MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC SESSION

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10:32 a.m.

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AGENDA PAGE

Reforming physician fee schedule updates and improving the accuracy of payments
- Geoff Gerhardt, Brian O'Donnell......................3

Lunch..77

Considering the participation bonus for clinicians in advanced alternative payment models
- Rachel Burton, Luis Serna, Pamina Mejia.............78

Recess..144

Structural differences between the PDP and MA-PD markets
- Shinobu Suzuki, Tara Hayes, Andy Johnson...........145

Adjourn...205

1 P R O C E E D I N G S

2 [10:32 a.m.]

3 DR. CHERNEW: Hello, everybody. Welcome to our
4 November MedPAC meeting. We have a lot of important topics
5 to discuss, three today, two tomorrow, and we're going to
6 start with a topic that we have been interested in for a
7 long time. And it is good to see this work moving along
8 and getting to fruition.

9 I think Brian is going to start with our
10 discussion of reforming the physician fee schedule.

11 MR. O'DONNELL: Good morning.

12 Today we'll discuss approaches to reform
13 physician fee schedule updates and improve the accuracy of
14 fee schedule payments.

15 Viewers can download a copy of this presentation
16 in the handout section of the control panel on the right-
17 hand side of your screen.

18 And before we begin, we'd like to thank our
19 colleague, Rachel Burton, for her assistance with this
20 work.

21 We'll start the presentation with some
22 background, the Commission's principles for assessing the

1 adequacy of fee schedule rates and the Commission's past
2 findings with regard to beneficiary access to care. We'll
3 then discuss some concerns with current fee schedule
4 updates and then a policy option to reform those updates.
5 We'll then pivot to discussing concerns with the accuracy
6 of fee schedule payment rates and approaches to improve the
7 accuracy of those payments.
8 We'll end with Commissioner discussion and
9 feedback. Depending on Commissioners' reactions to this
10 information, draft recommendations could be developed and
11 presented to the Commission in the spring.
12 First, to discuss some background. The fee
13 schedule pays for about 9,000 different clinician services.
14 These services are performed in a wide variety of settings,
15 including non-facility settings, such as clinician offices,
16 and facility settings, such as hospitals.
17 Each of the 9,000 services can be discrete, such
18 as the performance of an x-ray, or represent a bundle of
19 care, such as a surgical procedure bundled with post-
20 operative visits.
21 Payment rates for fee schedule services are
22 determined based on RVUs, the conversion factor, and other

1 adjustments. RVUs vary across services and can change
2 based on where a service is performed, with services
3 performed in facilities often having fewer RVUs.
4 RVUs are broken down into three components:
5 work, which accounts for factors such as the time, effort,
6 and skill of the clinician furnishing the service; practice
7 expenses; and professional liability insurance.
8 Within the broad category of practice expenses,
9 there are two distinct types of practice expenses, direct
10 and indirect. Geoff will talk more about direct and
11 indirect practice expenses later in the presentation.
12 RVUs are multiplied by a conversion factor to
13 calculate a payment amount. The Congress has used
14 different approaches to update the conversion factor over
15 time. Current updates are largely based on MACRA, which
16 I'll discuss in the next slide.
17 This slide shows that with the exception of one-
18 time payment increases from 2021 to 2024, which are noted
19 in orange text, fee schedule updates are below 1 percent
20 per year and are directly specified in statute. This means
21 that updates don't automatically adjust to changing
22 economic conditions, such as increases in inflation.

1 In addition, beginning in 2026, updates will vary
2 based on whether a clinician is in an A-APM or not, meaning
3 there'll be two conversion factors, a lower one updated by
4 0.25 percent per year for clinicians not in an A-APM, and a
5 higher one updated by 0.75 percent per year for clinicians
6 in A-APMs.
7 MACRA also specifies payment adjustments for
8 clinicians in MIPS and A-APM bonuses. We won't focus on
9 these topics in this presentation. Instead, our colleague,
10 Rachel Burton, will provide more information in a separate
11 presentation later this afternoon.
12 In assessing whether Medicare payment rates are
13 adequate, the Commission's principles hold that payments
14 should ensure beneficiary access to care, reflect efficient
15 care delivery, and promote high-quality care. Payment
16 rates should ensure beneficiary access and reflect good
17 stewardship of taxpayer resources.
18 Since MACRA was implemented, the Commission has
19 largely recommended implementing current law updates.
20 However, in response to increased levels of inflation and
21 other issues, in 2023 and 2024, the Commission recommended
22 updates of current law plus half of the growth in MEI,

1 which is a common inflation metric that measures the
2 average price change for inputs involved in furnishing
3 clinician services and additional safety net add-on
4 payments for treating low-income beneficiaries.
5 As I mentioned in the previous slide, ensuring
6 beneficiary access to care is a key factor in evaluating
7 the adequacy of fee schedule rates, and over many years,
8 the Commission has found that beneficiary access to care
9 has been comparable to the privately insured.
10 For example, survey data suggests beneficiary
11 access to care is comparable to that of the privately
12 insured. Clinicians accept Medicare at similar rates as
13 commercial insurance, despite lower payment rates than in
14 commercial insurance. Volume and intensity of care per
15 beneficiary has increased over time, and other longer-term
16 indicators of access have also remained positive.
17 In the June 2024 report to the Congress, the
18 Commission explored alternatives to current law updates of
19 fee schedule rates. In that report, the Commission
20 considered updating fee schedule rates by a portion of MEI
21 growth, such as MEI minus 1 percentage point. The
22 Commission also expressed multiple concerns about the

1 accuracy of fee schedule payment rates.
2 In the next few slides, I'll go over two concerns
3 Commissioners have expressed about future fee schedule
4 updates, starting with the issue of inflation.
5 MEI growth outpaced fee schedule updates by just
6 over 1 percentage point per year for the two decades prior
7 to the pandemic. However, from 2025 to 2034, the projected
8 annual difference between MEI growth and fee schedule
9 updates is larger, 1.5 percent for clinicians in A-APMs and
10 2.0 percent for clinicians not in A-APMs.
11 Historically, the Commission has found that
12 Medicare beneficiaries had similar access to care relative
13 to the privately insured, but the larger gap between MEI
14 growth and fee schedule updates could negatively affect
15 beneficiary access to the care in the future.
16 A second concern is that the differential updates
17 specified under current law will initially provide a very
18 small incentive to participate in A-APMs and, in later
19 years, a very large incentive.
20 For example, as shown in the figure, in 2027, A-
21 APM clinicians' payment rates will be 1 percent higher than
22 other clinicians' rates, but by 2045, that differential

1 will reach 10.5 percent.

2 Now I'll turn to the policy option to reform

3 physician fee schedule updates, and that policy option is

4 to replace the dual fee schedule updates based on A-APM

5 participation, with a single update based on a portion of

6 MEI growth. And as I mentioned earlier, the Commission

7 considered this approach in its June 2024 report to the

8 Congress.

9 In designing the specific update, policymakers

10 could consider a range of reasonable options, such as MEI

11 minus 1 percentage point with a minimum update floor.

12 Regardless of the specific approach, the key concept is

13 that historical evidence suggests that a full MEI update is

14 not needed to maintain access to care.

15 The policy option is intended to ensure continued

16 beneficiary access to care without incurring unnecessary

17 increases in Medicare spending. Updates based on a portion

18 of MEI, such as MEI minus 1 percentage point, have multiple

19 benefits, including that they are simple to administer, as

20 they would apply across the board to all fee schedule

21 services; automatically adjust to changes in inflation,

22 which as we've seen over the last several years can be

1 substantial and difficult to predict; improve
2 predictability for clinicians, beneficiaries, and
3 policymakers; and achieve good value for taxpayers and
4 beneficiaries.
5 As we mentioned in your mailing materials,
6 setting higher default updates would not negate the need
7 for future monitoring. The Commission would continue to
8 monitor access to care and, to the extent needed, recommend
9 higher or lower updates in the future.
10 I'll now turn it over to Geoff, who will switch
11 from discussing how fee schedule rates are updated to
12 improving the accuracy of fee schedule rates.
13 MR. GERHARDT: Thanks.
14 As Brian just mentioned, the second half of this
15 morning's presentation will explore issues related to the
16 accuracy of fee schedule payment rates.
17 Over the years, MedPAC has expressed concerns
18 about how the RVUs are determined and updated over time.
19 Ensuring that payment rates are as accurate as possible in
20 a relative sense is important because RVUs affect the
21 distribution of Medicare payments across different
22 services, clinicians' specialties, and place of service.

1 Payment rates also have a direct impact on beneficiary
2 liability through the 20 percent cost sharing.
3 It's also worth noting that many commercial
4 insurers base their rate on fee schedule RVUs, so mis-
5 valuations can carry through to other parts of the health
6 care system.
7 In 2006 and 2011, the Commission made a series of
8 recommendations on how to improve accuracy of RVUs. A
9 summary of those recommendations are shown on this slide
10 and appear in full in your mailing materials.
11 In addition to its formal recommendations, the
12 Commission has touched on numerous other issues in its
13 reports and comment letters. The June 2024 report, for
14 instance, drew attention to challenges with valuing work
15 RVUs.
16 There are three broad concerns about fee schedule
17 accuracy I want to highlight today. While there is some
18 overlap with the previous recommendations, the issues I'll
19 talk about are, in many ways, distinct and may warrant
20 additional attention from policymakers.
21 First, concerns have been raised about the
22 timeliness and accuracy of data on clinician practice

1 costs, which are used to help determine practice expense
2 RVUs.
3 Second, the data and assumptions that are used to
4 determine RVUs may not reflect current practice patterns,
5 which tend to change over time.
6 Third, the fee schedule does not currently
7 account for any financial relationship between a clinician
8 and a facility, such as a hospital.
9 On the following slides, I'll focus on three
10 illustrative examples of policies that could be used to
11 address those concerns about mis-valuation.
12 In the first example, I'll discuss how practice
13 costs for work, practice expense, and professional
14 liability insurance are allocated across total RVUs.
15 Second, I'll review two ways the payments for
16 global surgical codes could be improved.
17 Finally, I'll explain why the fee schedule may
18 overpay for indirect practice expenses in certain
19 circumstances and how that issue might be addressed.
20 I want to emphasize that this is not an
21 exhaustive list. There are numerous other examples of how
22 the current rate-setting process could be improved. That's

1 why if Commissioners decide to make a recommendation on
2 improving payment accuracy, you may want to consider a more
3 general recommendation instead of one that is highly
4 specific.
5 In our first illustrative example, we'll look at
6 how the distribution of physician practice costs are used
7 to determine RVUs. On an aggregate basis, the share of
8 RVUs devoted to work, practice expense, and professional
9 liability insurance are supposed to reflect the
10 distribution of those costs in a typical physician
11 practice.
12 The method for making these allocations is
13 complex, but it starts with looking at how the Medicare
14 Economic Index says those costs are distributed.
15 Several data sources are used to calculate the
16 MEI, including survey data from the American Medical
17 Association. The MEI has been updated many times
18 over the years, reflecting updated data about physician
19 practice costs. The most recent MEI is based on cost data
20 from 2017. Prior to that, the MEI was based on data from
21 2006.
22 Normally, CMS would update cost allocation among

1 RVUs concurrently with any updates to MEI. However, when
2 the most recent update was released, CMS elected to
3 continue using the previous version of the MEI. The agency
4 said it wanted to wait until the MEI completes another
5 round of data collection.
6 If the most recent MEI data were used to
7 determine how RVUs are distributed, the share of total RVUs
8 devoted to work, practice expense, and liability would
9 change from the shares currently in use.
10 The work share would decrease from 50.9 to 47.5
11 percent. The practice expense share would increase from
12 44.8 percent to 51.1, and the professional liability
13 insurance share would decrease from 4.3 percent to 1.3
14 percent.
15 I want to emphasize that these changes do not
16 represent changes in the absolute cost of these expenses.
17 Instead, they reflect changes in the share of total
18 expenses devoted to each type of cost among typical
19 physician practices.
20 Updating the cost shares using the most current
21 MEI would have different effects on different services,
22 depending on the size of work, practice expense, and

1 liability insurance RVUs.
2 However, we can make a couple of broad
3 observations. The table on this slide has some top-line
4 information about how updating RVUs using the most recent
5 MEI is likely to affect RVUs.
6 Compared to the current RVUs, using the updated
7 MEI, we tend to increase total RVUs for non-facility
8 services and decrease total RVUs for facility services.
9 This would happen because practice expense RVUs are larger
10 for non-facility services. So the increase in practice
11 expense component is the primary driver of change.
12 PE is smaller for facility services. So the
13 primary driver of change in those RVUs is the reduction in
14 liability insurance as a share of total costs.
15 Your mailing material has more information about
16 how using updated MEI would affect rates for different
17 types of services, as well as projected impact by
18 specialty.
19 Couple of other things to note. As a matter of
20 policy, it's probably a good idea to update the MEI-based
21 cost shares as frequently as possible. This would help
22 ensure that RVUs are based on the most recent data

1 available about physician practice costs.
2 Relatedly, more frequent updates could also act
3 to minimize large shifts in RVUs caused by waiting longer
4 periods of time between updates. However, it's difficult
5 to predict how costs will be distributed in future versions
6 of the MEI. So basing RVU cost shares on the next MEI
7 could have very different effects than what is shown here.
8 In our third and final example of possible
9 mispricing of fee schedule services, we look at -- sorry.
10 That's not our third example.
11 In our second example, we look at 10-day and 90-
12 day global surgical codes.
13 A little less than half of all fee schedule codes
14 bundled together are payments for all services that occur
15 on a day of a procedure as well as all post-operative
16 visits furnished by the clinician during the following 10-
17 or 90-day period.
18 Generating payment rates for these codes involves
19 making assumptions about average number of postoperative
20 visits furnished by the performing clinician during the
21 applicable 10-day or 90-day period.
22 Visits furnished by other providers are paid

1 separately unless there's a formal transfer of care
2 agreement.
3 Studies have shown that for most global codes,
4 fewer postoperative visits were actually furnished than is
5 assumed in the payment rate. This results in overpayment
6 for many global codes and higher beneficiary liability,
7 since cost sharing is based on the total global payment,
8 which includes visits that are not occurring.
9 One way of addressing this issue is to convert
10 all 10- and 90-day global codes to so-called "zero-day
11 codes." This would involve removing expenses associated
12 with postoperative visits from the total RVU for each
13 global code. Each postoperative visit would then be billed
14 separately. Thus, payments would reflect the actual number
15 of visits furnished rather than an assumed number.
16 Some stakeholders point out that although
17 beneficiary liability would decrease for the procedure
18 itself, probably go down on net, being asked to make cost-
19 sharing payments for each postoperative visit may
20 discourage patients from seeking appropriate follow-up
21 care.
22 CMS has proposed converting all global codes to

1 zero-day codes, but legislation prevented the agency from
2 carrying out the proposal.
3 Another way of addressing the issue is to revalue
4 global codes so the payment rates accurately reflect the
5 number of postoperative visits that are actually delivered.
6 A RAND study found that revaluing codes in this
7 way would reduce global RVUs by an average of 28 percent.
8 Applying a budget neutrality factor so that total spending
9 does not change would result in an across-the-board
10 increase to payment rates of 2.6 percent.
11 One benefit of this approach is that beneficiary
12 liability would decrease for most global codes, and they
13 wouldn't face cost sharing for postoperative visits
14 furnished by the performing clinician during the global
15 period.
16 However, the process of revaluating 4,000 codes
17 to reflect practice data that is not readily available
18 would take more time and resources than converting to zero-
19 day codes.
20 Our final example, illustrative example, concerns
21 how indirect practice expenses are paid when a fee schedule
22 service is furnished in a facility setting, such as a

1 hospital outpatient department. For most services
2 furnished in a non-facility setting, such as a clinician
3 office, fee schedule rates include payment for clinician
4 work and both types of practice expense, direct and
5 indirect, and professional liability insurance.
6 The indirect practice expense component includes
7 practice expense overhead costs, such as administrative
8 staff and office equipment.
9 Direct practice expense includes the cost of
10 medical equipment, supplies, and non-physician clinical
11 labor, such as nursing wages.
12 When a service is furnished in a facility, the
13 payment rate is somewhat different. Facility rates include
14 work, indirect practice expense, and PLI, but do not
15 include direct practice expense. This approach is based on
16 the assumption that when clinicians furnish service in a
17 facility, they are not paying for direct practice costs
18 because those expenses are being paid by the facility and
19 reimbursed through another payment system.
20 It also assumes that all physicians are
21 maintaining a freestanding office independent of the
22 facility, so they need to be reimbursed for those indirect

1 practice costs.

