MA plan characteristics, it would be also interesting to think about whether any of these organizations are vertically integrated to the extent that you know that, recognizing that also can be a hard space to really get good information on.

And then the differences -- so I recognize these are not adjusted results, but the differences in the two population characteristics made me wonder about factors contributing to the difference, and to some extent, this is like people's ability to advocate. So higher-income folks tend to be better at working the process versus lower-income patients and whether Medigap is paving the way for greater use. And, again, I note that information on

Medigap coverage is a little less than optimal, but it would be interesting to the extent we have any information on that.

Thank you.

MS. KELLEY: Brian.

DR. MILLER: Okay. Four major comments.

First is, for those listening, definitely be cautious about over-interpreting our data. The staff did a great job. I know that there's more to come.

Highlighting a few things in here, just so folks listening are aware that we still are working on this, when I looked at the variance in fee-for-service versus MA, there was lower mortality at day 60, but not 30 or 90. Again, not a criticism. It's just I know that there's more adjustment to come. For the folks who had looked at the slide deck and for my fellow Commissioners, I wouldn't over-interpret the data.

Same for the MA population versus fee-for-service. We saw that in MA, 22 percent got their entitlement from disability versus 16 percent in fee-for-service. More dual eligible, more minority, but then there was a higher community admission rate in MA for home

health, but also for IRF, even though the overall IRF rate is lower. There's a lot of stuff, I think, in here that is interesting, but is going to be further parsed out. So I'm not really making any conclusions about one market or the other. I'd encourage others to also wait.

My second comment is that I think we need to add a clinical lens to PAC services in the chapter and also collectively for us. I'd encourage my colleagues not to view this as an intellectual, academic, analytical exercise. This is a policy and clinical issue with real-world implications.

Site-neutral, I don't think actually applies well here. So site-neutral as the principle is if you are delivering the same service for the same patient in different setting, you should be paid the same rate. That's HOPDs, physician, clinics, and that's a discussion we've had for 10-plus years.

The different PAC sites are delivering different services. You might have a patient who's had a stroke who ends up in one site versus the other in home health, but they are getting fundamentally different services. So I really don't think it's clinically a good idea to apply

site-neutral when you think about that. I think that in this chapter, we need to collectively, and also hopefully you all, add more clarity about what is being offered where.

When I think about it as a physician, it's like you can go to a skilled nursing facility, or a SNF. SNFs offer therapy modalities. They also -- you know, physical therapy, occupational therapy, speech-language pathology. We should say that explicitly because I don't think our readers probably know that. Or nursing care, nursing care could be like IV therapy, like you're getting IV antibiotics for osteomyelitis or bone infection. You could be getting IV nutrition. Skilled nursing facilities also offer custodial care. So that's sort of what a SNF can do.

Post-acute care is you go -- if you're in a SNF, it's subacute rehab. You are going to the SNF. You have a defined stay with a clear duration that occurs. You could be in the SNF general population, which is also a long-term care population. You could also be in the subacute rehab wing of a skilled nursing facility, depending on how the facility is run. So we should differentiate between SNF versus subacute rehab, and that's a payment

differentiation, then also types of services that you're getting.

Then from SNF to SAR to IRF, inpatient rehabilitation facility or acute rehab hospital, you're getting two therapy modalities. That's PTOT or speech, three hours a day, five days a week, with 24/7 nursing care, licensed as a hospital. A SNF is obviously not licensed as a hospital.

In an IRF, you get three visits per week from a PM&R, or physical med and rehabilitation physician, or a physiatrist. You get also emergency coverage. If something happens to you in a skilled nursing facility, you could end up getting transported to the hospital by an ambulance. So that's a totally different level of care.

This is not to impugn SNFs or say that IRFs are better, but I think that we need to clearly differentiate between the types of care that is delivered, the intensity of care, and the types of clinicians and services available in each of those settings.

Obviously, in home health, you don't have a physiatrist, right? You have a physical therapist, occupational therapist, or a nurse, and that is sporadic,

you know, short visits, 30, 60 minutes, a couple times a week.

And so I think the other thing that we need to emphasize in post-acute care is that this is the one sector of the Medicare program that's focused on functional status, right? So the goal is people want to go to church, do Tai Chi in the park, go to the food bank, hang out with their buddies and play poker, whatever it is. This is what post-acute care is helping to get people back to independence, community living, and restore as much function as possible. The rest of the Medicare program doesn't really focus on that as much. So I think that's a lens that we really need to add.

The third thing I wanted to say briefly is that I do think we need to strengthen oversight of MA in this space. We have network adequacy for SNFs. We don't have network adequacy for IRFs, which are licensed as hospitals. Do we not think that high-intensity rehabilitation is as important as skilled nursing care? That doesn't, policy-wise, make much sense for me.

And then the fourth comment is about sort of MA plan behavior, right? Lots of folks have expressed

concerns. We've seen anecdotes of the media.

I want to say one thing here, which is that if you're in an acute care hospital awaiting home health, subacute rehab, or an IRF, you're stuck waiting in the hospital until your PAC services are set up. This could be because you're waiting your MA plan authorization. It could also be, as a patient I had the other week, your plan authorized your services, but for whatever reason, your home health stuff doesn't get set up. So I had a patient who was stuck in the hospital one day because they're waiting the BiPAP machine, the next day because they're waiting nebulizer, and the third day, I don't even remember why they were still there. But the point is that that was not a plan authorization issue, but there are other times where you are awaiting a plan authorization issue.

And then the question is, is that wait for the plan authorization reasonable or unreasonable? Sometimes that could be reasonable, because maybe you just need another day of PT or occupational therapy in the hospital. Instead of having to go to subacute rehab, you go home with home health because you've gotten better. And I've seen that happen with patients.

There are other times where you're waiting to go to an IRF, and then again you get better and you improve and you go to a short subacute rehab stay, and you go home. So sometimes the plan's delay could be efficient, and other times it could also be inefficient. And it's, I think, really hard for us to measure that, and I think we should be humble about that.

One other thing is that for whatever reason, it seems like the MA plans have targeted the IRF sector because they're focused on cost as opposed to value. Sometimes you have high-cost, high-value services, just like we can have high-cost, high-value drugs, as we discussed yesterday. And so I think we should be cognizant of that, because again, this is the one sector that is focused on functional status.

So four, just my four points. One is, don't over-interpret the data. Two is, I think we need to have a strong clinical lens, and I don't think site-neutral applies here because it's different clinical services. Three, I think we need to strengthen oversight of MA in this space. And then four is some of that MA plan behavior might be good and some of it might be bad, and there are

trade-offs.

Thanks.

MS. KELLEY: Tamara, did you have something on this point?

DR. KONETZKA: Yeah, just one thing about the site-neutral. I mean, there's been a long-standing interest, I think, by the Commission and by policymakers in looking at site-neutral and potentially developing site-neutral policies for this sector, in part because you have so much clinical uncertainty about who really needs, especially in the IRF versus SNF.

so what you have is IRFs being paid more than acute-care hospitals. I mean, those rates are super high, and it's true, people who go there get more therapy. But the underlying dilemma is, do they actually need that? And so when you think about a person getting discharged from the hospital for a stroke or for other neurological conditions or a variety of things where people have this choice, the underlying question that we haven't answered is, do they really need that higher-intensity service in an IRF?

There are many markets that don't have IRFs, and

people go to SNFs, and they seem to do just fine. But I think because we have limitations in the functional data, as people have mentioned, and because there are selection issues we haven't solved, it's been hard to get to that point. But the underlying goal of making sure we're not spending that much money on people who don't need that level of care, whether you want to call it "site-neutral" or not, is really an important issue. It's not really clear. They do offer different services, but it's not really clear that people need that different level of services. So that's the main point, I think.

DR. MILLER: Yeah. I was going to say, as a clinician, I think that's wrong, that those assertions are wrong, and just because someone does well when they go to a SNF because there's no IRF available doesn't mean that they could have done better.

MS. KELLEY: Robert.

DR. CHERRY: Yes. First of all, I want to thank you for this work, and I realize it's preliminary, but I definitely appreciate all the effort and looking forward to what this looks like in the springtime.

I think one of the ways of, perhaps, you know,

reframing the whole site-neutrality piece is -- and this was alluded to in the draft write-up -- is, you know, do MAs actually practice active care management in order to reduce utilization through appropriate and clinical care, or are they primarily managing their costs through a preauthorization process? And that could be very difficult to really tease out.

One way of teasing it out, though, is to look on the acute care hospital side to see if prior to obtaining post-acute care services were there are avoidable days, excess bed days, denial of acute care services towards the end of a hospital stay, because that may represent some delays on the MA's part in order to manage those costs more effectively, but then it's a cost shifting to the hospitals.

That data, though, may not be readily available through your traditional CMS databases, but internally, acute care hospitals do have that data.

So, when you're doing your structured interviews, you may want to inquire about the preauthorization process, have hospitals been experiencing any types of delays, and they may define it differently. They may define it by

avoidable days or excess bed days or through the denial process, and then eventually the patient gets in. That could be reflective of what perhaps is going on in terms of replacing these patients appropriately.

The limitation on that approach is that as you structure your interviews, there's going to be a wide variety of access to care issues based on the location, but at least asking the question may be able to provide some qualitative analysis regarding the appropriateness of placing patients in post-acute care settings and whether they do need rehab or whether they need outpatient physical therapy services, depending on the clinical situation.

Like many others, I'm somewhat cautious about interpreting preliminary data and utilization rates without adjusting for the characteristics between the fee-for-service and MA populations, especially when you look at, you know, fee-for-service having a higher post-acute care utilization rate, yet shorter length of stays in SNFs and rehab as well as home health.

One thing that might be helpful, too, is, you know, collecting cost data as you look at this, because as you apply your risk adjustment models, there may be some

equivalency there to kind of balance out the increased utilization versus the decreased length of stay. Hard to know, but definitely worth looking at.

And I'm sure as you're looking at clinical outcomes data, I guess I'll just, you know, state the obvious, you know, to look at ED visits, readmissions, and 30-day risk-adjusted mortality.

Otherwise, really fascinating work and looking forward to further discussion on this. Thank you.

MS. KELLEY: Danielle.

DR. PIEROTTI: There is a lot here, and I think where I really want to start is to get a slightly different lens on this discussion of site neutrality and, frankly, even the phrase "post-acute care."

It is very, very, very important to recognize the differences in these four settings, and I will explicitly call out home health as a unique and different service.

SNF, IRF, and long-term care have a primary goal of discharging someone to home to avoid long-term custodial care. Home health has a primary goal of helping you stay at home.

In the first three, there is a restorative focus

on a particular issue with awareness of other conditions. Home health is about the collectiveness of everything that the person is existing with.

The average home health recipient has five primary comorbidities. Most of those people, the vast majority of them, include a diagnosis of diabetes, heart failure, renal failure, and some version of cognitive decline as four of the five. That makes these people very complicated and very fragile.

When we talk about the adjusting of the data to control for certain things, I'm going to encourage that that goes in both directions, because if we're only controlling for the human variables to determine the policy or the payment implications, we're missing the alternative, which could be that people are choosing fee-for-service because they need something different. And those differences of the frailty, the comorbidities, and the need for things at home makes home health uniquely different than other locations.

The other thing that makes home health uniquely different -- and I will advocate is critical to MedPAC -- is that we remember the actual legislative definition of

care in the home explicitly includes care that maintains function to prevent or slow decline or deterioration. This is both in the actual legislation and was reaffirmed by the Supreme Court in the Jimmo v. Sebelius settlement of 2013. Home health is not supposed to be exclusive to restorative function. It must include the capacity to support people to stay in their home, and this shows up in the data.

When we look at the length of stay and the types of medical versus surgical conditions that drive people into one of these settings or another or the pathways that people are going from SNF or IRF to home with home health, that's the design.

We've had a lot of billing focus and billing review in home health that is pushing the service to not provide the maintenance aspect of care. That's why Jimmo went to the Supreme Court in the first place.

We had a comment from a fellow Commissioner about including some clinical aspects of this sorts of care. Home health might only be once a week, but in that once-a-week visit, the nurse is doing a medication management function that allows someone to safely take the pharmaceutical cascade where the average patient in home is

over 20 pills a day. That's incredibly difficult when you have a cognitive decline.

Home health may be a once-a-day visit from an aide who is helping someone get out of bed so that their caregiver can continue to go to work and then help them in the evening when they get home. That keeps the caregiver in the workforce and the person at home and not in an institution.

Home health may be two to three times a week to help someone take a shower so that the caregiver caring for someone with an extreme Alzheimer's can have an hour of relief three times a week and actually be able to maintain themselves as the caregiver in the home.

These are unique caregiving patterns that are only in the home health benefit, and when we try and merge home health as an equivalency to SNF, IRF, and long-term care, we are completely ignoring the underlying critical aspect and uniqueness of the original legislation and the design of this benefit to start from.

I greatly appreciate that this work is being done. I am incredibly stunned by the delightful data around the length of stay in the hospitals. This may or

may not be good or bad behavior on the part of the payer. I'm honestly not as worried about that.

What I would really like to know is, do we actually have some data about what is a more healthy and value-driven length of stay in a hospital? As an accidental outcome, maybe we just finally realized what, honestly, nurses have been saying for a very long time: We're discharging too quickly. That piece of data, more than being controlled for and equivalent to being understood for the whys and the hows of the payment, also deserves to be understood in the greater context of the quality and the patient outcome.

If an extra two days in the hospital makes a patient safer to be at home without needing to go to another institutional-based level of care, let's do some analysis on the overall cost implications of that decision, because if two days in the hospital saves two weeks in an IRF or a long-term care, we may have had a very significant breakthrough in the understanding of care trajectories and healing time.

This data, this assessment has huge opportunities to help people understand the implications of their choices

and understand how we can actually support people for greater health, not just for greater payment. The payment is an outcome of what care we are supposed to be providing. If we don't understand the full care, then we can't understand the use of the payment.

I really hope that all of this data and all of the future analysis of this data and the choices for the statistical adjustments and how we interpret this information can include the unique differences of these settings of care, particularly home health. Even in the categorization of the medical versus the surgical reason for care, medical patients are very complex and tend to be frail, particularly when we are talking about the 80- and 85-year-old-plus set. The comorbidities are a significant component of care in the home. They don't show up as much in the other settings of care.

Until you go to someone's home and sit in the chair that they spend 10 hours in and then slide your hand between the cushions and find two bottles of pills sitting there, medication management and reconciliation is kind of a joke. This is what happens in the home, and it is different than every other setting of care where the

environment can control things like that. Please remember the difference.

Thank you so much for this work. I do appreciate the intensity of the data. I just really want us to think more broadly about how we could possibly interpret and understand what's happening in these cases, particularly when we look at care in the home. Just because the visit only happened once every two weeks does not mean it was inefficient or inappropriate or excessive care. It could mean that it is entirely perfect level of care to help someone stay home without popping back into ERs, without needing the fire department to come pick them up off the floor every other day, and without needing them to relocate to institutionalized living.

Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks for this excellent work, and I love being on the MedPAC because you have so many different perspectives. And, Danielle, we appreciate yours.

The thing that I would add, one of the most disappointing things about being on the MedPAC is you

realize that we're talking about Medicare here, and Medicare unfortunately does not cover long-term care services and supports. It's the Older Americans Act and home- and community-based block grants. So a lot of the stuff that we would want for people and improving their health to support care in the home, it's not a Medicare issue.

It's shocking to people when they hit Medicare age. So for those of you who don't know, I'm with the SHIP program, so we do Medicare counseling. And people are pretty floored when they hit Medicare and realize what it doesn't cover, and a lot of it's the things you were just referring to. But I just want to remind us of that. We need a big red flashing light that Medicare does not cover long-term care services and supports in the home. It supports improving, maintaining, or compensating for lost care for a short period of time.

Okay. I just want to say a couple of things. Staying in the hospital, again, for people with Medicare Advantage, I just want to make the point, while it may be good for the insurance company, for the individual paying that daily rate, it can be a huge disadvantage. So I just

want to make that point when they're staying in the hospital longer.

At Table 1, you mentioned a SNF stay can be 100 days. I want us to add the words, two words, "up to" 100 days, because one of the things we get the biggest complaint about is people thinking I had 100 days in the skilled facility, whether it's through Medicare Advantage or fee-for-service, and then after, you know, day 20, you're getting lots of tests, and they're saying, oh, you need to go. So just add the words "up to" and make it clear that it's not always up to 100 days.

Page 8, let me just read something real fast here. On page 8, it says unlike fee-for-service, Medicare Advantage plans actively manage the use of acute care in two ways. First, plans contract with network of providers that restrict where beneficiaries can get their care, though some plans cover non-emergent care from out-of-network providers for additional out-of-pocket expenses to the beneficiary.

So we do SHIP Medicare counseling. There is no way we know that ahead of time for people trying to help them navigate. You know, I know I'm getting ready to have

a hip replacement; I'm going to need rehab. I can't go on the Plan Finder tool to figure out which insurance company is going to allow and match with this place you want to go for rehab.

We thought the Plan Finder -- it has improved, by the way. The Plan Finder, now you can look up nurse practitioners and PAs, not just physicians, in terms of networking, but you cannot easily find what insurance company is connected to what skilled nursing facility or for who. So we need to improve that to help the consumer. The Medicare Plan Finder, again, has improved, but it doesn't have the network and what providers.

I think we decided -- and this is to build off Cheryl's point. I think we realized that CAHPS survey does not include skilled nursing facilities. Is that right? Okay. Yes. So it's even more important, you know, that we look into that, but I just want to also go back on record as saying I think that CAHPS survey should include skilled nursing facilities and family members that are using rehab services there.

And then, also, just to clarify a point that Cheryl -- just to put an exclamation on it, I want to

clarify the default when people are waiting on appeal for Medicare Advantage replacement or even fee-for-service placement. Who's responsible while the person is waiting? Or, even more important, when they're in the skilled nursing facility and they say time is up and you're in Medicare Advantage, but you are waiting to hear back, is the default that the insurance company is covering because it's within that 100 days, or is the default -- I think a lot of SNFs make you sign something saying you'll pay if, you know, the decision is against you. We need to make sure that default clearly, you know, determines who will pay for that. And I hope it's the plan. If they're taking a long time to make that decision, yeah.

Okay. Thanks so much for this great work.

MR. MASI: Dana, can I jump in just for one quick moment?

And we weren't sure there was going to be a lot of interest in this session. I wanted to say thank you for this spirited conversation.