2 As we'll see on the next slide, however, the

3 assumption that all physicians are maintaining offices that

4 are independent of a hospital may no longer be as true as

5 it once was.

6 The data shown on this table comes from a survey

7 of physician practices fielded by the AMA every two years.

8 The column on the far left categorizes physicians according

9 to their employment or practice ownership status. The

10 percentage of physician in practices that are financially

11 independent of any hospital dropped between 2012 and 2022,

12 while the share of employed by a hospital or working in a

13 practice owned by a hospital have increased substantially.

14 These trends have been underway for some time,

15 but it's notable that by 2022, fewer than half of all

16 physicians worked in an independent practice, while more

17 than 40 percent were financially affiliated with a

18 hospital.

19 The results of this survey and similar studies

20 suggested the assumption that all physicians need to be

21 reimbursed for indirect practice expense when a service is

22 furnished in a facility may be increasingly flawed.

1 Addressing this issue would involve reducing or
2 eliminating practice expense RVUs for facility services,
3 when there's reason to believe that the clinician
4 furnishing the service has a direct financial connection
5 with the facility.
6 The impacts of such policy would depend on how it
7 is designed and implemented, but by definition, there would
8 be a decrease in overall payments among clinicians who have
9 a financial connection to a facility.
10 In order to maintain budget neutrality, the
11 reduction in payment rates for those services would result
12 in an increase in payment rates for all non-facility
13 services and facility services not performed by a hospital-
14 affiliated clinician.
15 Among services that can be furnished either in a
16 facility or an office, the increase in non-facility rates
17 could provide incentive to furnish more services in a non-
18 facility setting.
19 The policy may also reduce incentives for
20 clinicians who are not already hospital affiliated to
21 consolidate with hospitals and help them maintain financial
22 independence.

1 The impacts are less clear if the policy reduces
2 practice expenses for a specific set of hospital-based
3 services rather than hospital-based clinicians, depending
4 on how it's implemented.
5 We plan to do additional work on this issue and
6 provide more information in the spring.
7 We'll wrap up with several issues for
8 Commissioners to consider. First, do Commissioners support
9 reforming the current-law approach to fee schedule updates
10 by having a single conversion factor and basing annual
11 updates on a portion of MEI growth? Second, do
12 Commissioners see the need to take additional steps to
13 improve the accuracy of fee schedule payment rates? Based
14 on Commissioner feedback, the Chair may present draft
15 recommendations for consideration in the spring.
16 Brian and I look forward to your questions and
17 discussions. I'll now hand things back to Mike.
18 DR. CHERNEW: Thanks so much. There's a lot of
19 information there, and for those of you at home that have
20 not gotten to see the chapter, the level of detail and
21 complexity of the way we pay people is really stunning.
22 I'm going to leave -- I'll leave it there.

1 But I think we're going to start the queue, and I
2 think Amol is first in Round 1.
3 DR. NAVATHE: Great. Brian, Geoff, thank you for
4 this fantastic work.
5 So I had one clarifying question and then one
6 maybe just asking for you to go over some evidence that you
7 reference in the text.
8 So the first is, in the paper on page 37, there's
9 a quote -- I'm going to try to read it more or less
10 accurately -- which is "If indirect PE allocation increases
11 for services because work is increased, then indirect PE
12 for other services will decrease."
13 So I just wanted to -- I think I understand the
14 second part of that, which is why indirect PE for other
15 services will decrease. I wanted to quickly ask if you
16 could clarify or if I'm understanding correctly, the reason
17 that indirect PE will go up if work increases. Is that
18 because the ratio has to stay the same?
19 MR. GERHARDT: In terms of the allocation, yes.
20 In terms of if a PE valuation increases, that is made sort
21 of budget neutral within the PE world and would not affect
22 work, and work would not affect that.

1 The work thing comes into play, kind of two ways.
2 One is through the allocations that we talked about. The
3 other way is if work increases, then that has to be budget
4 neutralized through the conversion factor, and so that
5 would not push down the RVUs for PE, but it would
6 effectively push down the payment rates for PE-heavy
7 services. Does that make sense?
8 DR. NAVATHE: I think so. So it's basically a
9 combination of the two things. It's the ratio of PE to
10 work as well as the budget neutrality both end up kind of
11 playing a role in there.
12 MR. GERHARDT: Yeah.
13 DR. NAVATHE: Is that right?
14 MR. GERHARDT: Yeah. And, again, the budget
15 neutrality concept plays out differently depending on what
16 RVUs are changing.
17 If it's work, it goes in a conversion factor. If
18 it's PE, it's done within the world of PEOPLE.
19 DR. NAVATHE: It gets redistributed.
20 MR. GERHARDT: Right.
21 DR. NAVATHE: Okay. Okay, great. Thank you for
22 that. That was super helpful.

1 The second piece is, so we have quite a bit of
2 discussion around access and other elements here relating
3 to payment, and I think there's one of the sentences which
4 I'm just going to pluck out, if you will, is saying
5 evidence suggests that doing a full MEI update, meaning
6 just adding more dollars basically, would increase spending
7 without improving access. And I was just curious if you
8 could give us a sense of the evidence that you're
9 referencing there.
10 I mean, I would say, I guess, if I put my
11 economist hat on, I'm certainly aware of literature that
12 looks at payment changes that have happened historically
13 through a variety of different policies and looked at the
14 response on the supply side of physicians and others, and I
15 would say that's largely in keeping with what you're
16 saying. But I'm just kind of curious if there's other
17 things that you're referencing there, anything specific to
18 inflation, or is it just payment updates in general that
19 you're referencing there?
20 MR. O'DONNELL: No. So I think it's payment
21 updates, in general, and I think the concept is when we
22 went back over time and we looked at how the payment rates

1 were updated over time, they were updated after a series of
2 congressional patches at about MEI minus 1. And then you
3 look at payment rates in the commercial sector, which are
4 35, 40 percent higher than the Medicare rates. Then the
5 question is, okay, we've been going at MEI minus 1. Would
6 the marginal dollar buy us any increased access? And our
7 kind of comparator is the commercial insurance, which has
8 35 or 40 percent more dollars, and they didn't get any
9 better access. So I think that's the fundamental basis for
10 our conclusion that adding those extra dollars wouldn't buy
11 us any extra access.

12 DR. CHERNEW: I'm going to say something that you
13 might say if I don't say it. So I'm going to say it.

14 DR. NAVATHE: Okay.

15 DR. CHERNEW: So I understand -- thanks for that,
16 Just, I think, Amol referenced the beginning of this
17 question. There's also like quasi-experimental design
18 evidence that would, at least broadly speaking, be
19 consistent with the sort of small response. You can find a
20 response in particular ways. It's just a question of the
21 magnitude of that response in sort of a quasi-experimental
22 way.

1 DR. NAVATHE: Yeah. So that's exactly right.
2 That is what I was going to say. So, Mike, thank you for
3 stealing my words and my thunder.
4 [Laughter.]
5 DR. NAVATHE: But what might be helpful, just
6 because I think sort of conceptually, as I was thinking
7 through this, that ends up being a relatively important
8 point in terms of guiding our approach. So because there
9 is some quasi-experimental literature, if we can actually
10 cite to that or reference that, I think that would actually
11 be really helpful.
12 Thanks.
13 MS. KELLEY: Paul.
14 DR. CASALE: Yeah. Thank you for putting this
15 together. Very complicated, very helpful.
16 Just a clarifying question, one on the access.
17 When you mentioned the access, a few of the bullet points,
18 one was that clinicians who accept Medicare are similar
19 rates to commercial, and the other was more clinicians are
20 billing Medicare. Are there other pieces to how you define
21 access?
22 MR. O'DONNELL: So, sure. In our annual work, we

1 go through a series of measures to look at access, and I
2 think I always start out with a fundamental fact that in
3 the physician space, we lack cost report data to look at
4 margins, which is the foundation of so many other analyses.
5 But I think when we look at access in the
6 physician world, we start off with our own internal survey,
7 which looks at -- which surveys thousands of Medicare
8 beneficiaries. And then we look at survey -- and that's
9 just asking beneficiaries, can you access care? And then
10 we reference other surveys by the AMA, NHAMCS, CDC, to say
11 of clinicians who are taking patients, do they take
12 commercial? Do they take Medicare patients? So those are
13 the two kind of, I would say, kind of primary things.
14 But then we also look at things like volume, and
15 so, you know, we measure access through surveys. But we
16 also look at kind of the data to say, are they actually
17 getting services? And over time, they are getting more
18 services, and so even though that is an indirect measure,
19 it's a kind of a positive measure. And we have a series of
20 kind of smaller additional measures that we look at in
21 terms of access that all feed and point in the same
22 direction.

1 DR. CASALE: Yeah, thank you.
2 I guess the piece I was thinking about when I
3 think of access is sort of timeliness as part of it, and I
4 think, potentially, clinicians may preferentially see their
5 commercial patients as compared to Medicare based on what
6 you said around the difference in the payment. And so they
7 may have access, but it may not necessarily be timely.
8 That's probably a harder thing to sort of get at.
9 MR. O'DONNELL: On that point, I want to put a
10 plug in for next month, and we've heard this comment
11 before. And our colleague, Rachel Burton, who's behind us,
12 will go over some new results that kind of addresses that
13 issue.
14 DR. CASALE: Okay.
15 MR. O'DONNELL: And so I won't give the results
16 now. I won't steal the thunder, but I think, you know, we
17 hear you, and we're kind of working on addressing that.
18 DR. CASALE: Great.
19 And just one other clarifying question. Again,
20 you mentioned the AMA survey of specialty-level costs,
21 which I think has been challenging as a methodology, in
22 general, and it's been around a long time. In your

1 research and work, have there been alternatives to that,
2 that you think are maybe better than the AMA survey as it
3 relates to identifying specialty-level costs?
4 MR. GERHARDT: I mean, there are always
5 alternatives and different ways of doing things.
6 The AMA has been out there doing this thing for a
7 while. It is, as you referenced, not a perfect product,
8 not a perfect data source. There have been some that have
9 suggested that maybe specialty-level data shouldn't be
10 used, that it should be sort of an across-the-board
11 measurement of costs, which would, you know, kind of level
12 the playing field among different specialties in a way,
13 because, you know, there's quite a bit of variation for
14 reasons that you may want to not see reflected in the fee
15 schedule.
16 So I'm not going to say that the AMA is doing it
17 wrong or that they should be doing it better. I'm just
18 saying there are viable alternatives.
19 The question more is, you know, they collected
20 the specialty level for the most recent MEI. They're out
21 there fielding a new one. Shouldn't -- you know, should we
22 use the most recent one, and then when they have the new

1 data, just kind of update it? And that's sort of more the
2 issue.
3 DR. CASALE: Yeah. And I guess I come from that
4 based on some of the experience in cardiology, in
5 particular, where years ago, there was sort of -- again,
6 you know, they've been doing this a long time, but they
7 didn't get enough surveys necessarily around some of the
8 expenses. And that led to reductions that then had an
9 effect of integration to health systems, which I know
10 you're all aware of.
11 So I just was curious if there -- as you said,
12 maybe there are other ways.
13 MR. GERHARDT: Yeah. Of course, we have heard
14 about reports of poor response rates for particular
15 specialties as being a problem, which is why it can take so
16 much effort and time to do these surveys. So, yeah, that
17 is one aspect that is troublesome.
18 MR. MASI: Okay. And if I could just add on to
19 that.
20 So really appreciate you surfacing this, Paul,
21 and I think what comes to my mind in this conversation is
22 access can be challenging to measure. And so we recruit

1 lots of different types of information to try to -- in the
2 course of coming to our assessment, but it is a challenging
3 thing where we're always trying to look at more sources of
4 data.
5 And I would just underline Brian's plug that stay
6 tuned for December. We're going to talk all about access
7 as part of our annual December and January update
8 conversations.
9 DR. CHERNEW: I'm just waiting for Larry to get
10 in the queue, Larry. So I will say this, and then Larry
11 will get in the queue and say it again.
12 There's sort of this measures of access that we
13 have, and then to the earlier question, the responsiveness
14 of that to various policy things. And we could have a
15 discussion.
16 Now we are having a discussion about the fiscal
17 responsiveness, but there's a lot of other things that are
18 driving access in a range of ways and policies that you
19 might do to support access related to workforce and a whole
20 slew of other things that we will think through. But I do
21 think that the measurement theme is run through this pretty
22 deeply.

1 I think Gina is next.
2 MS. KELLEY: Gina is next.
3 MS. UPCHURCH: Thanks, and this is super helpful
4 information.
5 Just a quick question about surgery bundles, make
6 sure I understand it from a consumer's perspective.
7 So people that are in fee-for-service Medicare,
8 many of them have secondary coverage of some sort, and I'm
9 not sure that they're proactively told, oh, by the way,
10 when you have a follow-up within 70, whatever, 10 or 90
11 days, you won't pay anything. I don't think they
12 proactively know that. So I don't know that's why they're
13 avoiding the follow-up. So I'm just curious what you think
14 of that.
15 MR. GERHARDT: So it's true. If you have
16 secondary insurance and you're just not paying basically
17 any cost sharing, you're really not going to know the
18 difference in terms of whether they're bundled or
19 unbundled.
20 MS. UPCHURCH: Right.
21 MR. GERHARDT: The cost sharing will just be
22 taken care of by the secondary payer.

1 But for those who are feeling it more directly,
2 they're sort of paying a -- I won't say a lot, but a good -
3 - you know, this higher share of cost sharing at the front
4 end when they initially have the surgery, as it is now, or
5 under unbundled zero-day approach, it's a smaller cost
6 sharing initially and then smaller chunks as you do every
7 follow-up visit. So it just kind of spreads it out.
8 The main argument with the current bundling and
9 cost sharing is because the bundles include essentially too
10 much follow-up care as part of the cost, that's sort of
11 artificially inflating the entire cost and there's the cost
12 sharing. And so, in those cases, beneficiaries are paying
13 extra or their secondary insurance plan is paying more cost
14 sharing than they should.
15 MS. UPCHURCH: Okay. I guess the point I'm
16 making is they're probably not avoiding follow-up because
17 they have no idea that it's already included.
18 MR. GERHARDT: Right. So for those, the
19 incentives are kind of -- that incentive change does not
20 come into play, basically.
21 MS. UPCHURCH: Thanks.
22 MS. KELLEY: That's all I have for Round 1. Do

1 you want me to go to Round 2 now, or do you want to do
2 something --
3 DR. CHERNEW: Yeah. Let's -- so yeah. I do want
4 to go to Round 2. So just because we're contemplating
5 getting into some recommendations, I want everybody to get
6 a chance to weigh in at least on our direction so we can
7 get -- remember, it's important in the public meeting
8 session, not just what you think, but what counts is what's
9 said in the public meeting. So we're going to do that in a
10 minute.
11 So the plan is going to be we're going to start
12 with the Round 2 queue. Dana will go through, but those of
13 you that aren't in the queue, then I'm going to -- I have a
14 list here, and I know where you're sitting. This includes
15 you, Larry. And we will then go around just until at least
16 everybody say what they need to. But okay, yes.
17 MS. KELLEY: Okay. Betty is first.
18 DR. RAMBUR: Thank you very much. This was a
19 fascinating chapter, and I usually underline things I want
20 to remember in the documents, and the whole thing is
21 underlined in yellow. So that's really important.
22 I have a couple of comments. The RUC has

1 mentioned on page 8 sort of casually, and then on page 53,
2 it mentions their potential role in re-valuating global
3 codes. And I strongly support the re-valuation of global
4 codes. I think it's just important to have a definition of
5 the RUC just in the footnotes when it's first discussed as
6 AMA physician, specialty physician-dominated group.
7 They're hardly without skin in the game.
8 You don't necessarily need to include my personal
9 view that they have an outside role, but I think just
10 having a description of them is an important thing, and
11 then the readers can decide for themselves.
12 The second major point I wanted to make is on
13 slide 11. As I read the document and look at the slide, it
14 sort of implies that that difference between clinicians and
15 advanced alternative payment models and other clinicians is
16 a problem.
17 And I'd just like to share, I might have a
18 different sense of MACRA than you, and that will come in
19 the next session. But I've always viewed something very
20 positive about it is that there is an incentive for
21 providers to take on financial risk in MIPS over time and
22 in the alternative payment models more directly.

1 So I am comfortable thinking about the automatic
2 update, but I'm also thinking of former Commissioner Bruce
3 Pyenson, and he would be saying, what about deflation?
4 We're talking about inflation. And I'm very concerned
5 about how we move away from that addiction to volume. So
6 that's more of a philosophical piece, but it's really very
7 much how I look at this.
8 But thank you. I thought it was really great
9 work.
10 MS. KELLEY: Scott.
11 DR. SARRAN: Thanks, guys, for really great work.
12 I'm not sure I remember many presentations that led me to
13 think that there were so many clear, no-brainer next steps,
14 as you got us to this time. So very good work.
15 So I support essentially all of where you're
16 going.
17 The MEI minus 1, I feel like what you're doing a
18 great job of or where we're landing is a great threading of
19 multiple needles. It puts some predictable increases for
20 physicians who are going to be hurt realistically by
21 unpredictable inflation from year to year, and I think
22 there's fiscal prudence in the minus 1. So I think that's

1 just an excellent compromise and approach.
2 Updating the MEI, again, to me, no-brainer. It's
3 that as well as the indirect practice expenses. I think
4 both help significantly address the concerns about
5 hospital-employed physicians and the way that their scale,
6 playing field, whatever is tipped a little bit in their
7 favor right now. And that's not a direction we want to
8 continue to have, where it just pushes more towards
9 hospital consolidation of practices.
10 And then the global surgical bundle, it's just,
11 to me, a very logical thing to fix. It's not consistent
12 with -- the current approach is not consistent with the
13 practice that's out there now, the common set of practices.
14 I think, as you point out, the simpler approach,
15 which is take them all back to zero rather than trying to
16 get something specific for each of the surgical codes, I
17 think the virtue of simplicity in that makes that approach
18 the right one.
19 So thanks again, guys.
20 MS. KELLEY: Robert.
21 DR. CHERRY: Yeah, thank you. I just want to
22 echo Betty's comments as well. I think every line of this

1 was a value-add and so really put together quite well.
2 One of the things I want to mention is to really
3 explicitly state the overall problem that we're trying to
4 solve, and that's really to make sure that the physician
5 fee schedule keeps up with the increase in cost of practice
6 in delivering those services, because of inflationary
7 pressure. So anything that supports that, I'm in favor of,
8 which includes the MEI and even the great work that I think
9 many have put in in terms of the safety net index too,
10 which can also augment reimbursement too, particularly for
11 physicians that are practicing in underserved areas.
12 I think -- you know, just a few comments. I
13 think this whole aspect around, you know, because there's
14 not necessarily an access problem compared with commercial,
15 is there an urgency to problem-solve around this? I don't
16 think we want to wait until there's an access problem,
17 because when there's an access problem, it's going to be
18 really difficult to course-correct. So I think we want to
19 really start thinking about this much more proactively.
20 We're already getting signals from many different
21 physician groups advocating for keeping up with
22 inflationary costs and practice costs, and that's something

1 we really have to listen to and pay attention to. When
2 some practices are saying that they're losing money with
3 every Medicare patient that they take care of, that should
4 give us pause and some degree of concern.
5 And it's not just happening with private practice
6 physicians that are articulating this. There's a whole
7 group of employed physicians that are also very concerned
8 about keeping up with inflationary pressures.
9 And I'm also concerned that with the employed
10 model too, that we're seeing also an increased trend in
11 physicians, not just residents, becoming unionized. And if
12 that trend continues or accelerates because the only
13 pathway that physicians see in order to preserve their
14 purchasing power is through a collective bargaining
15 pathway, that will eventually start to change the health
16 care delivery model in ways that we can't anticipate.
17 I'm not saying that unionizing is good or bad.
18 It's just that we just don't yet understand the
19 consequences, but the consequences are because of
20 unfavorable circumstances in the environment that we're
21 talking about now.
22 And then as far as the RVU accuracy model, I

1 think, again, if it's linked towards solving the problem
2 around inflationary pressures, I'm fine with that, but I
3 just want to make sure we're not conflating the messages
4 here. But I think it's a complicated problem to solve
5 because there's a lot of things happening that can disrupt
6 that model. We still have telehealth regulations that are
7 still outstanding. There's site-neutrality legislation
8 that is still pending out there, and the safety net index
9 hasn't been adopted. And all of these variables can
10 disrupt any type of RVU accuracy model that you might come
11 up with. But, nevertheless, I'm open-minded to it because,
12 as I said, anything that kind of solves the problem around
13 inflationary adjustments, I'm all ears on that.
14 So thank you for all the hard work. Really
15 appreciate it.
16 MS. KELLEY: Brian.
17 DR. MILLER: This is a great chapter. I really
18 enjoyed reading it, and I think all of us, I hate to say,
19 nerded out when we read this.
20 Just a couple of old ideas and then new ideas. I
21 said these old things before. I know that we're getting a
22 new beneficiary access survey. I'm looking forward to

1 that. I just want to emphasize that qualitative measures
2 are important, but inefficient if you ask a retired
3 beneficiary if the appointment in three weeks at 11 a.m. is
4 sufficient, if they do not have to go to the office from 8
5 to 5, even if they have transportation barriers and are
6 unable to get there, that's different than a commercial
7 beneficiary where the plan is paying a doctor, hospital,
8 whoever 2 1/2 times Medicare and they get an appointment in
9 a week. I think we all know that those differences exist,
10 and we should measure them.
11 I think the volume intensity response that saw in
12 Figure 2 on Page 24 is actually pretty good market evidence
13 that the PFS is not adequate, because PFS is driving people
14 to higher volume of higher intensity services. I don't
15 think any of us want a 6.9-minute primary care visit, and I
16 don't think any of us think that is a good philosophy to
17 strive for, for Medicare beneficiaries.
18 There are some new comments. I am 300 percent
19 with my colleague, Robert, about being proactive in
20 addressing first things first. So I think in addressing
21 the inflation factor is critical. We've got to make sure
22 that doctors are paid adequately and it doesn't diverge

1 from other markets. And I think if site neutral were to be
2 implement, which there is a lot of pending legislation, we
3 don't want to unfairly penalize hospitals and clinics and
4 put them on a PFS schedule with a 0.25 percent update. I
5 think we can all agree that that is absolutely insane and
6 completely unreasonable. So I think we need to think about
7 this inflation factor something that's good for the health
8 system writ large.
9 A technical comment. On page 39 we talked about
10 employed clinical groups, hospitalists, ER docs, critical
11 care dogs, interventional radiology docs. I'm an employed
12 hospitalist. But there are lots of hospitalists that are
13 not employed. So there are lots of hospital-based
14 physicians, be it critical docs, ER docs, that are part of
15 a separate medical group, that have a different contract.
16 So I think we need to address that complexity and that
17 market structure and realize that hospital-based clinicians
18 are not all the same, that we don't unfairly either
19 penalize or reward one group or the other.
20 So I think our focus for this conversation, just
21 the broader thought, is that we should focus here with our
22 recommendation on the inflation update.

1 I agree with everyone else that mispriced
2 services are a problem. I think it's a whole bigger
3 discussion, and I don't think we want to sandbag -- and I
4 agree with Robert -- we don't want to unintentionally
5 sandbag that inflation update discussion for doctors and
6 doctors who work in hospitals and clinics, by addressing
7 and getting bogged down in the details of mispriced codes.
8 I think many of us agree that the rec can be
9 challenging and problematic. But I think as part of that
10 conversation we also need to recognize that CMS, as an
11 agency, does have agency and accountability. So we can be
12 as upset as want about someone making pricing
13 recommendations. But CMS has the opportunity to not take
14 those recommendations. CMS can do different things. They
15 can make changes. They can have latitude to make different
16 decisions about the valuation of services.
17 So I think that's sort of getting in the mix when
18 everyone knows that there are challenges with the rec. I
19 think us getting in the mix is not going to add value, and
20 frankly, is just going to cause more problems, because
21 this, to me, seems like that's an agency oversight issue as
22 opposed to a broader payment policy issue.

1 I think the other sort of challenge I have with
2 mispriced codes is I think it's a logical fallacy for us to
3 assume that the government can set the right price for
4 8,000-plus services annually, on an annual basis. The rest
5 of the economy, whether it's gas prices, iPhones, shoes,
6 concert tickets for Taylor Swift, whatever it is, we don't
7 have an agency that's sitting there making pricing
8 decisions on an annual basis in a 2,000-page rule.
9 So I think regardless of what happens, under that
10 current operating model there are going to be lots of
11 mispriced services. There are always going to be mispriced
12 services. And I don't think it's a good use of our time as
13 a Commission to try and do that technocratic tinkering when
14 that's largely an issue that CMS probably should address
15 and needs to address, and they have more staff than we do.
16 But I think we all agree that that's a problem.
17 So my suggestion for us, as a Commission, is that our PFS
18 discussion focus primarily on the inflation update, because
19 I think that's something that we can all agree on. And
20 that's something that's a very clear message to
21 policymakers, and the staff will work hard to support them.
22 DR. RAMBUR: Very quick on this one. I'm just

1 suggesting that we define what RUC is in a footnote, so
2 that the readers can understand what it is. That's all I'm
3 suggesting. And they can decide for themselves what they -
4 -
5 DR. MILLER: I absolutely agree with you. I was
6 just saying in terms of what our policy recommendations, I
7 think that we, as a Commission, should focus on the
8 inflation update. The mispriced services is a longstanding
9 issue that I don't think we're going to make meaningful
10 progress on because there are deeper philosophical and
11 operational problems that I don't think we can solve.
12 MS. KELLEY: Tamara.
13 DR. KONETZKA: Thanks for all the great detailed
14 work in this chapter. I learned a lot from it.
15 My reactions to the chapter are very much from my
16 economist point of view. I'm clearly not a physician and
17 have never tried to bill under these codes. But I had two
18 strong reactions, and the first is really consistent with
19 Amol's Round 1 question, and that is, you know, the problem
20 that we're trying to solve here in terms of access to me
21 seems very hypothetical, and it's expensive to solve. And
22 so I guess I didn't feel as strongly as Robert and Brian

1 just now that we really need to be proactive about this,
2 because to me it's just too hypothetical still.
3 So I guess a couple of things follow from that.
4 One is I really like the idea of using the inflation
5 update. I like it in its stability and predictability. I
6 those are really important things that were in the chapter
7 that will make a big difference. So I'm very much in favor
8 of doing some kind of adjustment like that.
9 In terms of whether or not there's an access
10 problem we need to solve, I echo what everybody says that
11 we need to drill down on access more in terms of other
12 measures or using all the measures we can.
13 But also, I guess that would imply, you know, I
14 would recommend that we start very conservatively. So if
15 we do this for stability and predictability, and I don't
16 know if MEI minus 1 is conservative or not. I'd love to
17 see more simulations of that. But I'd love to see if
18 there's any indication that these are actually connected to
19 access.
20 And I think consistent with what Amol was
21 suggesting, I think mostly indirect, but drawing on other
22 literature showing how payment rates will affect access

1 will be a good start, and then sort of monitoring that
2 carefully, and starting with a conservative update, to me,
3 would be the right way to go.
4 I think there's nothing magic about the current
5 rates that need to be updated for inflation. There's
6 nothing magic about the commercial insurance rates that
7 need to be updated. Like we don't know how accurate those
8 are. All we know is that we haven't seen problems with
9 access so far. So there's enough evidence, I think, that
10 those do matter, evidence from other kinds of studies,
11 direct evidence, that those do matter, and that the
12 relative rates should also matter under certain
13 circumstances.
14 So I think that drawing in all that literature
15 and then starting conservatively and monitoring it, given
16 how much it's going to cost to update these, would be what
17 I would recommend.
18 My other reaction to the chapter relates to the
19 volume and intensity. I think there was a paragraph in the
20 chapter that sort of discussed all the different reasons
21 why volume and intensity might change. So that's helpful.
22 The way Brian was just mentioning it was really as a