And just for the folks at home, at this time, the session is very much focused on, like, the initial descriptive analysis, trying to lay the groundwork of where

some analytics may go during the course of this year, and we appreciate that this can trigger a lot of really important policy questions. But, at this moment, the Commission is not contemplating changes in site-neutral or coverage policy. Those are certainly important things to have in mind as we go about this work, but just wanted to set that for our audience at home.

Now I'll get out of the way.

MS. KELLEY: Kenny.

MR. KAN: Carol, Betty, and Brian, outstanding preliminary PAC use analysis reflecting unadjusted risk profile characteristics of fee-for-service and MA benes.

I hope that the future spring analysis can help answer the following question. How much of the longer multi-setting fee-for-service pathway reflects clinically valuable rehab versus fragmentation created by fee-for-service payment incentives? And, conversely, how much of MA's shorter pathway reflects better care management versus restrictions on access?

Ideally, the next analysis would compare both risk-adjusted MA and fee-for-service total episode days, total span, functional outcomes, readmissions, mortality,

et cetera, rather than treating lower PAC utilization itself as evidence of greater efficiency.

Thanks for an outstanding initial analysis, and I look forward to next spring's version.

MS. KELLEY: Paul.

DR. CASALE: Yeah, adding my thanks for a very interesting chapter, a lot of data, and I'm just going to comment really on just one area.

There's so much data, and there's been a lot of great comments, but particularly on the length of stay of SNF, in SNF for fee-for-service versus MA, the 33 days versus 20. Having helped to lead the post-acute strategy for my hospital for a number of years, it was always remarkable. There were certain SNFs that always the length of stay was 30 days, whether -- it was always hard to know if it was needed or not. And then others were varied, and then we developed a communication process with some of them, and it was really more around to try to prevent ED visits back and hospitalizations, but raise the awareness around how consistently.

So, as you pointed out, some of the difference may be benefit design, which I think is part of it, or it

could be differences in patient complexity. And I think, as Robert pointed out, trying to get at that complexity difference would be -- if possible, would be helpful. I don't want to -- I think that would be good, and I think some of the interviews might be helpful also to tease out some of this difference. But I still think the benefit design is one of the -- at least in my experience, one of the main drivers of that difference.

And then I also wanted to underscore that data on transitions, which I think is really interesting. And I think, again, particularly around return to ED, hospitalizations, mortality, the quality pieces, I think we can learn a lot around that going forward, because I think it's hard to get at that data if you have ways of doing that.

So, again, great data. I really think this is an important chapter and appreciate the ongoing work.

MS. KELLEY: I have a comment from Josh Liao. Josh appreciates these findings while recognizing that they should be interpreted as potential signals at this stage. Within those limits, he believes that it's reasonable to contemplate whether MA and fee-for-service beneficiaries

experience meaningfully different courses of post-acute care.

If the patterns reported here persist after adjustment, the story wouldn't be simply one of lower utilization in one program, but one of layered differences in whether PAC is used, where it is delivered, how long it continues, and how certain types of care may be concentrated among certain beneficiary subgroups. There are plausible signals, each of which has clinical distinctions, to be worked through.

More broadly, as other Commissioners have alluded to, this work speaks to a bigger question about whether care management reduces unnecessary care while preserving access versus creating delays, displacements, or restrictions to needed care. Adjusted and stratified analyses can help sharpen the picture, but the important questions about appropriateness and barriers to care are likely to remain.

To that end, Josh is supportive of interviews, which can help illuminate some of these issues and, in particular, how placement and continuation decisions are made and how clinical considerations enter those decisions.

He likes the ideas raised by Cheryl to broaden groups that are interviewed, the benefits of which would be to go beyond questions about whether utilization or outcomes differ and give context to whether beneficiaries receive the appropriate type and amount of care in appropriate settings without shifting unmet needs to other parts of the system.

That's the last I have in the queue, Amol.

DR. NAVATHE: Great. Thank you for a robust discussion.

I think I appreciate the equipoise that you all have brought, understanding that this is a preliminary cut of the work without adjustments, and as Carol, Betty, and Brian have very nicely articulated, this is in-process work and to be interpreted with caution.

There's a number of comments that you all made, I thought that were really helpful in terms of informing the analytic work that we'll do as well as informing some of the qualitative work that we'll do, and so we will certainly take that into consideration.

As Paul said, I just wanted to echo a couple things. This work is really about looking at the use, kind

of a comprehensive look at use of PAC, less or really not about contemplating distinctions in coverage or site neutrality. I think there's actually a lot of complexity. You all have highlighted a lot of that complexity along the lines of the clinical evidence of who can benefit from certain types of care versus other types of care. Availability of access to those services is based on geographic market variation.

In the IRF world, there's qualified and unqualified conditions. There's a whole richness here, and I would say a lot of that is outside the scope of what we're addressing here. We're really just focused as much as we can focus on the utilization aspects of it. So I just wanted to reinforce that point.

Otherwise, I think we'll bring this particular session to a close. Thank you again, Carol, Betty, and Brian, for the excellent work.

We'll take a five-minute break or six-minute break and start at 10:40 for our next session on risk adjustment.

[Recess.]

DR. NAVATHE: Thank you, everyone, for your

patience. We will now get started with our next session, which is on the accuracy of Medicare Advantage risk adjustment at the plan level. And Andy, I will turn it over to you.

DR. JOHNSON: Thank you. Good morning, in this session I will discuss the accuracy of Medicare Advantage risk adjustment at the plan level. The audience can download a copy of the slides from the control panel on the right side of your screen.

We began this work in response to Commissioner interest, and today we will expand on the Commission's discussion from March 2026, which focused on incorporating Medicare Advantage encounter data into risk adjustment. We plan to have a follow-up session in the spring and are tentatively planning to include this work as an informational chapter in the June 2027 report.

The presentation will start with a discussion of why accurate risk adjustment is important for competition in Medicare Advantage, how the current risk adjustment model performs across plans, aspects of the current model that affect performance, and example policy approaches that could improve plan-level accuracy of risk adjustment.

Finally, Commissioners will discuss potential directions for future work.

Medicare Advantage plans offer beneficiaries a range of coverage options for their Medicare benefits. Plans provide services covered under Medicare Parts A and B and often offer supplemental benefits.

Beneficiaries choose among plans based on premiums, cost sharing, provider networks, and additional benefits. Plan competition helps to ensure that beneficiaries have Medicare coverage options that meet their needs and offer high value.

To support fair competition, payments to MA plans are risk adjusted to reflect differences in the population of beneficiaries who enroll in each plan. Plans enrolling beneficiaries with higher expected health care needs receive higher payments, and plans receive lower payments for beneficiaries with lower expected health care needs.

The primary goal of risk adjustment is accuracy at the plan level, so that plans are compensated fairly for enrolling higher or lower risk populations.

Perfect prediction for individual beneficiaries is not the goal of risk adjustment. Some overprediction

and underprediction at the individual level is expected. What matters is whether beneficiary-level errors balance out across the enrollees within each plan.

If prediction errors systematically favor or disadvantage certain plans, risk adjustment can create overpayments or underpayments that undermine plan competition.

Risk adjustment must also balance accuracy with other objectives. Risk adjustment accuracy should be maintained in the presence of strategic behavior, such as diagnostic coding efforts that can increase MA enrollee risk scores.

At the same time, policymakers should seek to minimize administrative burden for plans and providers, and also should avoid imposing costs that divert resources from patient care and other productive uses. High administrative burden may fall disproportionately on small plans.

Finally, we note that overall Medicare Advantage payments relative to fee-for-service is important. That issue is addressed in our March MA status report and is not the focus of today's discussion.

Accurate risk adjustment supports competition based on cost efficiency, benefit design, and quality metrics, by leveling the playing field for plans enrolling populations with different risk profiles.

Plan-level inaccuracies can undermine beneficial competition by generating advantages or disadvantages for certain plans. Inaccuracies can lead to some plans receiving larger rebates, making them more attractive to beneficiaries. Such advantages can strengthen a plan's market position or facilitate expanding participation to new markets.

The benefits of achieving a risk adjustment advantage may lead plans to invest in raising risk scores or improving their risk profile instead of improving quality or lowering costs.

This slide illustrates how a plan that does not invest in increasing risk scores is at a disadvantage relative to other plans. The example uses two plans with the same enrollee risk profile. Plan A has an average risk score of 1.035.

Plan B increases its average risk score to 1.085 through more intensive coding. This raises Plan B's rebate

from about $88 to $120 per member per month. That increase in rebate is comparable to the increase the plan would have received from a quality bonus increase to its benchmark.

As a result, Plan B can offer more generous benefits or lower premiums. Plan A may need to charge beneficiaries a premium to offer a supplemental benefit package with similar generosity as Plan B, or Plan A may risk losing enrollees.

Several concerns have been raised regarding the current risk adjustment system. First, the model is calibrated using fee-for-service data, so the model reflects the relationships between spending and health conditions in fee-for-service Medicare.

That relationship may differ in MA because of coding practices, utilization management, and other factors. Model coefficients that don't reflect actual MA spending may disadvantage some plans.

Second, plans that code diagnoses more intensively have a risk score advantage over other plans. A large body of research has demonstrated significant variation in coding intensity across plans, suggesting meaningful competitive advantages for plans with higher

coding effort.

Aside from coding intensity, certain plans may attract a more favorable risk pool relative to others, net of risk adjustment. Although research on this topic is limited, stakeholders have reported that having certain health systems in their network may attract enrollees whose higher costs are not fully compensated by risk adjustment, causing an underpayment for the plan.