1 behavioral response, and that's consistent with kind of
2 what I really want us to know more about in the chapter.
3 Like what do we know about whether the volume intensity
4 changes really are a behavioral response on the part of
5 physicians, or whether they're due to all those other
6 factors? This is probably a hard thing to answer, right,
7 but what can we expect in terms of volume and intensity
8 changes if we start updating the physician rates, the
9 physician fee schedule, using the MEI minus 1, et cetera.
10 Is there any way we can drill down on that a little bit, in
11 a little bit more detail? Thanks.
12 MS. KELLEY: Amol.
13 DR. NAVATHE: Thanks, Geoff, Brian, and Rachel,
14 as well. Really fantastic work. I think it's very
15 complicated and super dense, and I think you've done a
16 really fantastic job of kind of breaking it into chunks and
17 explaining a lot of the complex interplay. I learned a
18 tremendous amount from reading this chapter, even having
19 been working with you all on PFS for a while now. So thank
20 you for that.
21 A couple of kind of overarching points, and then
22 I have a few smaller things, as well. First, I just wanted

1 to voice overall strong support for the approach for the
2 PFS here. I think, in particular, I really agree with this
3 notion of an MEI-based update, particularly instead of or
4 kind of rather than the way the current structure of the
5 0.75 percent versus 0.25 percent update, is that this makes
6 a lot more sense, I think, given what we know about the
7 future of A-APMs, issues around access. You know, some of
8 Tamara and other Commissioners' points notwithstanding, I
9 think not wanting to get behind on that. I think symmetry
10 across other fee schedules in the Medicare program. And
11 given there are several other moving parts here, obviously,
12 that is hard to perfectly read the tea leaves. But I think
13 this is striking a good balance between what we understand
14 from the evidence and kind of what we're worried about from
15 the perspective of access and beneficiaries, like a lot
16 what Brian was saying, to a certain extent.
17 One thing that's interesting is to some extent I
18 think one of most compelling parts is maintaining symmetry,
19 not only across their fee schedules, generally speaking,
20 but also particularly with respect to the way that OPPS
21 works, given there's so much overlap between the services
22 that are delivered in the facility versus non-facility

1 setting. You've described that well.
2 It did make me wonder, if we're going to, in the
3 policy option space, think about a floor in terms of the
4 update with respect to MEI, would we also potentially want
5 to consider a ceiling? I mean, if we're at 5 percent, 6
6 percent, 7 percent on MEI growth, and we think somewhere
7 around 50 percent of that is really practice expense and
8 input costs piece of this that's really sensitive to
9 inflation, then would we also want to contemplate something
10 like a ceiling in that context.
11 But nonetheless, I think it strongly supports
12 this approach. I want to make sure I'm clear about that,
13 in addition to some of the musings.
14 The second big overarching point is I also
15 strongly agree with the approach, and I think it's actually
16 very important that we do this work around improving the
17 accuracy of the codes. I think the Commission already has
18 -- and you referenced this in the slides, as well -- I
19 think the Commission already has standing recommendations,
20 standing work, that this is not something that we're really
21 taking on anew. I think it's a continuation of a lot of
22 work that the Commission has been doing that far predates

1 me, and I think probably several of us, except maybe Mike,
2 on the Commission. Just to call him out on that.
3 So I think certainly there are several aspects I
4 guess I would highlight why it's important. You know, this
5 is an active, as the world is, an active, kind of evolving
6 area, and I think data changes, input cost changes, a lot
7 of this stuff changes over time, the way practice patterns,
8 technologies. So if we're using old data, we're just very
9 likely to not be doing it in the right way. And that leads
10 to misaligned incentives. I think that's kind of intrinsic
11 to what we might think about in terms of payment policy
12 from a very general perspective.
13 The other thing, very specifically, that I wanted
14 to highlight, I think important work, and I really agree
15 with the approach, and I think the illustrations that you
16 gave, Geoff, were also really on target.
17 On the global code piece of this, I think the
18 cost-sharing pieces, to me, feels very compelling. So kind
19 of Medigap or supplemental insurance set aside for a
20 second. We're essentially having this cost-sharing burden,
21 whoever is paying it, for services that aren't actually
22 happening that way. And, in fact, there's an incentive

1 from a financial perspective to not deliver those and have,
2 if I'm a surgeon, to have my NP or my PA deliver those
3 visits. And you can get the same outcome, but we can have
4 greater payment because of that.
5 And I think that this notion of not only is it
6 more practical to pursue this zero-day approach, because
7 it's easier to do relative to trying to do this for a very
8 large number of codes, but it also is probably the right
9 incentive structure here. And I think we could hopefully,
10 I would suggest that maybe we consider adding that.
11 And I'm surprised that I'm going to say this out
12 loud, but in this particular case, fee-for-service may
13 actually be the better incentive than the bundled global
14 code, even if it's reduced in its size and its payment. So
15 it's amusing to me that I'm saying that, as somebody who
16 otherwise champions bundles and population-based payments
17 and other kinds of ways to avoid fee-for-service.
18 So last couple of points. I know I've been
19 speaking for a while. We have some commentary upon A-APMs,
20 and we've talked about how there's been kind of unevenness
21 or something about the impacted. I think one thing that's
22 worth noting alongside that, and this will probably come up

1 in a future session, as well, is that A-APMs are one of the
2 few tools that we have in the Medicare program to actually
3 address the volume and incentive part of it. You know, you
4 go through some history about SGR and the old systems. So
5 I think that's worth nothing.
6 And the other piece is while net savings has
7 certainly been hard to get, in a very general way, gross
8 savings, or more importantly the practice change piece --
9 so actually getting clinicians to practice differently -- I
10 would say somatically has actually been pretty successful
11 across the portfolio of A-APMs. And that's worth noting
12 because that relates V&I point, right. But I think we
13 should make that point.
14 The other part I would also note is just
15 appreciation for you all, that you make this point that
16 growth in fee-for-service spending per bene should not be
17 interpreted as profit. I think that's important, and that
18 partly leads to Brian's point in a sense, as well.
19 So overall, super great work. Thanks for bearing
20 with my long comment here, and I'm very supportive of the
21 approaches that we're taking.
22 MS. KELLEY: Greg.

1 MR. POULSEN: Thanks, and let me add my
2 appreciation for the great work that went into this. I'm
3 bouncing off a whole bunch of things that people have said,
4 so I'm going to try and make this coherent without
5 repeating everything that everybody said that I agree with.
6 First off, I think that the points that Brian and
7 Robert made are really very important. That is, I would
8 hope that we would make sure that the key points that we're
9 making don't get lost for the detail of the trees. And the
10 key points we're making is we need to keep up.
11 And I guess I am more concerned than maybe a
12 couple of folks in here about falling behind, because I
13 think once we do and once it becomes apparent it's really,
14 really difficult to fix that. And an example, we've got
15 lots of examples, but maybe the primary one that comes to
16 mind is Medicaid. And if we look at Medicaid access in a
17 number of states, in a number of specialties, it is really,
18 really deficient -- duh -- but also, it's really, really
19 difficult to fix, because people have made decisions about
20 what practice they want to focus in, what kind of patients
21 they want to see. And redressing it once it's gone is
22 really, really tough.

1 So I think this isn't one where we can say, oh
2 okay, now we're starting to see slippage. We need to
3 address it. I think at that point it may be too late.
4 So I think this is one where looking for
5 empirical evidence may be very, very difficult, and we may
6 regret that we did that, if we do that. So I suggest that
7 we do what we need to, to be proactive to a degree on this,
8 which then brings me to couple of points that Amol made
9 that I also, I think, are really important.
10 I think that the concept of the ceiling, and the
11 concept of the variation, I absolutely believe that we need
12 to be proactive in terms of determining this. But I also
13 think that it probably makes sense, as opposed to an MEI
14 minus, say, 1 percent, to rather make it a percentage of
15 MEI, so that we could simply say 75 percent of MEI.
16 Because I think that if we get to a really high number we
17 wouldn't want to -- oh, 1 percent minus 10 is a lot less
18 than 1 percent minus 1, or 1 percent minus 2, from 2.
19 So it would seem to me that 75 percent of MEI, or
20 something like that, may be an easier and less troubling
21 mechanism over time, because we don't know what MEI is
22 going to be next year or five years from now.

1 The other point, though, that I think is really
2 just kind of potentially a big deal is the concept that if
3 we look at MEI and look at what that ceiling could
4 potentially be, that we have the opportunity to look at
5 that as, of course, we all do. We do. Congress does. CMS
6 does. But to look at the relative perspectives that we get
7 from feedback from clinicians. Because I think that before
8 they start to make actual practice decisions, you'll start
9 to hear noise, and if we keep our ear to the ground, we'll
10 be able to recognize that, as well.
11 So thanks again for the great work. I appreciate
12 the opportunity to be part of it.
13 MS. KELLEY: Stacie.
14 DR. DUSETZINA: Great. Thank you.
15 Like Greg just said, I feel like other people's
16 comments have made me think about a lot of other things,
17 and this chapter was already full of things to think about.
18 So I'll try to keep this brief.
19 I really appreciated the history lesson in the
20 chapter. It was really valuable and informative, but also,
21 like, wow, we've really gotten into a mess over time, like
22 many of our payment systems.

1 In general, I do support the MEI update approach.
2 I do think that is a really good move. I like the floor
3 and ceiling combination for that. I think that's
4 important.
5 I certainly do worry about the volume and
6 intensity having made up the difference in the meantime.
7 So I think it goes back maybe to Betty's initial comments
8 about the A-APMs and some of Amol's comments where, you
9 know, if we don't have incentives for people to be
10 practicing in a way that tries to tamp down some of the
11 volume and intensity by doing this additional growth in the
12 update, we might be just spending more and more and more.
13 So that is kind of like an overlay of things that I've been
14 thinking about as folks have been talking.
15 You know, I think in general, the questions about
16 the improving payment accuracy, it's hard for me to ever
17 say no to a question when framed like that. Like, yeah, we
18 want to be more accurate, and I think Scott really got it
19 right. I agree with the examples that you give. They
20 appear to be really good examples of where we could improve
21 payment accuracy.
22 One of the challenges, though, it seems to me, is

1 that there appears to be a lot of intended and unintended
2 consequences associated with the plans to do that. So the
3 example you walk through in such detail in the chapter
4 around the practice expense piece, just on its face seems
5 like super smart. Like, why would we pay for you to have a
6 practice that doesn't exist if you work for a hospital?
7 But some of the suggestions about how to get there, you
8 know, either identifying codes that are used mostly in the
9 hospital or identifying clinicians that are practicing or
10 don't have separate practices, it feels like there is that
11 chance that you get that wrong, because it's not perfectly
12 coded. And then, you know, so you do a very nice job of
13 laying that out in the chapter.
14 I will also maybe just say a plus-one to the idea
15 of trying to get these codes right, and, you know, Brian
16 makes the point about all the things the government doesn't
17 price, the shoes and the concert tickets. Like, well,
18 taxpayers are not paying for your Taylor Swift concert. So
19 I think it is important for us to be involved here and get
20 this stuff right.
21 Thanks.
22 MS. KELLEY: Paul.

1 DR. CASALE: I'll add my thanks again, as I did
2 with my questions. This was really a terrific chapter, a
3 lot of great work.
4 I'll be very brief because, really, I agree with
5 a lot of the comments that have already been made, but I
6 just wanted to say that I also support the update using a
7 portion of the MEI growth. As Tamara said, it provides
8 that stability and predictability that I think is really
9 important.
10 And then on the work on improving accuracy,
11 again, I think there's an opportunity for us to weigh in,
12 just as you've pointed out in some of your examples,
13 including the timeliness of the data that's used, et
14 cetera.
15 So, to Brian's point, not getting too far into
16 the weeds on the fee schedule, but I think there are
17 certainly opportunities, like you pointed out, where I
18 think we can provide information that would be helpful in
19 terms of the accuracy, how to make the fee schedule more
20 accurate.
21 So thanks again.
22 MS. KELLEY: Gina.

1 MS. UPCHURCH: Yeah. Thanks so much for this
2 chapter. Just a couple quick questions.
3 I also support adopting some increase relative to
4 MEI.
5 I would echo Tamara's concern about being
6 conservative as we move forward, given that there are so
7 many things that Medicare dollars could be used to improve
8 health that's not just, you know, the physician fee
9 schedule. So I would support that.
10 One of the things that I'm, you know, very
11 interested in is supporting team-based care and, you know,
12 quite frankly making physicians, PAs, nurse practitioners,
13 clinicians' lives better by being surrounded by a team
14 that's improving care. So I don't know how that fits in
15 here, whether you use chronic care management codes,
16 transitional care codes, hiring a committee health worker.
17 I mean, maybe there's other codes that you use, but somehow
18 if in the physician fee schedule we support, like a lot of
19 geriatricians, use team-based care as a way to signal that
20 we appreciate team-based care, how that can be built in,
21 I'm not sure, but just want to put that out there -- or if
22 it's a separate code that people use.

1 And, lastly, just Robert's comment. I just want
2 to echo that I appreciate his comment about the safety net
3 providers and making sure that in looking at MEI if there's
4 some special thought or in another way, we look at safety
5 net providers, I think it's really important as we move
6 forward, but support this work.
7 Thank you.
8 MS. KELLEY: The next comment is from Larry, so I
9 will read that. Larry says, "This chapter is very
10 informative and nicely done. Brian and Geoff have done
11 terrific work."
12 He agrees with changing to a single conversion
13 factor.
14 He strongly agrees with the general idea of tying
15 annual PFS payments to inflation.
16 At this point, he's okay with MEI minus 1 plus a
17 floor. For several reasons, current law, 0.25 percent or
18 0.75 percent annual increases in perpetuity with no regard
19 for inflation makes no sense and will only result in
20 Congress having to make annual patches in lack of
21 predictability and in clinician discontent with the system.
22 Larry's main two suggestions are to strengthen

1 the written presentation of the material to make it more
2 convincing to clinicians.
3 First, make it even more clear that MEI minus 1
4 is an example and one which we think is reasonable, but
5 that policymakers could choose MEI minus 0.5, MEI equals
6 inflation, et cetera. He realizes that the material does,
7 in fact, say this, but it could be more prominently placed
8 and repeated.
9 Second, make our justifications for recommending
10 a less-than-inflation increase more clear. The staff do a
11 good job of this, but he thinks the justifications should
12 be made much more prominent in the intro and in the body of
13 any chapter we publish.
14 Larry is not sure that the staff and probably
15 some Commissioners understand how a recommendation for
16 annual below-inflation increases in pay, continuing
17 indefinitely, looks to clinicians. He is certain that
18 nearly all clinicians will see such a recommendation as an
19 annual pay cut that implies that MedPAC thinks that
20 clinicians are paid too much.
21 We don't make such a recommendation for any other
22 sector, and another difference is that individual

1 physicians will take this cut personally, whereas people
2 who work for a hospital, for example, may be affected by
3 payment rates to hospitals but would not see
4 recommendations as directed at them individually.
5 Some may think it doesn't matter how clinicians
6 feel, but he thinks this would be a mistake. So he thinks
7 we should make more prominent and more explicit that, one,
8 MedPAC's responsibility is not to decide how much
9 physicians or hospitals deserve to be paid but rather to
10 recommend policies that don't pay more than necessary to
11 maintain or improve beneficiary access to high-quality
12 care.
13 Two, there's evidence over the past 20 years that
14 a policy of MEI minus 1 percent with a floor of at least
15 half of MEI growth or zero percent if no MEI growth is
16 likely to maintain beneficiary access.
17 Three, MEI minus 1 would have resulted in larger
18 increases in the physician payment rate over the past 20
19 years than what actually occurred, and it might be helpful
20 to feature a quantification of this, including a line in
21 Figure 2: "And our projections are that it would result in
22 greater increase in the future compared to current law."

1 Again, quantify and show.

2 It would probably be worth giving two to three
3 examples; for example, MEI minus X, and showing what they
4 would have meant retroactively for the physician fee
5 schedule compared to what happened and what they will mean
6 prospectively compared to current law.

7 Four, MedPAC will carefully monitor access and
8 quality and reconsider whether the recommended formula for
9 payment rate increases should be changed.

10 Larry likes the section on improving the accuracy
11 of fee schedule payments. He agrees with Betty that much
12 more should be done in the meeting material to describe the
13 RUC and criticisms of the RUC. He agrees with several
14 Commissioners that we should separate discussion on recs
15 about the accuracy of fee schedule payments from the
16 inflation update rec. He does think we should have
17 recommendations about improving the accuracy of the fee
18 schedule, though.

19 A comment on access. The fact that access is
20 similar between commercial and Medicare is important to
21 state, but it risks implying that access is good. Larry
22 does not believe that access is good at this. He feels

1 quite sure from personal and clinical experience that there
2 is an access problem both in commercial and Medicare. He
3 is just living through that for family members this week
4 and last. The exact questions that are asked in surveys
5 regarding access -- for example, are you satisfied versus
6 how long did it take to get needed care -- are important.
7 He strongly agrees with Brian's comments on this.
8 Larry agrees with Robert that by the time it is
9 clear that there is a major problem with access, it will
10 take a long time to fix the problem. That said, Larry
11 doesn't believe that a percentage point here or there will
12 affect access unless the cumulative effect of one-point-
13 lower annual payments becomes very large going forward.
14 As Michael implied, access depends much more on
15 things other than small differences in payment rates. For
16 example, it depends on the supply of clinicians and
17 possibly to some extent on clinician morale. For example,
18 how willing is a physician to squeeze in patients who
19 should be seen but are not on the schedule in a given day?
20 And I have Scott next with a Round 3 question, I
21 guess.
22 DR. CHERNEW: Before we do Round 3 --

1 MS. KELLEY: Would you want to do that? Okay.
2 DR. CHERNEW: Yeah. we'll save Scott for Round
3 3, but I think if I am right, we still have to hear from
4 Kenny and Wayne. Okay. So, Wayne, and then Kenny.
5 DR. RILEY: Yeah. A great discussion, great
6 work, gentlemen, on that very complicated -- I had to
7 really think this through as well, but for all the reasons
8 that many of you have stated very succinctly, I do agree
9 that we need to change the conversion factor to something
10 more focused and single.
11 The RUC thing, I'm glad -- I can't remember who
12 brought that up. I think it was Betty who first brought it
13 up. I think there is widespread unknowingness or
14 misunderstanding or just a void about the role that the RUC
15 plays in all this, which I think is really
16 underappreciated, which, again, contributes to the policy
17 model, I think, that we're attempting to cut through.
18 So, again, I think this is very good work and am
19 supportive as for all the reasons laid out.
20 MS. KELLEY: Kenny?
21 MR. KAN: Thank you for an excellent chapter. I
22 learned a lot. Especially echoing Stacie's other comments,

1 I really enjoyed the history lesson on the evolution of the
2 PFS.
3 Just two points to convey. Number one, I do
4 support an MEI-based inflationary update for its simplicity
5 and its predictability.
6 And point number two, regarding addressing the
7 RVU accuracy issue, I support a balanced directional
8 recommendation that does not get into the weeds, being
9 mindful of the administrative burden to CMS and the various
10 health care stakeholders, and then unintended consequences,
11 especially on practice patterns, because I think -- and
12 obviously, the impact of lagging data and how that could
13 change a few years from now, which for me would be too hard
14 to handicap.
15 Thank you.
16 DR. CHERNEW: Scott.
17 DR. SARRAN: Just a brief comment on the volume
18 and intensity issue. I have mixed feelings on that. On
19 one hand, I think there is some evidence. And, Brian,
20 thanks for sending something around that says physicians do
21 try to maintain in the time of decreased reimbursement
22 their overall revenue, and that makes sense, right?

1 But I think a fair amount of the increase in
2 volume and intensity is appropriate and logical because it
3 seems quite clear to me that health care has gotten more
4 complex, particularly the care of Medicare beneficiaries.
5 There is an increased population as we age of
6 polychronic, multi-morbid, however you define that,
7 beneficiaries of high complexity. That's one point.
8 Second point, certainly, the variety of
9 therapeutic alternatives and the complexity of the
10 decision-making around choosing and executing on one or
11 more of those has dramatically changed, and that's part of
12 why primary care has become so difficult and part of why a
13 lot of good care of Medicare beneficiaries with chronic
14 disease is truly now in the specialty rather than the
15 primary care arena or significantly requires a specialist
16 to be participating in an ongoing basis.
17 And, thirdly, I think there has been a very
18 appropriate increase in the expectations from beneficiaries
19 for truly informed decision-making -- shared decision-
20 making, rather. And that takes -- you know, it's a lot
21 quicker and easier if you have a completely passive patient
22 in front of you and you don't have an expectation or an

1 obligation. You don't feel a responsibility to engage in a
2 truly shared decision-making process.
3 So I think what I'm saying is much of the volume
4 and intensity increase, I think, is an appropriate and
5 logical reflection of where medicine has evolved.
6 DR. CHERNEW: Greg.
7 MR. POULSEN: This should have just been the
8 senility round rather than the Round 3. There was a point
9 that I just wanted to tag on to something Amol said that I
10 intended to do earlier and forgot, and that is simply I
11 think there is an appropriate differentiation between the
12 folks who are part of an APM and those who aren't.
13 But what we saw is the problem of it accelerating
14 over time, becoming, you know, from minimal to really being
15 significant, and an alternative may simply be to have a
16 differentiation that is constant, that is modest and
17 remains constant over time, say, 2 or 3 percent below those
18 that are in advanced APMs.
19 DR. CHERNEW: So that's the -- thank you. That's
20 the last I have, Dana. Am I missing anything?
21 [No response.]
22 DR. CHERNEW: All right. So this has been a

1 great discussion, and I'm glad you all weighed in. And I
2 appreciate that everybody remarked how strong the work, the
3 underlying work is, and so I thank that. Thank you all for
4 that.
5 I'm just going to give a few broad overviews.
6 One is I take general support for this direction, so that's
7 point one.
8 We will take all of these comments under
9 advisement so we come up with draft recommendations, and to
10 the extent that we do, there will be separate
11 recommendations for an MEI-based inflation update and any
12 type of repricing of codes. And we'll have to go back and
13 review the conversation, but we are there. But I
14 appreciate all the thoughts on that.
15 A few general things. I've heard loud and clear
16 -- and this came up before, and I believe this to be true -
17 - that to some extent getting ahead of the issue, to pick a
18 frame, is important, that there's a lot of long-term
19 planning that people do in the workforce, and our measures,
20 which is going to come up a lot going forward -- our
21 measures are inherently backward-looking. So it is tricky,
22 I admit, and we have to be an evidence-based entity. But

1 it is hard to drive the car looking just out the back. And
2 so these conversations are helpful in how we do that, and
3 certainly, that gets to our thinking.
4 But to the point that Tamara and Gina said, we do
5 want to be conservative in how we think about what we do,
6 because it's very tempting for people to say, yes, there's
7 not a problem. We need a lot more now for a problem that
8 hasn't yet materialized, and we've spent a lot of time
9 thinking through that and how that's going to play out. So
10 that's very, very much on our mind.
11 The second thing -- and Brian raised this kind of
12 subtly, so I'll raise it less subtly. There is -- because
13 of the way in which independent physicians work and
14 physicians that are part of facility work, there is parts
15 of the fee schedule that are paid either through the PFS or
16 the OPPS, and those in the current system are not parallel
17 for things that are conceptually parallel.
18 And as Brian mentioned, the site-neutral context,
19 we in our site-neutral work sort of talk about harmonizing
20 those things, but if you thought about harmonizing those
21 things to PFS and the PFS had no update, you would really
22 worry about how all that is playing out. And, in fact,

1 when we did our original update -- when we did our annual
2 update recommendations before we had half of MEI, the
3 recommendation, a lot of that discussion was around how
4 practice expense was dealt with and how was the underlying
5 inflation there and trying to capture that, and that is
6 sort of what was motivating that work. And I think that
7 kind of thinking and the parallelism flows through.
8 And I appreciate Larry's comments. So I will
9 say, in the parallel sense, in the facility space, all
10 those facilities as part of the ACA have, in current law,
11 an inflation-based update factor that is below inflation.
12 It's the productivity adjustment, right? So while we have
13 not chimed in on those particular things, there is a sense
14 in which the type of recommendation we're contemplating is
15 to bring into harmony how we're paying in the PFS and how
16 we're paying in other things, most notably the OPPS, which
17 is, in fact, consistent with our site-neutral, broad
18 philosophy, even though we haven't tied them together in
19 some explicit way. And the services are different. The
20 unit of payments are different, and there's a bunch of
21 other things. But I think, conceptually, there is this
22 parallelism that plays out.

1 Greg, thank you for your Round 3 comment, because
2 there's this issue of MEI of half, MEI minus an amount, how
3 you're dealing with that, and as Amol mentioned, things
4 about ceiling and floors. So we're going to have to ponder
5 what our recommendation is, but I want to emphasize
6 something, and I think Larry said this in his comments. We
7 are not contemplating replacing the current process of
8 analyzing and making recommendations about what should
9 happen in the subsequent year. So should there be a
10 change, whatever we recommend, we would still expect that
11 in -- every March there's going to be a MedPAC
12 recommendation about the current law being current, current
13 law or any revised current law, what that would mean, and
14 how we should adjust.
15 And so I am less worried about putting into the
16 formula all possible contingencies, because we can -- not
17 we. Congress can deal with all possible contingencies as
18 they see fit. What I'm really sort of worried about is
19 just -- and several people said this -- a world going
20 forward that is -- and I view -- I don't know when, but
21 broadly speaking, unrealistic. I don't think in 2040,
22 we're going to expect an inflation update between now and

1 then of 0.25 percent. I think that part is problematic,
2 and I think getting through that is more important than
3 sorting how we might get a formula. And, frankly, I don't
4 think -- again, we have the ability to really parse all the
5 details of where all of that should be.
6 So I think the message that I hope people at home
7 hear is we are concerned about the current formula's lack
8 of connection to inflation. We believe that we can address
9 that in a sort of fiscally prudent way, but we really don't
10 need to go much more in the details kind of beyond that.
11 And I have somewhat similar views about how we
12 think about mispriced codes, and to Kenny's point -- and I
13 think your framing is right, and again, we have to take
14 this discussion to formulate our recommendations -- we are
15 not going to get into specifics in any recommendation about
16 all of the exact nitty-gritty of what goes on. But I do
17 think that the evidence is clear, in part, because it is
18 hard to price. I don't know how many -- Brian says 8,000,
19 so we're going to go with 8,000 -- how many codes there
20 are. There's certainly a lot. I don't believe it is the
21 case that it's easy to get those all right. I think that's
22 correct.

1 On the other hand, I do believe there's some
2 clear examples of where we've gotten them wrong, and I
3 think in this world, for a bunch of reasons, that matters.
4 And I think to the extent to which there's some basic
5 principles, get the best data you can. Address problems
6 when they rise to the level where it's a clear problem,
7 that there's something clearly going on. I think there is
8 some merit in making those sort of general points and
9 allowing the organizations that are responsible for this to
10 then sort through how they do it and what happens. And so
11 we will then have that kind of discussion, and we'll see
12 where it goes.
13 But, in any case, that's where we are. I
14 appreciate all of your comments. And for those of you at
15 home -- because we're going to break now for lunch, unless
16 Paul wants to say anything.
17 MR. MASI: Good show.
18 DR. CHERNEW: "Good show," for those of you that
19 couldn't hear the British version of Paul.
20 But please, we do want to hear from all of you at
21 home. I expect that we will. You can reach out to us in a
22 number of ways, including at MeetingComments@MedPAC.gov,

1 through the website. This is an important issue, and I
2 appreciate the discussion. Feedback from those of you that
3 are listening at home is actually quite important to us.
4 We have heard some. I expect we'll hear more.
5 So, again, thank you. We will be back after
6 lunch. Much of this discussion talked about the form of
7 payment. We'll be discussing a little bit APMs and the
8 related bonus, and we will do that after lunch. So, again,
9 thank you, and we'll see you at, loosely speaking, 1:45.
10 Yeah, 1:45.
11 Okay, thanks.
12 [Whereupon, at 12:04 p.m., the meeting was
13 recessed for lunch, to reconvene at 1:45 p.m. this same
14 day.]
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1 AFTERNOON SESSION

2 [1:47 p.m.]

3 DR. CHERNEW: Welcome back, everybody. We're
4 going to have a terrific afternoon session. We have two
5 great, and frankly somewhat complicated topics. We're
6 going to start with a discussion of the bonus payment for
7 the advanced alternative payment models. And with that I'm
8 going to turn it right over to Rachel to take us through
9 it.

10 MS. BURTON: Good afternoon. In this
11 presentation we'll consider the participation bonus for
12 clinicians in advanced alternative payment models. We last
13 talked about this in April, and in our June report we
14 mentioned the idea of extending the bonus for a few years.
15 Since that time, there have been some new policy
16 developments, and we have run some new analyses.

17 A copy of this presentation is available for
18 download from the handout section of the webinar's control
19 panel, on the right side of your screen.

20 I'll start with some background on advanced
21 alternative payment models. Luis will then present some
22 analyses intended to help answer the question of whether

1 the bonus has influenced participation in A-APMs. I'll
2 note some new policies that may alter the A-APM landscape,
3 and then turn things over to Commissioners for discussion.
4 So first, some background on advanced alternative
5 payment models.
6 The physician fee schedule incentivizes
7 clinicians to increase the volume of services they provide.
8 Alternative payment models, or APMs, try to counteract this
9 incentive by layering on additional payments, such as
10 "shared savings" if clinicians can keep their patients'
11 spending below a target amount while meeting quality
12 targets. Clinicians in an APM can also incur a financial
13 loss, if they owe a penalty due to poor performance or if
14 they make investments to help them succeed in a model but
15 then fail to qualify for a performance bonus.
16 APMs became more widely available after Congress
17 established the Medicare Shared Savings Program and the CMS
18 Innovation Center, which now operates a whole suite of
19 mostly voluntary models.
20 Clinicians in APMs often change the mix and/or
21 quantity of services they deliver, and APM entities usually
22 maintain or improve performance on quality measures.