Next, let's turn to our preliminary assessment of risk adjustment performance across MA plans.

Risk adjustment is focused on MA plan costs, which include medical expenses, administrative costs, and profit. Medical costs make up about 86 percent of total plan costs on average.

Plan costs vary based on their enrolled population, geographic practice patterns, and the ability to manage costs through utilization management, negotiated prices, and provider networks. Risk adjustment is intended to reflect variation in costs related to their enrollees.

This analysis assesses how well risk adjustment achieves that goal. We use bids as a measure of the plan's cost to provide Part A and Part B benefits. Bids are

specific to each plan's enrolled population and therefore reflect the risk profile of plan enrollees. Plans with higher-cost populations should have higher bids and higher risk scores.

We compared the distribution of plan bids before and after accounting for a plan's average risk score. First, we looked at the distribution of unstandardized plan bids. Then we divided each plan bid by the plan's average risk score, and assessed the distribution of risk-standardized plan bids.

In addition, we standardized all bids in this analysis to account for differences in the geographic composition of plan enrollment as a way to address differences in geographic practice patterns.

We expect that plan bids may vary even after standardizing for risk scores and geography due to multiple factors. Plans differ in their ability to manage medical costs and their administrative costs, profit, and the actuarial assumptions used to develop their bid.

There is no ideal level of variation in risk-standardized plan bids. However, substantial systematic variation after standardization may suggest that risk

adjustment does not fully compensate plans for differences in costs related to their enrollee populations.

Finally, I note that this analytic framework is similar to the Commission's previous work assessing risk-adjustment accuracy in Part D.

This figure shows that risk adjustment explains a substantial amount of variation in plan bids, but some variation remains after risk standardizing. Looking at the orange bars, the dotted lines mark the 10th and 90th percentile unstandardized plan bids. We see a wide range between these two points in the distribution.

Now looking at the dark blue bars representing the risk-standardized bid distribution, we see that the 10th to 90th percentile difference is less than half of that for the unstandardized bid distribution.

However, meaningful variation among risk-standardized plan bids remains. Looking at the two dotted dark blue lines, we see that the 90th percentile plan bid is about 40 percent higher than the 10th percentile plan bid. That means that either the 90th percentile plan has 40 percent higher costs and profit than the 10th percentile plan or some systematic distortion in risk adjustment

remains.

The next slide shows the same distributions, but separately for SNPs, or special needs plans, and non-SNPs. Special needs plans enroll beneficiaries who have higher risk scores, including beneficiaries who are either eligible for Medicaid benefits, have certain chronic conditions, or reside in an institution.

Therefore, risk adjustment has a much larger impact on bids for SNPs, as shown in the top figure. The large shift between the orange unstandardized distribution and the dark blue standardized distribution illustrates how strongly risk adjustment affects payments in this segment of the MA market.

The effect of standardization on the non-SNP bid distribution is much smaller as shown in the bottom figure. Note that for both SNPs and non-SNPs a 90th percentile bid is about 40 percent larger than the 10th percentile plan bid after risk standardization.

To reiterate these findings, risk adjustment narrows the distribution of plan bids, indicating that risk scores account for some variation due to plans' differing enrollee populations. After standardizing, the 90th

percentile bid was about 40 percent larger than the 10th percentile bid, and that was true for all plans and for SNPs and non-SNPs separately. Again, that means that either the 40 percent difference reflects higher costs than profit or some systematic distortion in risk adjustment remains.

There is no ideal level of variation in risk and geographic standardized plan bids, and we expect variation due to differences in efficiency, administrative costs and profit, and actuarial assumptions. In future work we could revise this analysis to limit some of these remaining sources of variation. If plans have higher bids due to higher cost enrollees but do not have risk scores that fully reflect the higher costs, those plans experience unfavorable selection net of risk adjustment, and are at a competitive disadvantage to other plans. Similarly, plans coding diagnosis less intensively than other plans are also at a competitive disadvantage.

Next, we'll discuss aspects of the current risk adjustment model that could affect plan-level accuracy, starting with the basics of how the model is developed.

Risk adjustment models are developed from a

beneficiary-level regression that models the association between the outcome variable and a set of explanatory variables. In Medicare, the regression model uses demographic characteristics and diagnosis codes to predict annual spending on Medicare services.

The output of the model is a set of coefficients, one for each explanatory variable. Each coefficient reflects that condition's or that characteristic's marginal contribution to annual Medicare spending.

In the illustrative formula at the bottom of the slide, coefficients are represented by beta symbols, and each coefficient is multiplied by one of the model's explanatory variables. For each risk adjustment model, CMS publishes the coefficients in the annual announcement of MA payment rates.

Because the outcome variable is annual spending, the model's coefficients are estimated in dollars. To convert the dollar-based coefficients to risk score units, each coefficient is divided by the average annual spending. That process, called normalizing the model, establishes a risk score of 1.0 for a beneficiaries expected to have average annual spending. Risk scores therefore represent a

beneficiary-specific index of predicted spending relative to the national average spending.

Once a risk model is calibrated, the model's coefficients can be used to calculate beneficiary risk scores. We will walk through one example in this slide.

The first row shows this beneficiary's demographic characteristics. The beneficiary is female, 74 years old, community residing, and not eligible for Medicaid benefits. These characteristics define a demographic coefficient of 0.395 for this beneficiary.

The other coefficients are based on diagnoses, which for this beneficiary are diabetes with chronic complications and vascular disease with complications.

In the right columns, the coefficients for the demographic characteristics and the documented conditions are added together. The sum of the dollar-weighted coefficients produces a predicted annual spending value of $10,727. Similarly, the sum of the risk score unit coefficients produces a risk score just above 1.0, indicating expected spending slightly higher than average.

For the remainder of the presentation, we consider challenges with the current risk adjustment model

using three categories: the calibration population used to estimate the model coefficients, the model's input variables used to explain Medicare spending, and the approach to model fit which defines the relationship between model inputs and Medicare spending used for model calibration. Challenges with current model in any of these categories may contribute to risk adjustment inaccuracy and undermine competition.

First, the calibration population. The current MA risk model is calibrated using the fee-for-service population, and therefore risk scores reflect fee-for-service spending patterns and treatment costs, which may differ for Medicare Advantage plans due to population differences, the effects of utilization management, or differing diagnostic coding practices.

Differences in MA enrollee spending predicted by the risk model and actual spending is likely to provide an advantage to some organizations.

Second, the model inputs. Demographic characteristics are useful in the risk model, but they do not account for much variation in health spending on their own. Diagnosis information improves predictive accuracy,

but it also creates incentives to document additional conditions. Some diagnoses are prone to clinical discretion, which contributes to variation in coding intensity across plans. Greater coding intensity benefits some organizations by allowing them to generate larger rebates. The current incentives to document more diagnosis codes leads to greater administrative burden for plans and providers.

While alternative inputs could improve accuracy, policymakers must balance those benefits against the influence of strategic behavior and additional administrative burden.

Third, is the approach to model fit. Health care spending is highly skewed and difficult to predict due to a large share of spending being concentrated among a relatively small number of beneficiaries.

Two common measures for assessing model accuracy, or "fit," are the R-squared statistic, which reflects the overall amount of spending variation that is explained by the model, and a predictive ratio, which is a ratio of the model's predicted spending over actual spending for a group of beneficiaries.

Alternative approaches to model fit trade off predictive power and model interpretability. The current regression approach relies on a linear relationship between annual spending and the model inputs. This relatively simple assumption produces a model that is highly understandable, but may be less predictive than more complex statistical approaches.

Finally, I'll note that the choice of model inputs also affects model fit.

Next, we turn to policies that have the potential to improve plan-level accuracy of risk adjustment. We briefly describe illustrative examples of policies that would address some of the challenges we just discussed with the calibration population, model inputs, and model fit.

The policies mentioned are not an exhaustive list of such policies. Following the Commission's discussion, we can provide more detailed analysis of the policies described here or describe additional approaches that have been proposed.

The first policy would change the model's calibration population by basing the risk model on MA encounter data. The Commission discussed considerations

for implementing an MA encounter-based risk model at the March 2026 public meeting.

Implementing such a model would require several important technical and policy decisions. Here is a summary from our March presentation.

Technical choices focus on how to calculate annual spending for MA enrollees, such as whether to calculate spending using standard prices for services or the amounts paid to providers, and whether to include denied or out-of-network services.

Policy choices include whether a single model should apply to all beneficiaries, how to address any coding intensity differences, and whether to apply separate normalization factors.

The discussion focused on implications of the various policy choices on the overall level of payment between MA and fee-for-service. Commissioners generally supported continuing work toward understanding the implications of an encounter-based risk model.

Using an MA-based model could improve plan-level accuracy because the model would better reflect the MA population and the coding patterns and treatment costs that

exist in Medicare Advantage. Specifically, model coefficients would more accurately reflect the relationship between spending and health conditions for MA enrollees.

However, the incentive to code more diagnoses to increase payments to plans would remain under an encounter-based model and would continue to undermine competition between MA plans.

Calibrating an encounter-based model would change the coefficients relative the current model. For example, the coefficient for diabetes in the current model is 0.166. That coefficient could be higher or lower under an MA encounter-based model depending on the effects of utilization management in MA or the differences in the average severity of diabetes being coded in MA.