1 Although these changes often generate gross savings, APMs
2 usually fail to produce net savings once the cost of new
3 payments like "shared savings" are included.
4 It is important to note that estimates of the net
5 spending effects of APMs usually do not take into account
6 the fact that when a model causes fee-for-service spending
7 to increase, it also increases the fee-for-service spending
8 benchmarks that Medicare Advantage plans bid against, which
9 ends up raising MA spending.
10 Estimates also typically do not include spending
11 on the participation bonus that we will be talking about
12 today. At a minimum, estimates could be made more accurate
13 if spending on the participation bonus were included in
14 calculations.
15 Although APMs usually include their own financial
16 incentives for clinicians to participate in them, Congress
17 has established three additional policies that could
18 theoretically boost clinician interest in APMs.
19 First, clinicians with a substantial share of
20 payments or patients in "advanced" APMs receive a
21 participation bonus worth 5 percent of their fee schedule
22 payments in 2019 through 2024. This bonus has been

1 extended at a reduced rate of 3.5 percent in 2025 and 1.88
2 percent in 2026.
3 Clinicians in A-APMs are also exempt from MIPS
4 adjustments to their fee schedule payment rates. The size
5 of MIPS adjustments is based on performance on MIPS
6 measures, and so far, the highest MIPS adjustment has
7 usually been worth less than the A-APM participation bonus.
8 Until now, CMS has paid out $500 million more in
9 positive adjustments than it has collected from negative
10 adjustments each year, but MIPS adjustments are required to
11 become budget-neutral starting next year.
12 A third way participation in A-APMs is
13 incentivized is through differential updates to physician
14 fee schedule payment rates. Starting in 2026, clinicians
15 in A-APMs will see their payment rates increase by 0.75
16 percent per year, while rates for all other clinicians will
17 increase by 0.25 percent. As shown in the graph, the
18 difference between payment rates for these two groups will
19 be small in the late 2020s but large by the 2040s.
20 Given the inconsistent incentives produced by
21 these differential updates and other factors, the
22 Commission supported replacing them with a single update to

1 payment rates in our recent June report to the Congress.
2 This would mean that after 2026, when the bonus sunsets,
3 the only incentives to participate in A-APMs would be the
4 payments available in A-APMs themselves.
5 In general, the Commission maintains that payment
6 incentives in different programs and policies should all
7 send consistent signals encouraging efficient, high-quality
8 care. To date, A-APM participation has been incentivized
9 by payments in A-APMs themselves, the participation bonus,
10 and low MIPS adjustments for non-A-APM participants. The
11 participation bonus is slated to sunset after 2026, but the
12 Commission has discussed extending it for a few years,
13 given uncertainty about how much of a draw MIPS might be to
14 clinicians. Our objective is to avoid creating incentives
15 for clinicians to prefer MIPS over A-APMs.
16 As an aside, although this presentation talks
17 about the incentives that clinicians face, we note that
18 decisions about whether to participate in an A-APM are
19 typically made at the provider organization level, based on
20 an assessment of whether having an organization's
21 clinicians participate in an A-APM will be financially
22 advantageous to the organization's clinicians.

1 In our June report, we mentioned that if the
2 bonus is extended, a question for policymakers is whether
3 to also restructure it. One way to restructure the bonus
4 would be to calculate it as a share of a clinician's A-APM
5 payments, rather than a share of all of their fee schedule
6 payments, and to eliminate the requirement that a certain
7 percent of a clinician's payments or patients be in A-APMs.
8 The advantage of this bonus approach is it would
9 expand availability of the bonus to specialists who
10 currently struggle to qualify for it in episode-based
11 payment models. A drawback is the size of the bonus would
12 decline for all current recipients.
13 Another restructuring approach, considered at the
14 April meeting, would calculate the bonus as a flat payment
15 for each beneficiary attributed to a clinician through an
16 A-APM. The flat payments would need to be risk adjusted,
17 which would in turn require clinicians to document
18 diagnoses for fee-for-service beneficiaries more thoroughly
19 than they do today. An advantage of this approach is it
20 would remove the bonus' volume incentive, although the
21 compensation schemes used by employers
22 would continue to incentivize most clinicians to increase

1 the amount of services they deliver. A drawback is most
2 specialists would lose access to the bonus, since
3 beneficiaries tend to be attributed to primary care
4 physicians.
5 A drawback that applies to both of these options
6 is that they would both make it more difficult for
7 policymakers and clinicians to determine whether
8 participating in an A-APM or MIPS is more financially
9 advantageous. In contrast, right now, the bonus and MIPS
10 are both calculated as a percent of a clinician's fee
11 schedule payments, which makes it easy to see how these two
12 options compare.
13 I will now pass things over to Luis.
14 MR. SERNA: Next, we will present some analyses
15 that explore whether the bonus has influenced participation
16 in A-APMs.
17 Although we do not know how many clinicians have
18 joined A-APMs specifically due to the bonus, it is notable
19 to see that the number of clinicians who qualify for the
20 bonus has steadily grown over time. For example, 384,000
21 clinicians qualified for the bonus in 2024, based on their
22 A-APM participation in 2022. This is an increase from

1 about 100,000 clinicians the first year the bonus was
2 available.
3 Here we note that the size of the bonus is small
4 for most clinicians. For example, for about half of bonus
5 recipients in 2022, the bonus was worth less than $1,000
6 per clinician. The clinicians who tend to receive smaller
7 bonuses are nonphysicians such as advanced practice
8 registered nurses and physician assistants.
9 Next, we focus on clinicians in the Medicare
10 Shared Savings Program or MSSP, since 88 percent of bonus
11 recipients are in this A-APM. First, we estimated the size
12 of shared savings payments per clinician and compared this
13 with the A-APM participation bonuses CMS assigns to each
14 clinician. Our analysis was restricted to clinicians in
15 bonus-eligible tracks of MSSP, which are tracks that CMS
16 determines involve "more than nominal" financial risk.
17 Based on interviews with ACOs and the published
18 literature, we assumed ACOs distribute much larger payments
19 to primary care physicians than other types of clinicians.
20 In addition, using information from the literature and MSSP
21 financial performance data, we assumed that 50 percent of
22 shared savings were retained by ACOs to pay for their

1 administrative costs and profits.

2 As shown in the bottom bar, we found that the

3 participation bonus was larger than estimated shared

4 savings payments for 63 percent of clinicians. This

5 suggests that the bonus could have contributed to some

6 clinicians' interest in MSSP.

7 When we disaggregated these results by clinician

8 type, we found that the participation bonus was larger than

9 shared savings payments for only 20 percent of primary care

10 physicians. This stems from our estimate that the median

11 primary care physician received relatively large shared

12 savings of $10,783. In contrast, we found that the bonus

13 was larger than shared savings payments for 72 percent of

14 all other types of clinicians. We estimate that the median

15 shared savings payment for these clinicians was a modest

16 $235.

17 These findings suggest that the A-APM

18 participation bonus may not be the main factor determining

19 whether primary care physicians participate in MSSP, but

20 the bonus could be a larger factor for other clinicians.

21 To see how clinicians would have been affected by

22 a smaller bonus, as will be the case in 2025 and 2026, we

1 returned to our main analysis of all clinicians, shown in
2 the top bar, and then redid our calculations using smaller
3 bonus percentages. We found that if the bonus had been
4 worth 3.5 percent, it would have been larger than estimated
5 shared savings payments for 59 percent of clinicians. If
6 the bonus had been worth 1.88 percent, it would have been
7 larger than shared savings payments for 51 percent of
8 clinicians.
9 These findings suggest that if the A-APM
10 participation bonus were to be extended, a smaller bonus
11 might be sufficient to provide a meaningful increase in the
12 amount of A-APM-related payments received by a large share
13 of clinicians.
14 As noted earlier, we estimate that ACOs disburse
15 only modest amounts of shared savings payments to non-
16 primary care physicians. The A-APM participation bonus
17 increases these amounts but still leaves non-primary care
18 physicians with relatively small total A-APM-related
19 payments.
20 For example, among non-primary care physicians in
21 the seventh decile of A-APM-related payments, we estimate
22 that the value of new payments received through MSSP plus

1 the participation bonus equaled $1,925 for the median
2 clinician in this decile. Given the relatively small size
3 of total A-APM-related payments, they may not be a primary
4 motivating factor for many of these non-primary care
5 physicians.
6 To understand why so many non-primary care
7 physicians participate in MSSP, despite low A-APM-related
8 payments, we turned to our annual focus groups with
9 clinicians for insights. In our 2023 and 2024 focus
10 groups, we found that although a desire to obtain
11 additional revenue was one reason clinicians indicated for
12 joining an ACO, they also cited several other motivating
13 factors.
14 For example, clinicians mentioned wanting to
15 continue to receive referrals from primary care providers
16 who had recently joined an ACO. They also described
17 joining an ACO so they could access useful data analytics
18 on their patients, for example, identifying patients who
19 are due for a visit.
20 In this last analysis, we assessed how appealing
21 MSSP would be compared with MIPS, if the participation
22 bonus were not available. We examined the MIPS adjustment

1 for clinicians and bonus-eligible tracks of MSSP who did
2 not qualify for the bonuses. We found that the MIPS scores
3 of these clinicians were slightly higher than the ACO level
4 MIPS scores of clinicians who did qualify for the bonus.
5 Using the subset of clinicians in bonus-eligible
6 tracks who did receive a MIPS adjustment, we compared the
7 value of this adjustment with the value of clinicians'
8 shared savings payments. We found that among our subset of
9 clinicians in bonus-eligible tracks of MSSP, their median
10 MIPS adjustment was worth 1.1 percent of their annual fee
11 schedule payments. In contrast, the median value of shared
12 savings was worth 1.4 percent of these clinicians' fee
13 schedule payments.
14 This analysis suggests that even in the absence
15 of the participation bonus, clinicians will be able to earn
16 higher payments by participating in MSSP rather than MIPS.
17 Finally, we note that the A-APM participation
18 bonus does not help clinicians who lack access to an A-APM.
19 Most A-APMs are only available in certain areas of the U.S.
20 and are geared toward a handful of specialties such as
21 primary care providers, surgeons, and nephrologists.
22 MSSP, is available nationwide to a wide range of

1 clinicians, but due to benchmark methodology changes, MSSP
2 ACOs now have an incentive to include clinicians who serve
3 beneficiaries with low risk-adjusted spending relative to
4 their region. In turn, there is an incentive to avoid
5 clinicians with higher spending.
6 ACOs are responding strongly to this incentive.
7 In 2023, among ACOs in bonus-eligible MSSP tracks, 90
8 percent had risk-adjusted spending that was low for their
9 region. This means that clinicians with high risk-adjusted
10 spending per beneficiary are likely having difficulty
11 finding an MSSP ACO willing to include them, and the A-APM
12 participation bonus is not helping these clinicians.
13 I will now turn things over back to Rachel.
14 MS. BURTON: I want to briefly note some new CMS
15 policies that may alter the A-APM landscape.
16 First, CMS has decided to freeze the current MIPS
17 performance threshold through the 2029 payment year. As a
18 result, we now estimate that in the late 2020s, the top
19 MIPS adjustment will be around 2.25 percent, which is
20 similar to what it has been in past years.
21 This means that if the A-APM participation bonus
22 is extended, it would not need to be very large to ensure

1 that A-APM-related payments are larger than the top MIPS
2 adjustment. But we caution that there is high uncertainty
3 around our 2.25 percent estimate, due to MIPS's many moving
4 parts.
5 Another development is the launch of a new
6 episode-based payment model, which will be mandatory in a
7 fifth of all towns and cities starting in 2026. CMS is
8 also contemplating a new mandatory model for specialists in
9 ambulatory settings, possibly as early as 2026. CMS would
10 phase in specialties over time, but notes that it has
11 already developed applicable measure sets for 80 percent of
12 specialties.
13 CMS plans to include model design features that
14 incentivize partnering with clinicians in other A-APMs,
15 such as primary care providers in ACOs. If this model
16 launches, it could obviate the need for the bonus, since we
17 would no longer need to worry about specialists exiting A-
18 APMs for MIPS, but it is unclear when this model will
19 launch and how many specialties will be required to
20 participate in the initial years.
21 Our overall takeaways from the findings we've
22 presented and the new developments just mentioned are that

1 there is uncertainty about whether the bonus has influenced
2 participation in A-APMs, and uncertainty about what
3 programs and policies will be in place in the late 2020s.
4 On the one hand, extending the bonus for a few
5 years could guard against attrition in A-APMs during this
6 period of flux. A reassessment of the need for the bonus
7 could be undertaken in the late 2020s, once we have greater
8 clarity about the size of top adjustments in the budget-
9 neutral version of MIPS, and a better sense of which A-APMs
10 will be in place. However, if the number of clinicians in
11 A-APMs continues to grow in 2025, despite the bonus
12 declining in size, there may be less need for the bonus.
13 At last, we reach your discussion. As you
14 consider the new information in this presentation, we are
15 curious if you have any questions about our analyses or
16 feedback on the material.
17 I'll now turn things back over to Mike.
18 DR. CHERNEW: Rachel, we thank you very much.
19 I'm going to have a few introductory comments, but I'm
20 going to do that between Round 1 and Round 2. So I think
21 we should start with Round 1, and if I have this right,
22 Greg is the first Round 1 person.

1 MR. POULSEN: Thank you, and great work. I don't
2 feel quit as nerded out as I did this morning, Brian, but
3 it was great.
4 Do we have an indication on participation in A-
5 APMs between independent physicians, employed physicians by
6 health systems, and employed physicians by large groups,
7 like Optum, especially for non-PCPs. Do we have that?
8 MS. BURTON: I'm not aware of that. Luis, are
9 you?
10 MR. SERNA: For MSSPs specifically, CMS
11 designates low revenue and high revenue ACOs, so that could
12 be a proxy for system base. But that participation is
13 generally fairly balance. It sways from 45 percent to 55
14 percent, in each category.
15 MR. POULSEN: That's helpful. I'm just going to
16 posit without evidence that physicians that are part of
17 organized groups and particularly part of health systems
18 are likely to participate in A-APM sort of irrespective of
19 the individual incentives that are provided, because
20 there's motivation at a system level that's different, so -
21 -
22 DR. CHERNEW: Are you saying that the system

1 motivation is reflected in the -- is influenced by the
2 bonus, or it's just there's different systems that's
3 unrelated to the bonus?
4 MR. POULSEN: I guess what I'm suggesting is I
5 think that the physician bonus plays a smaller part for
6 large organizations in determining whether they will
7 participate in a given ACL model than does -- than it would
8 for a smaller group.
9 DR. CHERNEW: That was a clarifying question on a
10 clarifying question. I apologize, if the Chair should put
11 me in my place.
12 MR. POULSEN: I'm sure he will.
13 DR. CHERNEW: Yeah. Later at night in front of
14 the mirror.
15 I don't know if you have -- were you done?
16 Okay. So then that brings us to Cheryl and then
17 Dana.
18 DR. DAMBERG: Thanks for this work.
19 I had two questions. The first was around bonus
20 payments supporting infrastructure investment, and I'm
21 curious, maybe in your focus group work, have you heard how
22 that bonus money is being used, and is it actually going to

1 infrastructure?

2 MR. BURTON: In some evaluation reports, they

3 talk about how the money is used. I'm thinking of like

4 some advanced primary care models, and they talk about

5 hiring nurse care coordinators as a major expense.

6 DR. DAMBERG: Thanks.

7 My second question is, do we know anything about

8 what the private commercial plans are doing related to

9 participation in ACOs in the non-Medicare market? Are they

10 paying any types of bonuses?

11 MR. SERNA: Honestly, I'm not sure.

12 DR. DAMBERG: Thanks.

13 MS. KELLEY: Tamara?

14 DR. KONETZKA: Great work. Thanks.

15 I'm really interested in that selection of

16 physicians into ACOs bit and just wanted to ask -- it seems

17 there's a few references you had in the chapter, but is

18 your sense of the evidence so far that ACOs -- to what

19 extent are ACOs just selecting physicians that already have

20 low spending compared to other physicians, and to what

21 extent does that sort of change over time once a physician

22 is part of an ACO? Do you have any sense from the

1 literature about that proportionality?

2 MR. SERNA: So, as far as the change over time,

3 we don't have a sense of that.

4 I will say that an ACO's participant list can

5 change from year to year. So it's something that the ACO

6 has a chance to reevaluate every year as they examine who

7 they think should -- or who they want to be participants in

8 the ACO, whether that continues or not.

9 MS. KELLEY: Amol?

10 DR. NAVATHE: Luis and Rachel, thanks for this

11 work.

12 I am going to apologize in advance. I have

13 several questions.

14 So one which may have been in the paper and maybe

15 reading materials and I just missed it, but I'm curious.

16 What percent of clinicians receiving the A-APM bonus are

17 primary care versus specialists?

18 MS. BURTON: That was not in the paper. I'm

19 trying to think of the June chapter. We talked about,

20 like, what percent of different specialties received the

21 bonus. So that's probably the most useful thing I can

22 point to. I don't have that memorized, but I can send that

1 to you after.
2 DR. NAVATHE: Okay. I mean, I think partly I'm
3 asking the question because my prior would have been that
4 it's more primary care than specialist. But then when we
5 look at some of the numbers that we present, I think, for
6 example, slide 14 and 15, if I'm right about this, that we
7 have the 63 percent number that the A-APM bonus is greater
8 than shared savings. And then when we break it out,
9 however, that number is much higher for specialists,
10 because that's a weighted average. It looks like then
11 there's more specialists for non-primary care?
12 DR. CHERNEW: I think -- so I'm sorry. I should
13 let you answer it. I think there's a lot more specialists.
14 So percentage-wise, there's an issue, but in absolute
15 sense, you just have a ton more specialists.
16 DR. NAVATHE: But who are qualifying, who are
17 meeting the --
18 DR. CHERNEW: No, I understand. But --
19 DR. NAVATHE: Yeah, I understand there's a lot
20 more specialists. I'm just saying like the -- yeah, I
21 guess that would have been my prior. So when I look at
22 this data, it gives me the impression -- and maybe I'm

1 misinterpreting the data. That's why I'm asking the
2 question. But maybe we can follow up with that
3 information. It sounds like we may not have that.
4 MR. SERNA: You're not misinterpreting the data.
5 DR. NAVATHE: Okay.
6 MR. SERNA: So there's more specialists in the
7 MSSP advanced participation list than there are primary
8 care physicians.
9 DR. NAVATHE: I see. Okay, okay. That's
10 helpful.
11 And then to your point, I think, just to serve
12 what I think of as kind of closing that point is that,
13 however, the way that those shared savings from
14 participating those models end up flowing down, those flow
15 disproportionately to the primary care. And so that's what
16 we get when you kind of compare a bonus versus your
17 savings, you're going to get a tilt in that direction.
18 MR. SERNA: That's correct.
19 DR. NAVATHE: Okay. Got it.
20 The next question I had was in the reading
21 materials on Figure 6, we have the deciles, and then based
22 on the deciles of the clinicians -- I think it's the

1 deciles of the clinicians -- then we've broken it again by
2 physician specialties, primary care physicians, other
3 practitioners.
4 I'm hoping this is a straightforward question,
5 but I was curious if the deciles there are -- we're lumping
6 all the physicians, all the clinicians together and then
7 constructing the deciles and plotting each of the curves,
8 the dot, each of the dots is specific to the physicians,
9 primary care physicians, other practitioners, or are those
10 deciles specific to that, to each of those groups?
11 MS. BURTON: It's the latter.
12 DR. NAVATHE: They're specific to each of those
13 groups. Okay.
14 All right. Then I have one more clarifying
15 question. I apologize.
16 Because then if we look at Figure 6, for the
17 fifth decile of primary care physicians, it looks like the
18 average participation bonus for that fifth decile is about
19 $2,000 on that chart. So then I was curious what we should
20 be -- how I should interpret Figure 7, because in Figure 7
21 -- I guess this is for many clinicians.
22 So, in Figure 7, we have this fifth decile of

1 $858, but that looks a lot lower than a lot of the
2 specialties' numbers look, for example, like the primary
3 care again.
4 MS. BURTON: Yeah, because this is including all
5 clinicians, including non-physicians, and they get much
6 lower bonuses.
7 DR. NAVATHE: I see. Okay. So it's because
8 those numbers are so low for the other practitioners and
9 APRNs and PAs that we're getting -- that's being pulled
10 down. Okay. Thank you.
11 Last question is, we make a point that only 6
12 percent of MSSP -- I think MSSP ACOs actually experience
13 shared losses and payback losses. I just wanted to make
14 sure that we're clear and I'm clear, but that we're also
15 clear, that that is the kind of ex-post experience of we
16 achieved gains or losses, 6 percent achieved losses.
17 That's very different than how many or what share of them
18 could potentially experience losses.
19 MR. SERNA: That's correct.
20 DR. NAVATHE: Yeah. Okay. Great. Thank you.
21 MS. KELLEY: Brian, Round 1?
22 DR. MILLER: Thank you. Highly detailed and

1 technical work.

2 I have a simple sort of focused question. When I

3 read this chapter, it seems sort of like a monolith in

4 support of funding for APMs. I know last year, the Paragon

5 Health Institute, non-partisan independent think tank, sent

6 us a cycle -- or sent us a letter last cycle against

7 extending the A-APM bonus and pointing out that,

8 functionally, Medicare's APM model largely has not worked

9 to lower costs and improve quality. I didn't see any

10 discussion of that alternative viewpoint.

11 In this chapter, it seemed like the prelude and

12 the premise of the chapter was that we absolutely must have

13 APMs, that we must spend money on APMs. So I guess I'm

14 curious. Can there be a technical edit where we include

15 different perspectives in the chapter to encourage better

16 discussion?

17 MS. BURTON: I think we were trying to capture

18 the sense of the Commission. We have three, in a row, June

19 chapters, where we expressed support for APMs, June '20,

20 '21, and '22.

21 DR. MILLER: Right. But I guess what I'm saying

22 is, you know, if our end customer is policymakers and

1 here's a reputable think tank that has a different
2 perspective, why are we not encouraging or at least
3 including a discussion of that different perspective in our
4 chapter?
5 DR. CHERNEW: So I'm not sure that's actually
6 clarifying, but the point remains, that's a reasonable
7 point. So, yes, we can certainly -- I'll say something
8 about that in my -- in between Round 1 and Round 2 things,
9 but that's probably a little bit more of a Michael thing.
10 And I'm happy to continue that discussion.
11 DR. MILLER: Thank you.
12 MS. KELLEY: Betty.
13 DR. RAMBUR: Thank you. Very interesting and
14 informative.
15 So my question follows a bit on Amol's second or
16 second to the last comment on Figure 6 that shows the
17 participation bonuses. I was just curious, for my
18 understanding, if an APRN or a PA is required to do
19 incident-to billing, does that bonus then show up on the
20 physician bonus or --
21 MS. BURTON: Yeah, that's right.
22 DR. RAMBUR: It does. So, in a sense, the actual

1 work is masked, nevertheless, that we have --
2 MS. BURTON: Yeah, yeah. Some of these really
3 high bonuses you're seeing for physicians in the 10th
4 percentile probably is multiple clinicians.
5 DR. RAMBUR: Thank you.
6 MS. KELLEY: Unless I missed anyone, we are done
7 with Round 1, Mike.
8 DR. CHERNEW: Great. So thank you. I'm going to
9 look forward to all of your comments, but just a few level-
10 setting things.
11 Right now, depending on how this discussion goes,
12 we're not planning to come up with a recommendation per se
13 about what to do, although as the presentation suggested,
14 there are some approaches that you may want to advocate or
15 not. And I'm really looking forward to the general
16 discussion. So that's sort of point two -- point one.
17 Point two is -- and I think it came out in a
18 number of these comments in a bunch of different ways --
19 alternative payment models vary, and so there's a core
20 question. If you say, well, on average, most of them don't
21 work, but a few of them do, what would you think about
22 that, and how would you react to that? And what would you

1 do? If you were having the same discussion about drug
2 development, you wouldn't say most molecules fail. Then we
3 shouldn't have new drugs, right? So there's this issue
4 about how we think through that and what we do, and you
5 certainly can talk about that.
6 But, relatedly, the A-APM bonus now is set up in
7 a very uniform way. The bonus is structured in ways that
8 are similar for, say, episode models and for population-
9 based models.
10 Now, in the world we're in, some of the episode
11 models are mandatory, which at a minimum merits discussion
12 if you're discussing a bonus and, at a maximum, you know,
13 what are we trying to incent if something's mandatory?
14 But, again, we can have a discussion about how to deal with
15 that variation and what the ramifications of that are and
16 whether we're thinking about the bonus for the current set
17 of A-APMs, whatever we think about them, whether we're
18 thinking about some version of it in a different APM. And,
19 again, that's just up for discussion.
20 A second -- another theme that comes out in this
21 work, which I think is important -- the MIPS stuff
22 illustrates it most clearly -- is -- and I actually very,

1 very much appreciate this -- is the connection between the
2 bonus and, for that matter, A-APMs, in general, with other
3 things going on in the environment. MIPS, for example, is
4 one, but there's a bunch of other payment model changes
5 that aren't inherently an APM, different codes and fee-for-
6 service. There's some discussion on the Hill about
7 changing ways that primary care doctors are paid and stuff.
8 And I think one of the themes about this is the
9 connection between the A-APM program writ large and the
10 bonus more narrowly and just overall environment and how
11 we're trying to harmonize things across all of those
12 various things, and I'd be interested in people's thoughts
13 on that.
14 And then the last point -- and this may be a
15 little bit in the spirit of what Brian was saying, but it
16 is important.
17 I'll now speak for me, but your reactions are
18 welcome. Participation in an A-APM is not an end in of
19 itself. I'm pretty sure we could figure out a way to get a
20 lot of people in A-APMs if that was ultimately the goal.
21 The goal is a broader goal about having a health care
22 system that encourages efficient, high-quality production

1 of care, and there's reasons to believe, we can debate,
2 that the structure of alternative payment models can help
3 further that goal.
4 But my general sense is at least sort of in the
5 long run and kind of stability, you don't want to say
6 something is great because it's saving money and then pay
7 so much, like this came out in the theme, that now the
8 whole thing is no longer saving money, because you're
9 paying way too much money to get people into the things
10 that otherwise would save money. So there's just sort of
11 connection between there, and, you know, I want to point
12 out that -- and again, Rachel, we said this -- the models
13 themselves at some point should be designed in ways that
14 make them appealing both to participate and to accomplish
15 the goals we have set out for them, and I think that leads
16 to -- I said that was my last point, but I just -- I hope -
17 - well, the transcript is going to be embarrassing.
18 So I'm going to say one other point, which is one
19 can think about the features of the bonus more holistically
20 in how we do A-APM design. We are not contemplating any
21 work. I don't actually think MedPAC is well suited to do
22 micro-detailed analysis of how AAPMs should be designed,

1 but I think we can acknowledge that they do exist and they
2 serve a purpose.
3 And so thoughts on sort of that and how we might
4 do things could end up in a place like if we had a model
5 that was good, holistically, we might want to think about
6 something like, for example, how we would get people in.
7 Maybe it's when we pay, pay sooner, the structure of how we
8 pay, and a much more flexible approach.
9 So, anyway, those are the type of things I'm
10 listening to broadly. Right now, depending on how this
11 conversation goes, we're not planning any specific
12 recommendation, but this all could go otherwise. And so,
13 in that context, I guess it's good.
14 Brian, you are up.
15 DR. MILLER: Thank you. Thank you for this work.
16 I have some detailed comments, and then I have some
17 summative comments.
18 So my detailed comments are, about a year ago the
19 CBO published a re-estimate of CMMI and alternate payment
20 model -- models, showing that they increased spending by
21 several billion dollars between 2011 and 2020, based upon
22 the evaluation of 49 models and budgetary data. So it

1 changed -- that estimate changed from $2.8 billion in
2 savings to -- I believe it's $5.4 billion in expenditures,
3 which is a pretty wide swing.
4 The CBO then looked forward and said, well, from
5 2021 to 2030, I think it will increase spending by $1.3
6 billion. So that's not really a great result.
7 And then they looked a little farther and said,
8 well, if we look at 2024 through 2033, might increase by
9 $50 million.
10 We were, in the private sector, running a
11 business, and I know we have several CEOs here and have had
12 people who've run businesses on MedPAC. That line of
13 business would have been closed years ago, because we've
14 spent billions of taxpayer dollars and untold thousands of
15 hours of labor and had an extremely negative result.
16 If our goal is to increase quality and decrease
17 program expenditures, it actually looks like we funded a
18 decade of failed experiments, and this is different from
19 the pharmaceutical industry, because we failed a decade of
20 failed experiments purely on taxpayer dollars. So five, I
21 believe, of 50 models have saved money. That's not really
22 great performance.