To understand how coefficients would change, we could calibrate an encounter-based model and assess changes to coefficients, risk scores, and payments to MA plans.

Next up are example policy approaches to improve model inputs. The first set of example policies aim to reduce the effects of discretionary diagnosis codes by removing them from the risk adjustment model or by adjusting MA risk scores.

Removing health risk assessments and chart reviews as a source of diagnoses for risk adjustment is one way to reduce discretionary inputs. Health risk assessments do not reflect treatments, and chart reviews are often conducted by entities who advertise or guarantee a certain return on investment for their chart reviews.

Diagnoses that with wide coding variation are likely to reflect codes that are prone to clinical discretion and could also be removed from risk adjustment.

Finally, applying a tiered coding adjustment based on parent organization coding levels would more fairly adjust for coding intensity compared to the current 5.9 percent across-the-board adjustment.

The second strategy to improving model inputs is to incorporate additional data into the model. Some research has demonstrated modest improvements from incorporating patient survey data about health or functional status.

Other approaches would use utilization data to enhance diagnostic information, such as by using prescription drug data to confirm diagnoses, or by limiting diagnoses based on place of service. For example,

diagnoses requiring treatment from a hospital, such as stroke or heart attack, would only be allowable if documented on a hospital encounter record.

Finally, some approaches would use utilization or medical record data directly as model inputs when calibrating a risk model. These approaches tend to also rely on more complex statistical modeling, which we will turn to next.

To improve model fit, the statistical approach could incorporate machine learning or other non-linear model fit assumptions. Such approaches tend to produce a higher level of predictiveness, but they also have lower transparency because the model is comprised of many more parameters compared to the current set of coefficients.

Other approaches focus on alternative ways to pay for high-cost beneficiaries, for whom the model tends to produce average underpayments to plans. For example, the system could incorporate budget-neutral transfers across plans to adjust payments when plans enroll a disproportionate share of very high-cost beneficiaries.

Finally, the current risk model uses prior year diagnoses to predict beneficiary spending in the following

year. A concurrent risk model, such as the one used in the ACA market, uses current year diagnoses to predict beneficiary spending. Concurrent models have higher predictive accuracy than predictive models; however, they may have less incentive to prevent diseases and control costs.

Finally, we seek your feedback on potential directions for future work.

Potential future work could include refining the analysis of risk adjustment accuracy at the plan level. We could update this analysis to use historical medical costs, which would exclude variation due to administrative costs, profit, and projection error in the bids.

Second, we could explore technical aspects of alternative risk model approaches, which could include calibrating an encounter-based risk model to assess how coefficients would differ from the current model, modeling various approaches to reducing the effects of discretionary inputs, or exploring how risk adjustment could incorporate additional data or alternative model fit approaches.

Third, we could conduct interviews with MA actuaries to gather input on risk adjustment accuracy and

practical implications of alternative risk-adjustment approaches.

Finally, we could continue to evaluate the advantages and disadvantages of different policy approaches for changing the model calibration population, model inputs, and model fit.

I'm happy to take questions about this material and look forward to your discussion. We are planning to return to this discussion during a spring presentation and could include this material in a June 2027 chapter.

Thank you. Now back to you, Amol.

DR. NAVATHE: Thank you, Andy. As always, very well done, very well-articulated.

As you all know, we're focusing here on risk adjustment within MA, and this is part of an ongoing series of work. And I think the prior presentation that Andy did was March of last cycle, and so this is kind of the follow-up to that, and then we'll have another one, as he mentioned, this spring.

So, with that, why don't we go ahead and start with the queue. I think we had Gokhan as first for the Round 1 question.

DR. METAN: Thank you, Amol.

Great work, really enjoyed it, really appreciate the hard work here.

A couple quick questions to clarify. My first question is, the 40 percent residual and 82 percent residual for the SNPs, is the variation reported in this analysis? And it's also called out that some of this could be due to the administrative costs in the bids and all these things. Do we have at least some directional sense around, like, what percent of this residual is more related to the inaccuracies of the risk adjustment model at this point?

DR. JOHNSON: We don't have a sense yet. I think that -- I think you're suggesting it may be worthwhile to do that additional analysis, to look at not plan bid-level variation, but just the variation in the medical cost portion. I think that might be the best way to assess how that 40 percent difference would change.

And I should say that there's an error in the paper that the SNP and non-SNP difference in the risk standardized 10th and 90th percentile bid is that both of them are 40 percent. There was not a difference for SNPs

and non-SNPs in that distribution.

DR. METAN: Okay. And the historical medical cost-based analysis, is it something that we are going to -- we should expect in the spring readout?

DR. JOHNSON: It sounds like it, yeah, if there's interest in that.

[Laughter.]

DR. NAVATHE: Yeah, so I think, Gokhan, to the extent that you would find it interesting, of course, you should comment that way.

DR. METAN: Okay. I find it interesting. I just don't know how hard it is to get it for the spring, if it is something reasonable.

DR. NAVATHE: Okay, yeah. Please articulate your interest, and then we will try to make it happen.

DR. METAN: Yeah. I have an interest.

[Laughter.]

DR. METAN: My second question, Andy, is the R-squared around 12-19 percent versus the ACA models, 39-44 percent, is a substantial difference. So how much of this, if we know -- and that's my question -- is due to -- attributable to prospective versus concurrent choice alone?

Do we have any sense around, you know, what that choice contributes in that differential?

DR. JOHNSON: My sense is that most of it is due to the concurrent model versus the predictive model. I think there have been some studies. It's been a while since they were put out, but looking at the same population and concurrent versus predictive and the magnitude of difference was similar to that, what we see in the ACA model and the current MA prospective model.

DR. METAN: Okay. Thank you.

And my last question is, so one of the, again, alternatives is using MA encounter data as a follow-up. So I think I know the answer, but I just want to confirm I'm not thinking this wrong. Is there a risk that calibrating on the MA encounter data bakes the MA coding intensity into the model and normalizes already into the model? And so, essentially, the model ends up with already kind of reflecting that coding intensity in its predictions.

DR. JOHNSON: That's right. So, by normalizing the model to the average spending in the MA population, it is effectively normalizing to the average coding practices as well. So there would still be differences between

plans, and we don't have a strong reason to think that that variation would change a lot. The incentives to code more would still be there on the encounter-based model, but the average 1.0 risk score would also reflect average coding practices in MA.

DR. METAN: Okay. Thank you.

MS. KELLEY: All right. That's all we had for Round 1. So I'll go to Round 2. Okay? And, Kenny, I have you first.

MR. KAN: Andy, I'm very excited about the paper and support the four proposed areas of future analysis as noted on this page 30.

Number one, refine plan-level accuracy. Strong support. Moving from bids to actual medical costs should provide a better measure of long-term payment accuracy.

Number two, calibrate using MA encounter data. Support, but with caution. MA calibration should improve fairness, but its value depends on encounter data completeness and accuracy. We should also consider how the model handles services with limited claims information, especially capitated arrangements.

Number three, engage MA actuaries. Support.

Actuaries can identify systematically undercompensated conditions, model limitations, and unintended operational burdens.

Number four, evaluate policy alternatives systematically. Strong support. For the three policy domains of calibration population, inputs, and model fit, I suggest evaluating the alternatives against five criteria: payment accuracy, coding incentives, administrative burden, transparency, and market disruption.

I would also encourage consideration of three additional ideas: number one, tiered coding intensity adjustments to reflect better variation across plans; number two, greater use of objective utilization markers that are typically available, such as inpatient admissions, nursing home stays, dialysis utilization, et cetera, rather than continuously adding diagnosis that may create additional coding incentives; number three, a high-cost risk pool for infrequent outliers. Rather than continually refining HCCs to capture infrequent catastrophic cases, consider carving out a portion of extreme costs so the core RA model can better serve the broader population with a high R-squared.

Overall, I like the paper's shift towards plan level payment accuracy and competitive neutrality. The goal should not necessarily be the most predictive model, but one that fairly compensates MA plans while minimizing administrative burden and coding opportunities.

Thank you.

MS. KELLEY: Gokhan.

DR. METAN: I have a couple of comments.

So my first comment is more about clarifying the purpose of this chapter a little bit more. We also had a lot of discussions around, you know, MA payments being more than the fee-for-service payments. This chapter is mainly focusing on within plan variations, if my understanding is correct. So firewalling the two objectives very clearly so that we don't kind of find ourselves in confusion would be really helpful to state in the executive summary.

Addressing the endogeneity of calibrating on MA data is super important.

And tying back to my last question, again, if the coefficients come from the MA encounters and the model can erode existing MA coding intensity and utilization management, normalizing the behavior we want to neutralize,

and essentially kind of like this way we can trust this model better. I think that's very important.

Score fit gains net of their incentive costs. What I mean by that is concurrent modeling and high-cost risk pools raise R-squared, but also kind of like change the incentives for the plans. So concurrent model weakens the pool to manage kind of chronic cognitions, and a risk pool dampens the plan's incentive to manage catastrophic cases. So, if we can present the findings that fit improvements versus the trade-offs very clearly, that would be super helpful to get our head around what trade-offs we will be making with those improvements.

The next comment I have is, I would recommend -- again, it's a choice, but modeling the levers in combination rather than one at a time. And the reason I say that is, you know, these encounter calibration, input cleanup, and a high-cost pool likely do more together than any single one of them can achieve in the modeling. So, if we are going to try the effects of these, I recommend like doing a combination of these rather than at the end a menu of items in front of us.

If I were to do this myself, the analytical work,

my prioritization would be, I would do the model inputs fix first. I think this is the fastest and would provide most juice for the squeeze, if you will, for cleaning up the model inputs would tell us like what kind of -- you know, how much we can curb the discretionary coding.

And, in parallel, I think building encounter calibration as an analytical project would be really helpful, and this is the most powerful lever for overall predictiveness, but it's also slow and analytically, technically heavy. But I think the very valuable to learn how coefficients and fits would change paired with the coding intensity adjustments.

And then, in terms of the modeling, I really agree with Kenny that using a targeted high-cost pool is super important in this type of models, along with non-linear, some machine learning kind of approach. I mean, we live in a non-linear world, and we sometimes expect too much from these linear models.

And in terms of the model purpose, I think predictive quality is more important than explainability at this point, I would say. And we could sacrifice a little bit of the transparency of the model, you know, for getting

more accurate predictions out of it. So I strongly suggest, you know, targeted high-cost pool, using a targeted high-cost pool plus some non-linear techniques to improve the accuracy of the model.

Other than that, this is great direction. Thank you very much.

MS. KELLEY: Stacie.

DR. DUSETZINA: Andy, thanks very much for this work. I think it's really great to see it moving forward.

I think this potential future work, the set of options look great. I would say when reading the chapter, I really do like the idea of generating the coefficients using the MA encounter data, and seeing how they change versus fee-for-service, I think that would be a nice thing to do.

You also had asked kind of -- or put in the chapter whether, you know, how to think about pricing, and my gut reaction to that was standardized prices would probably be the right approach there. And I do like the idea of eventually getting to a place where we have separate models for MA and fee-for-service.

I also am very supportive of moving away from

what you're calling the "discretionary model inputs." I think we've seen that those are not necessarily helping, at least in some ways, like the health risk assessments. That's, you know, work for someone to do, but also leads to potentially more coding than necessary.

For thinking about the interviews to the MA actuaries, I'll also say that I appreciated how consistent that theme was through all the work streams presented this week. I think one thing that I wonder is, could you target that to the plans that are kind of falling on the tails of the bids? Because it does seem like -- you know, one of the things you raise is that there could be, like, you know, plan sponsors that just are better at coding or more efficient or using different providers or tools. And so maybe by trying to, like, engage with plan sponsors who are on those tails, you might find out a little bit more about those issues.

And then the last thing about the other ways to do the future work, I am a little bit disinclined towards doing more, like, machine learning or more advanced modeling there at this point, because I think we have a data quality question mark. You know, it's like -- so

putting that into a machine learning model, it's like, well, maybe that makes it less gameable in the future, but it could also make it more gameable. So I think having the transparency on what's going into it is a really important first step, and then maybe advancing from there if we felt that -- you know, you've gotten some of the things out that we wouldn't want to be getting into those models.

MS. KELLEY: Greg.

MR. POULSEN: I love this chapter. Thank you. This is really, really good and really important

I would agree broadly with what Kenny, Gokhan, and Stacie have said.

And with the approach that's being envisioned and discussed, I think I'd just like to highlight a couple of the things that I think are really, really important and then raise one additional point.

On page 2 on the chapter, we say accurate risk adjustment combats incentives for selection. We talk about adverse selection all the time, and it is so important. If we did this really well, adverse selection becomes a dramatically less significant issue. And I think that's a really important concept going forward, because it's

plagued Medicare+Choice before MA even existed, and it was probably the biggest challenge we faced back then before we were doing risk adjustment to the same degree of complexity. I was going to say accuracy, which I think is wrong. I think it's complexity, not accuracy that we've added.

And then I guess I would say on page 3 where we talk about risk adjustment resources may divert from care management for other good things, if it were up to me, page 3 would be put up in Times Square so everybody could read it, because it's a really important concept. Risk adjustment is not -- and the coding that goes behind it is not just about money. It's also about the care that's delivered to people, because a dollar that's spent on risk adjustment mechanisms is not being spent to improve care.

And if I can -- which in these numbers are not totally pulled out of thin air. If I can get a $4 return for a $1 investment in risk adjustment and I can get a $2 return for a $1 investment in care management, 4 to 1 beats 2 to 1 almost every day. And that's where it has gone. I think that we're depriving people of better care by the virtue of the fact that we have given organizations a way

to invest and make money more easily than actually providing better care. And I think that's not a trivial concern.

So, with that, then as we talk about this, I just think that there's one mechanism that we may not be fully aware of. We looked at it on page 12 in the report. We talk about the R-squareds from what we get today from all the demographic information that we collect and all the risk adjustment we put together. And on an individual basis, obviously the population basis -- which, Andy, you've done a great job illustrating and then the chapter does as well, but on an individual basis, those are the building blocks from which we build up the population scores.

And I love the fact that you illustrated and pointed out, which I hadn't seen in our work before -- it may have been there and I missed it -- was that the R-squareds for those collectively are between 12 and 19 percent, which sounds kind of feeble and it is. And that's why. I mean, this is individual versus collective, and we all get that that's the way insurance works.

But I thought it was really interesting to find

an old study that suggested that the correlation coefficient between -- this is for individuals -- a prior year's individual health care spend and the current year health care spend has a correlation coefficient of 0.36, which turns out to be an R-squared of 0.13, which is right in the middle of what we're getting by doing all the work that we do to gather all the risk scores associated with people, all of the diagnostic codes and all the things that go into it, plus the demographics. And here, we could get by just simply looking at last year to this year, something that's roughly analogous in terms of the descriptive ability.

And that doesn't even include the other obvious things we could get, age, sex, where people live, you know, the basic demographics.

I was not able to find anybody who tried to put those additional correlation factors into the mix, but it makes me wonder as we've had -- you all know that I've always loved the idea of looking at previous year spending as a predictor of going forward. But it may be that there's statistical validity of doing that in an individual level and not just at a population level, which is what I

had previously envisioned. So we may have multiple pathways forward there.

And, again, if you look at last year's spending, that's much harder to game. I can increase spending, but a typical company doesn't want to forego profits this year in order to get some more next year, right? So there are bounding mechanisms on that abuse, which we don't have, obviously, with diagnostic coding.

So, at any rate, I think this is a spectacular chapter. Thank you. I think that we've made real progress, and I appreciate it very much.

MS. KELLEY: Brian.

DR. MILLER: Thank you for this work.

Three buckets of thoughts. First is environmental comments, and I added one, which is that CMS eliminated 1876 cost plans for a reason, and DoD cost-plus contracting has not worked well. So I'm generally not a fan of that.

Two other sort of environmental thoughts. One is the normal distribution of risk-standardized bids suggests to me that there's a vibrant competitive market with sub-segmentation.

The third is an environmental thought for all of us, which is like plan payment is like a bathtub. There's a lot of water in it, right? And so if think that the water level is too high and we or the government want to lower the water level, my question would be, why are we focused on mucking around with complex risk adjustment when you can instead just have a negative rate environment for a little bit and get to the same place faster and easier? Right? So if you think payment is 10 percent too high, you could just run a negative rate environment for a couple of years and not have to muck with all that machinery. Those are environmental comments.

Second bucket is sort of insurance-based comments. For those who are upset about risk adjustment and want to eliminate it, I know in prior cycles, people have mentioned that. And the reason we have risk adjustment is because MA can't underwrite. This is a fair policy trade, right? So MA can't underwrite.

Med Supp does underwrite, right? That's why there's no risk adjustment in Med Supp. So MA, in fact, is, as far as I know, the only insurance business where you can't underwrite. So you underwrite Med Supp. You

underwrite in commercial insurance, right? You can in ESI and other areas. You underwrite in life insurance. You underwrite in disability insurance. You definitely underwrite in auto insurance, right? There are some varying driving practices around the table here, I'm sure.

If you have -- well, it was an attempt at a joke. Tough crowd.

If you have medical conditions, in many states you actually can't get Med Sup, right, because either, one, you won't be able to get it or it's so expensive you can't.

The other thing to note about is that MA is permanent guaranteed issue, right? Med Supp is not. It's definitely not permanent guaranteed issue. So guaranteed issue, permanent guaranteed issue, and no underwriting are not favorable business terms for health plans. I just want to say that once more. Guaranteed permanent issue and no underwriting are not favorable business terms for plans. So, to counterbalance that, the policy trade is that we have risk adjustment.

That being said, we do need to make risk adjustment probably better. So policy options that I would think about for improving risk adjustment, one is one which

many of my colleagues have mentioned, which is moving towards an encounter-based data, risk adjustment source for an encounter-based risk adjustment system.

Gokhan made earlier points, which I'm probably going to massacre them, so he can correct me if I screw up, but that it would -- the normalization would address some of the coding intensity difference between fee-for-service and MA. It might not necessarily address coding intensity differences between plans, which would still persist.

I would say in some counties, it actually doesn't make sense to base MA risk adjustment off small fee-for-service population, right? That just doesn't make sense. But then there are other counties where you might have actually a very small MA population. You have a very large fee-for-service population. And so you might want to have an exception with a clear pathway for that setting where if you have a very small MA population that you still use fee-for-service as a comparator for risk adjustment, but in other areas, the default is that you have an MA encounter-based risk adjustment system. And I think that this would improve calibration and accuracy and hopefully allow us to then think about differences between plans.

For those who don't think that the encounter data are complete enough, I can guarantee you when you base payment based upon data, people tend to submit data really well. Reviewing our hospital quality discussion yesterday, I'm sure that plans would happily submit 99.9 percent of encounter data if suddenly billions of dollars of payment were based on it.

So a couple other ideas. One is we could do a tiered coding intensity adjustment to address for differences between plans, right? I do recognize that there are odd incentives from, you know, quartile systems that we have in, say, benchmark payment. So you might want to be more gradation. You could do buckets, more buckets, less buckets, right? Same problem with stars, with a half a star. A lot of people want to move to 0.1 star. But tiered coding intensity adjustment might help.

We're all angry about HRAs and chart reviews. I get that. I'm a little angry about HRAs and chart reviews. So, if you want to get rid of it, which is, again, reasonable, one of the things you have to think about is what about a new small plan entrant or someone who's growing quickly? Right? So, if you get rid of HRAs or

chart reviews, you favor someone who has large membership, you know, the Uniteds, the Humanas and other large plans, right, because they already have the data, and most of their members are already old, you know, already in the plan, so they already have that risk adjustment score already there. So, you know, the compromise could be, right, because you want to promote new plan entry. Yu also want to promote people to be able to switch plans when appropriate, right, or switch between fee-for-service and MA. So a compromise could be that you only allow chart reviews for patients who are new to MA from fee-for-service or who are switching between MA plans, right?

Right now plans don't have an incentive to pick up those new members, right? They want to wait until someone else codes them and eats that in the first year if they get it wrong. So, if you have 100,000 new members, that could really mess up your finances. And so, if you're smart as a plan, you wait for someone else to take all those new members, code them up, and then you take them. So we want to discourage that sort of behavior.

So, essentially, we want to eliminate HRAs or charts or chart reviews unless you're switching plans or

new to MA.

I would say also for HRAs, you want to make that part of routine care. You don't want an NP knocking on your door and saying, hello, Mrs. Smith, let's talk about all of your diseases, right? Like, that doesn't really sound like a good use of Medicare dollars and, frankly, not a good use of clinical labor. So if you're doing an HRA at home, you should be getting like home care. We should be titrating your goal-directed medical therapy and heart failure or your diabetes meds or whatever it is.

And then I would say, a policy improvement that we could do for people who are new to Medicare is I think that we should let plans pull again with the idea of we want competition. We don't want bad incentives. We should let and facilitate MA plans pulling diagnoses from commercial plans. That way, we don't overpay or underpay when people enter Medicare.

Thanks.

MS. KELLEY: Tamara.

DR. KONETZKA: Thank you, Andy. This is a really great chapter. I enjoyed reading it. I think I'm happy about it in a couple of ways. One, it's nice at this point

to look at some sort of within-MA heterogeneity, which we bring up all the time but we haven't really dug into it. So I think that's a really valuable direction.

And obviously there is the bigger context of how we have talked many times as a group about how it's sort of increasingly untenable to just keep building these risk adjustment models for MA on a sort of shrinking and selected fee-for-services population. So I think this kind of helps with both of those issues.

I kind of think of it as a short run/long run problem, because in the short run we're kind of stuck with this fee-for-service-based model, at least for a few years. I hope it's not such a long short run. And so for that problem I think just continuing to tweak that model is probably valuable enough to do for a little while let. So I'm very much in favor of looking at what happens in the model if we eliminate the health risk adjustments, et cetera, health risk assessment derived comorbidities, et cetera.

In the longer run I think we do want to, within MA model based probably on encounter data. I think we kind of discussed some differences in policy options in other

sessions last year, and I do hope we return to those because I think that's the direction that we have to go. And again, hopefully it's not too long term.

But for this whole body of work, I want to talk a little bit about the modeling. I agree completely with Gokhan that linear model, the sort of -- we've gone too far in favor of transparency and simplicity as opposed to getting a better model. And the linear model, sure, it provides us transparency. Linear additive model provides this transparency. But, one, I'm not sure the transparency is always great. Should it be obvious that if you code this disease you're going to get X dollars more? I'm not sure that's good. Maybe it is.

The other thing is complexity. The vast majority of people don't really see a difference in complexity between a linear regression and a non-linear regression with some interactions in it, right. So I think a little more complexity is really warranted here.

And specifically, what we're really worried about, and probably what's driving some of these distributions, is this really high cost end? We know it's a very skewed distribution. A linear additive model is

never, ever going to predict that end, that skewed end, so using a linear model we're just never going to get a very predictive model. And maybe if we can sort of tweak it to get better for the middle of the distribution but not for those ends.

So I think that it may be as simple as adding interaction, or using a non-linear model, doing some transformations. I'd love to really explore how can we get a better prediction model. Machine learning is another option, and I'm really not opposed to that. I think that is sort of the far end of lack of transparency to everybody involved, including usually the people running it. But it may be worth it if there is a better model.

There is some work by Maya Lozinski that's not in the chapter but I think might be worth looking at. She basically was quantifying exactly this risk adjustment model and seeing if you use machine learning to better predict that high cost and what do you lose in sort of administrative transparency and simplicity. So she's tried to quantify that tradeoff. It might be worth looking at it, especially for just how well her machine learning model worked.

So I'm very much in favor of actually improving the statistical model, and it may be you can, by using non-linear methods, improve it enough that you can still just use one model, but I'd like to also compare that to sort of carving out the high cost and using a separate method for that.

Yeah, I think that's about it. I really love this line of work and I'd love to see us continue to explore how to better improve the predictability of the model, even if it reduces complexity and even if it reduces transparency. Thanks.

MS. KELLEY: Gina.

MS. UPCHURCH: Well, thank you, Andy, for this. I did well in my one stats class but I'm relying on the rest of you to analyze this. So I'm trying to look at it from a consumer's perspective as much as I can.

On page 2, and I mentioned this earlier, I think yesterday, it says, "Beneficiaries choose based on premiums, cost sharing, provider network, supplemental benefits, and other features." We need to add medicines to that. Again, the Plan Finder drives it based on the medicines you entered into the system. So if we could add

that, that would be great.

My general comment is that health care in the U.S. is a major jobs program, and this risk adjustment is a great example of it. So every year there is variance with these Medicare Advantage plans in terms of what are the benefits every year, what is the benefit design every year, it can change every year, the networks can change every year, access rules can change every year. It's driving consolidation as people get bigger and bigger.

So getting adjustment right is really important, and I appreciate your work on this. But I think it adds such administrative burden and costs, not only to people trying to figure it out, but as Greg has reminded us many times that people follow financial incentives. And I'm just curious if we think we can outpace the gaming that happens. Again, gaming, because there is profit to be made and there are shareholders to be paid. So can we keep up with that.

So I guess my main comment is, as much as we can focus on the objective, as objective as we can get following encounters, is a good thing.

And lastly, just to respond to the Medigap

comment, Medigap does not do underwriting for most people as long as you continue to pay your premiums. So it would be good for us to know -- in another chapter, not this one -- of the Medigap policies that people have how many of them got them during guaranteed issue rights versus those that underwent underwriting, because mostly the people we see in North Carolina anyway, they didn't have underwriting because they got them during the guaranteed issue period. So it would just be good to know that separate from this chapter.

Thank you for your work and thanks for the brains around the table.

MS. KELLEY: Cheryl.

DR. DAMBERG: Andy, thanks for this chapter. I was really excited to see this work and that we're now moving down the path. I know we've been talking about this topic for a while, and it's nice to see that we're going to get go to the next stage.

And I agree there are many problems with the accuracy of the MA risk adjustment and that these inaccuracies undermine competition among the plans. And I fully support all the work that you've laid out, including

changing the calibration to focus only on the MA population. And I also support, I think it was Stacie who made this comment, about comparing the coefficients between the current approach and this MA-only model. I think that would be interesting to see. Although I guess you would have to fit it in a linear fashion to have that be side-by-side.

And then in terms of changing the model fit, I also appreciate that linear models are more easily interpreted, but likely don't necessarily represent the best fit for these data. And these risk scores aren't necessarily additive, so it doesn't always cause two times as much to treat a patient with two conditions. And some initial exploratory work that some folks at Rand have done around the accuracy of the HCC risk scores shows that we're both sort of underpaying in certain situations and overpaying in others related to that non-additive element.

I also support exploring the effect of removing the high-cost outliers to see how that affects the model fit, given the skewed nature of the data.

And then in terms of changing the inputs, I agree about eliminating diagnosis from HRAs and chart review.

And I also agree with exploring applying some type of coding intensity adjustment. I think you mentioned in your slide a tiered approach.

And I was also wondering, but this may make it more complex, considering modeling with a more limited set of risk variables, those that would be tougher to game, and those that have a larger impact on cost of delivering care.

And I also like Greg's idea that he's brought up at previous meetings and today about trying to better understand the correlation between last year's spending and this year's spending. Thanks.

MS. KELLEY: Okay. I have a comment from Tom Diller. He says this chapter is focused on MA risk adjustment, which clearly is a focus of concern as is well laid out in this work. CMS also uses risk adjustment in many of the CMMI value-based plans, especially Medicare Shared Savings Plans, or MSSP. Compensation to ACOs and physicians is very dependent in these models on risk adjustments as well.

That said, the efforts to optimize coding and documentation is much more emphasized in MA plans. Thus, comparing MA risk adjustment data to MSSP risk adjustment

might be more informative than comparing MA risk adjustment to all of fee-for-service beneficiaries.

And I have Robert next.

DR. CHERRY: Yeah, thank you for this excellent report. You know, during my tenure here we've had a number of discussions about how the MA capitated model, based largely on the risk adjustments from the fee-for-service population, may lead to favorable selection and favorable net operating margins for the MA plans. So I'm glad we're taking a look at this.

I do have a cautionary note, though, and I think we'll need to weigh all of this very carefully since there may be unintended consequences by recalibrating the payment model. One of the attractive features of the MA programs is the fact that many of them reinvest their positive margins into supplemental benefits, which includes vision, hearing, dental, and sometimes transportation services, gym memberships, and so on, as well as offering competitive premiums.

Any analysis on adjustments to the risk model would need to take into consideration the possible downstream effects that a new model might have on these

supplemental benefits as well as premiums. Otherwise you might end up driving more patients to fee-for-service if there is a material loss in the incentives that will eventually drive patients away, potentially away from MA into fee-for-service.

On a separate note, some of these data models that we're entertaining here are not entirely intuitive and probably does involve some trial and error, especially when dealing with incomplete claims and encounter data. So I do agree with you that machine learning and perhaps AI tools could really be useful in optimizing the potential risk models. I think that comment is not really specific for here, but probably around a wide variety of things that we do. So the ability to develop these AI tools can be really helpful in optimizing all of the different statistical analysis that we do.

Otherwise, I'm looking forward to continued and ongoing discussion on this work. Thank you.

MS. KELLEY: Danielle.

DR. PIEROTTI: Well, I'm so glad someone paid more attention in stats than I did, and I appreciate the expertise. I have to admit, I have a constant vague

discomfort when we talk about money without involved with what are we paying for. We do that, I understand, but it always give me pause. And I think it's reflected in the many comments around the separation here in coding and normalizing current practice without really understanding what current practice is.

Having said that, my one meaningful request, maybe, out of this particular segment is a discussion on improving the model fit, and several of my colleagues have supporting the ideal of pulling out the highest-cost enrollees for statistical purposes. And I do understand that. I also need to harken back to our many conversations about the 6 percent who are spending 60 percent in Part D, and I think that there is a lot of knowledge to be gleaned from understanding those highest-cost people. And it may not be directly related to model fit, although I suspect it is, and it comes back to the earlier comments about last year's spend and next year's spend.

But I think it would be a shame if we took that group away for the purposes of this modeling and then didn't go back to them, understanding who they are, how they got there, and what is being paid for in those

highest-cost bills. I think it's very meaningful to our overall thought process around the selection and creation of these plans. Thank you.

MS. KELLEY: Paul.

DR. CASALE: Thank you, and thanks for a great chapter. Just two points. One, I agree with what others have pointed out about the HRA and chart reviews as a source of diagnosis being an issue. I think the potential for gaming is large. And I particular liked Greg's comment about the return on investment. So if you're investing in doing these, what care are you not delivering because of the incentive to do that work. So I think that was a really important point.

And then the other point, I just want to be on record supporting further work on the encounter-based risk model. Thank you.

MS. KELLEY: I have a comment from Scott Sarran. He says excellent work. He's very impressed with the rigor of the work and the methodology used. Clearly we have an issue, differential coding energy by plans creating an uneven playing field. Therefore, this work is important and should continue.

He's supportive of all the pathways of future work as laid out. Of those, he would be most supportive of deeper dives into, one, removing HRAs and chart reviews from inputs, as those activities are too disconnected from clinical care and generate no value.

Two, explore ways to adjust for unpredictable, very high cost members, with an emphasis on unpredictable. Especially for a small plan, this could be a wild card source of variation.

Three, explore a move to concurrent risk adjustment. This makes intuitive sense and also will better reflect the increased cost incurred towards the end of beneficiaries' lives.

And the last person in the queue is Ben.

DR. IPPOLITO: Thanks. I'll read the email I was just writing you. I didn't think you would get to me.

First, you mentioned -- and this is just a small thing -- you mentioned that stakeholders said that including certain health systems in the network attracts enrollees whose costs may not be fully compensated by risk adjustment. I just wanted to flag that there is empirical evidence in support of this exact point.

I'll send it to you, but Mark Shephard in the American Economic Review where he illustrates a very similar phenomenon in the commercial market, where enrollees who have a strong preference for star hospitals with high utilization, and in the commercial market, of course, high prices, is sort of a pronounced phenomenon there, at least to excluding star hospitals in that market.

Second, I wonder whether the chapter should clarify what we know about the consequences of the inaccuracy in risk adjustment. You obviously highlight the overarching concerns about what this means for competition, but what is this actually manifesting? Is it purely higher profits? Is it more supplemental benefits? There was a question of what the value of those are, but is it that these plans are attracting more enrollees over time? What is the sort of manifestation of this in the market outcomes that we observe?

I think that's kind of important for thinking about any policy, both in terms of what are the welfare consequences, and just what are the tradeoffs that you may have to think about, and I think this came up earlier, if you were to change those.

Just for sake of piling on, I'm quite supportive of several of the ideas that were mentioned. Assessing the variation in plan costs seems like a very useful analysis. Leaning to diagnosis with less variation and other similar proposals, again, seems like a pretty good idea.

I'm open to using MA data, although I'd like to learn more about what the specific concerns are related to upcoding. I sort of know that these plans are upcoming more aggressively. I guess that means the weights associated with a given diagnosis are probably going to be lower in this market. But anyway, regardless, I would like to learn more about what the potential downsides are if we go down that route.

I also sort of agree with other folks in terms of non-linearity, thinking about risk corridor type approaches. And I'm also, similarly, not too concerns with this idea that the model might get more complicated. I think the horse has sort of left the barn. You know, there are only so many people that are going to be following this. Anyway, I don't know that those people are really concerned with a little non-linearity or anything like that.

And I'll leave it there, other than to say I'm less inclined -- you know, there was one brief mention about using adjustments where it's literally just pegged to the organization that's running the MA plan. That feels like a pretty awkward policy to try to implement. So I'd probably steer away from that and try and think about other approaches.

But thank you very much.

DR. NAVATHE: Great. All right. Thank you for all of the thoughtful input. I think we had a lot of analytic suggestions, which is great. As you all certainly track here, the focus was on within MA, and so we can focus, I think, in the future of bringing encounter data and trying to implement, essentially, an encounter-based model with some of the variations that you all have spoken about. So we can explore those from an analytic perspective.

I think what we should also be mindful of is there is an aspect of this, which is how does a risk adjustment model perform within the context of MA beneficiaries. I want to differentiate that just like conceptually in your minds, of then how could that model

actually be utilized and applied. And Andy, in March, actually had done a presentation that talked about the different ways one could take an MA encounter-based model and apply it. And it would have potentially very differing implications, in terms of how coding intensity is adjusted or not adjusted for across the fee-for-service and MA.

There are many different dimensions there so I'm not going to go through all of those. But conceptually I do want to just call out for you all that those are two different things, so keep them in your minds as two different things.

That being said, I think you all have made a number of great suggestions, and while, in some sense, this workstream is going to a more technical, narrow area around the encounter-based model, some of the suggestions you all brought up would have implications around incentives for plans and incentives in a broader sense. So thinking about the idea of holding out high-cost or high-risk populations, for example, that would have implications.

So I think we'll have an opportunity to revisit this work and talk about it. We're going to look at the transcript and see all of the suggestions that you have

made, and then kind of plan our work going forward. And then we will revisit this in the spring.

Andy, thank you, as always, for great, thoughtful work, and a great presentation. And thank you, Commissioners, for very, very thoughtful conversation.

DR. NAVATHE: So that brings this MA risk adjustment topic to a close. Before we wrap up I wanted to, of course, give any in-person attendees the opportunity to make a public comment if they would like to do so.

Yes, please come up to the mic. We'll allocate three minutes per individual. Please introduce and identify yourself.

DR. WU: Yes. My comments will be short. Good morning, everyone. My name is Shannon Wu. I'm the Director of Payment Policy at the American Hospital Association. We appreciate this opportunity to come in person once again.

We commend MedPAC on going to work to examine the access and care provided to Medicare Advantage beneficiaries.

As the AHA has noted numerous times, enhancing network adequacy requirements and oversight of practices

such as prior authorization would help improve beneficiary access to high-quality care.

But lack of in-network, post-acute care providers can be seriously disruptive for patients who need continued care at LTCHs, IRFs, and home health agencies. The omission of these provider types is especially striking given CMS's recent efforts to ensure parity in access to these services between MA and traditional fee-for-service Medicare beneficiaries. Including these provider types in network adequacy requirements would be a commonsense step that would help ensure parity between the two groups.

In addition, MA plans continue to employ prior authorization tactics that push patients to lower-cost settings, even when there is a demonstrated clinical need for care at an IRF or an LTCH. Enhancing oversight of these practices will ensure MA plans receive the right care at the right place.

The AHA stands ready to assist MedPAC on analysis of the impact current inadequate MA post-acute network requirements as well as prior authorization practices on beneficiaries' access to care and welcomes any collaboration with MedPAC that it might find helpful.

So thank you for that.

DR. NAVATHE: Thank you very much for your comment.

For those of you who are listening through the web platform, we would love to hear from you, as well. You can submit your comments at meetingcomments@medpac.gov.

And otherwise that would adjourn this meeting. Thank you, everyone.

[Whereupon, at 11:58 a.m., the meeting was adjourned.]

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