1 And, in this setting, CMMI has pivoted to
2 mandatory models, which some could argue is usurping the
3 role of Congress and the people by making massive policy
4 changes through regulation in the administrative state.
5 And so, functionally, in this setting, the APM bonus is
6 propping up what is a failing program, and as we denoted
7 through the statistics in much of our own work, the bonus
8 is larger than the savings.
9 So on page 4, we talked about how the A-APM bonus
10 is larger than a clinician's net shared savings for 72
11 percent of non-primary care physicians. That's a lot of
12 money.
13 I think that the other thing that we've often
14 also ignored is beneficiary autonomy and agency. So the
15 Medicare population is a vulnerable population. They have
16 polychronic disease. A significant percentage have
17 impairments and IADLs and ADLs, right, so, like, not being
18 able to go to the grocery store, balance your checkbook, or
19 ADLs, put on a sweater and comb your hair or wash yourself.
20 And so this is a population that we are enrolling without
21 their consent in alternate payment models like ACOs, and to
22 me, that's an ethical question.

1 Now, I think Medicare Advantage has many warts
2 which need to be addressed, but at least the beneficiary
3 makes a conscious choice.
4 So my concluding thought in thinking about the A-
5 APM bonus is that the bonus really reflects the policy
6 community's obsession with centralized technocratic
7 tinkering of payment through an ever-expanding bureaucracy
8 that has failed to control spending growth for 60 years in
9 the Medicare program.
10 This approach of APMs and funding the bonus of
11 APMs, this doesn't mean that we shouldn't continue to
12 experiment with alternative payment models because we
13 should, but it's different than bonusing them.
14 This approach is based upon the idea that a
15 centralized bureaucracy can solve distant, highly
16 localized, and customized problems. I and many others
17 would argue that this premise is false and that the last 10
18 to 15 years have shown us that this is the case.
19 I'd also posit that while it's unpopular, we
20 really need to be the adults in the room on Medicare
21 spending. We really shouldn't be setting taxpayer money on
22 fire funding participation trophies. If we believe that

1 models will improve the financial performance of
2 organizations and improve quality and save money for the
3 Medicare program, that should be enough. If it doesn't,
4 then we should be trying different models.
5 Thank you.
6 MS. KELLEY: Stacie.
7 DR. DUSETZINA: Great. Thank you very much for
8 this. I have very minor comments, and most of it is around
9 descriptive epidemiology, and just wanting to know a little
10 bit more about some of the numbers of people.
11 So a couple of things that really, I think,
12 would've helped as I was reading the chapter are like
13 number of participants, number who received bonuses, and
14 things like that, especially for Figure 1, for example. I
15 kind of felt myself thinking, I need a little bit more of a
16 handle on this. And part of it is this is outside of the
17 area that I spend a lot of time thinking about, so I think
18 that would be really useful.
19 The other thing that I thought was really
20 interesting in the chapter was about the practices that
21 don't qualify for participation, and if there was some
22 ability to get us more details on who they are. I think

1 you kind of get to this in the later part of the chapter
2 where you're talking about, you know, if you're higher
3 spending you're probably not going to be able to be
4 included. But I think that just generally be a nice set of
5 information to have, thinking about how these work today.
6 But very good work. Thank you.
7 MS. BURTON: Thanks. We can add that. And just
8 FYI, it tends to be clinicians in episode-based payment
9 models that really struggle to qualify for the bonus.
10 MS. KELLEY: Robert.
11 DR. CHERRY: Yeah. Thank you for the outstanding
12 report. I do enjoy the alphabet soup of physician payment
13 models. It's always a little bit counterintuitive and a
14 little bit confusing, so I definitely understand that.
15 I do want to say something about Greg's remarks,
16 because I do agree with him that in some cases,
17 particularly employee physicians in large health systems,
18 the choice of whether to participate or not is not
19 necessarily their own. So it's a health system business
20 decision around how much risk the organization wants to
21 take on.
22 But there is an underlying question here, which

1 is do you favor extending the participation bonus. I would
2 say yes, mainly because I like the Approach 1 that was
3 outlined within the presentation, because it incentivizes
4 more specialists to actually participate.
5 One of the problems is that we're trying to
6 figure out what works. So you have this APM model. It
7 works differently for primary care as it does for
8 specialists. And it's competing in this environment with
9 MIPS as well. So it's not really intuitive, particularly
10 if you're part of a smaller system or a small group
11 practice, where you want to spend your time and which is a
12 better choice in terms of payment model to be in.
13 And I think in terms of the APM model, we
14 probably haven't given it enough of a chance to thrive
15 unless it's incentivized to increase the number of
16 specialists across a wide variety of areas and see how it
17 actually functions. So I'm not really surprised that it
18 doesn't have great reviews right now, but I think to really
19 see whether it's going to have an impact we have to
20 incentivize more people to actually be able to participate.
21 So I think the bonus can be actually a good
22 bridge in terms of improving the APM model, particularly

1 the number of physicians that choose to participate, and
2 then kind of model it out and kind of, to use Mike's words,
3 to see how things can be harmonized over time. Because I
4 think we need a little bit more of a runway to kind of
5 definitively decide where we want to go. Thank you.
6 MS. KELLEY: Scott.
7 DR. SARRAN: Thanks, Rachel and Luis, for
8 excellent work. There's a lot of complexities to this
9 space, and I think you did a really nice job of walking us
10 through those.
11 I'm going to briefly set the context for what I'm
12 going to recommend, and then I'll say what I'm going to
13 recommend.
14 Brian's comments, which are typically well
15 thought out and articulately expressed, many of those
16 resonate with me in terms of the concerns that we've been
17 at this body of work for a long time, and have not
18 conclusively demonstrated savings. So I resonate with
19 that.
20 But I just don't see how we get to where we need
21 to be to consistently enable and incent optimal, team-
22 based, ongoing, proactive, continuous chronic care for an

1 aging population that is increasingly complex, when we
2 have, as discussed earlier, an increasing set of care
3 options that are, in and of themselves, increasingly
4 complex. I don't see how we do that in a fee-for-service
5 model.
6 So recognizing that we've not been successful in
7 demonstrating savings from these models yet, I don't think
8 it's appropriate to abandon them.
9 I also think it's important to note that there
10 are, I think, more consistent demonstrations of quality
11 improvements in the models. So we haven't demonstrated
12 consistent savings. But I think there has been at least
13 moderately consistent demonstrations of quality
14 improvements, and I think there's certainly been
15 essentially an absence of any concerns about decrements in
16 quality in the model, and that's important.
17 So given that, I think we should continue the
18 bonus. And I like your Approach 1 on Slide 9. And I
19 particularly like that because, again, I contextualize this
20 by thinking about, as we discussed earlier, good chronic
21 care disease management needs to significantly incorporate
22 specialists in it. Like the population is sicker. The

1 choices of treatments often require active specialists'
2 involvement over ongoing periods of time. So I like how
3 Approach 1, I think as you expressed it, is more likely to
4 secure and continue to secure the participation of
5 specialists.
6 So that's where I land for the reasons I laid
7 out.
8 MS. KELLEY: Cheryl.
9 DR. DAMBERG: Thank you. I have a couple of
10 comments. I think it would be interesting to the extent
11 that you have access to the data to try to, as Stacie
12 noted, better reflect the epidemiology of what's in play
13 here and maybe characterize the types of practices that are
14 participating versus not. And I just think that would help
15 people understand the landscape better.
16 I do share a concern that the bonuses, at least
17 at this point, don't seem to be materially important
18 related to participation, so I struggle a bit about whether
19 there's a need to continue them or not. But given the
20 selection issues that are in play, I know Tamara flagged
21 that, it does seem particularly problematic that the high-
22 cost providers who potentially could be moved in the

1 direction of improvement care and more efficient care are
2 not at the table. And so I don't know whether it's going
3 to be through this newly proposed CMMI demonstration that
4 will get specialists at the table, or some version of
5 Approach 1.
6 But I personally think if there was some way to
7 better target the bonus, that trying to get those people to
8 the table who have historically not been at the table, I
9 think that would be highly desirable.
10 And I guess my last point, and I suspect this
11 came up in the previous discussion that I was not available
12 to participate in, you know, just really some of the
13 distortionary effects around MIPS and the penalties that
14 focus on these small providers in solo practice who are not
15 submitting data. I think it underscores the need to get
16 rid of MIPS and come up with something better.
17 MS. KELLEY: Betty.
18 DR. RAMBUR: Thank you. Very interesting. A
19 couple of thoughts, just to kind of share where I'm at.
20 You talked about gross savings versus net, and I always
21 think about is the aim at this time really cost savings?
22 Sure, of course. But to me the most important thing is

1 redesign of the delivery model, for the reasons that Scott
2 has said. And we can talk about a failed system.
3 Certainly fee-for-service is reactive, it creates
4 unnecessary care, it prevent care coordination, et cetera.
5 So I think we have to keep that in mind.
6 I just have to make a comment on mandatory. Too
7 many of you have heard me say this before. I strongly
8 support mandatory models. And if DRGs would've been
9 optional we'd still be discussing it. We'd be saying I
10 just don't think we can do that. We absolutely would. And
11 remember, it's only mandatory of the providers want to be
12 paid. It is a government program, so it seem the
13 government actually has the right if this should work.
14 I agree with Robert that I think the bridge is
15 important, because it's actually really hard to transition.
16 Fee-for-service, in a sense, as a delivery model, it's so
17 easy. It's just so easy to order it. It's just so easy to
18 do those things. And there's no consequence for that. So
19 I think the bridge really is important, so that people can
20 have what they need to start thinking very differently.
21 So I support ongoing bonuses. What happens when
22 things are mandatory, if that all happens, and Chevron

1 doesn't somehow blow that up? I think that could be faced
2 at that time. Thanks.
3 MS. KELLEY: Greg.
4 MR. POULSEN: Thank you, and again, appreciation
5 for the great work.
6 You know, as I sort of mentioned in the Round 1
7 questions, bonus, I think, has a very different impact
8 based on physician organizational structure that's there.
9 I think for independent physicians, the bonus is a key to
10 participation. It might be the key to participation for
11 some physicians. For large groups that are owned by
12 somebody outside of the group -- I'm thinking of PE groups,
13 Optum groups, others -- I'm a little more vague in terms of
14 how their incentives line up. I suspect they look more
15 like the independent physicians since they're intended to
16 create a P&L primarily on their own merits. But I'm not
17 sure about that.
18 With health systems groups, I think that's a very
19 different kettle of fish. I think that the bonus has a
20 much lower impact on the participation decision. The main
21 reason is simply whether the organization believe that the
22 APM can deliver value holistically, and at that point they

1 simply enroll their physicians in it.

2 So I think that leads us to something that's
3 interesting. But before I get there, I think that the
4 point is really important, the variability of ACO models
5 performance, as Brian mentioned. Many are net negative,
6 some are neutral, and some are positive. But the other
7 thing that we haven't mentioned, which I think needs to be
8 stated, is that the performance of those tends to also be
9 dependent upon the medical group type that's participating.
10 So if we will do a cross tab, if you will, I believe that
11 the data suggests that there are ACO types, when blended
12 with different group types, that perform very poorly, and
13 some that perform consistently well.

14 And if what we're trying to do is to find a way
15 to move to the models that perform well along with the
16 group types that perform well, that's when I think we need
17 to decide how much we're willing to invest in the future,
18 because in the short term, independent groups have not got
19 a good track record of being able to provide that. That's
20 not to say they can't move into that type in the future.

21 So if we believe that the right way to go is to
22 have large groups that do this effectively, then I don't

1 think we need the bonuses, because I think their motivation
2 is different, and the large groups will participate simply
3 because it's the same reason they get involved in Medicare
4 Advantage. They believe there's a mechanism to achieve it
5 that's unrelated to the bonuses.
6 If, on the other hand, our goals is to have a
7 path forward for independent physicians who don't want to
8 be part of those large groups then I think we now have a
9 mechanism, we're starting to see a mechanism among those
10 models that are effective. And there are some ACO models
11 that have proven to be effective. And if we think of CMMI
12 as the center for innovation, then, in fact, I think that
13 those innovations can lead us to a path to different models
14 that can be effective.
15 And if we provide rewards, which I think leads us
16 back to the bonus question, for people participating in
17 those models of care and those models of ACOs, then I think
18 that we do have a path forward that's worth considering,
19 and probably worth the investment. But we have to do it in
20 a more nuanced way than simply throwing bonuses at
21 everybody who does any kind of an innovative model.
22 MS. KELLEY: Amol.

1 DR. NAVATHE: Great job, Luis. Thank you so much
2 for, again, a very detailed and systematic analysis. So I
3 really appreciate the work here.
4 So I think my fellow Commissioners have made a
5 number of fantastic comments, I think kind of around the
6 horn, if we will. I think a couple of things kind of loom
7 large for me in thinking about the broader question of A-
8 APM, and then when we dig underneath that, the second layer
9 of what do we do with the bonus or how should we think
10 about the bonus.
11 A point that Commissioners have made that I would
12 just echo, the importance of A-APMs, I would agree a lot
13 with the way that fellow Commissioners have characterized
14 the performance of models. I think it's been uneven
15 certainly across all the models, and there's been few that
16 have generated net savings, several of which have created
17 practice changes or growth savings, and there is that
18 tension that Betty highlighted.
19 But it seems like it's the one tool that CMS may
20 have here to counteract this issue around volume and
21 intensity that we've seen has been such a challenging
22 thing, right. Think about the number of times that

1 Congress has had to make fee fix at some point. Obviously,
2 we addressed some of that earlier today, but nonetheless, I
3 think that is a very driving factor, at least in my
4 thinking, around why A-APMs end up being an important tool
5 for us to really explore fully and think about, alongside
6 delivery system reform pieces. I think it is not that hard
7 to find evidence of great fragmentation in care that a lot
8 of our Medicare beneficiaries face, especially those with
9 chronic conditions.
10 So if we're going to find a way to make this
11 system work together in a more harmonized or seamless
12 fashion, at least on the fee-for-service side, it seems
13 like A-APM is part of that toolkit. I don't know of a lot
14 of other tools. I think if other folks brought others up
15 I'd, of course, be very curious to hear.
16 So I think that kind of brings us, in some sense,
17 or at least me, to this conceptual question of why do we
18 need a bonus. I think one of the pieces that struck me,
19 certainly early on, was this question of uncertainty,
20 especially when we didn't have experience in A-APMs, how
21 was it going to go. We didn't really know.
22 I think one of the pieces that strikes me is we

1 should be careful about looking at ex-post analyses of how
2 organizations or clinicians ended up experiencing
3 performance, and then turning around and saying how that
4 may or may not have influenced their decisions to
5 participate, because I think that uncertainty piece is
6 really important.
7 There is also, maybe there's startup costs and
8 early investments that need to be had, and those are hard
9 to pay with shared savings because those come ex-post, and
10 if we require organizations to be able to capitalize from
11 the startup costs then we may obviously be pushing toward
12 certain types of organizations that may or may not be our
13 intent, or we may be freezing out smaller practices, for
14 example, which may not be our intent.
15 And another maybe conceptual reason is we need
16 enough participation to get over the hump, to be able to
17 actually create system reform. And then there's this other
18 question, I guess, do we even need participation bonuses
19 when we do have mandatory models, given that those
20 organizations are presumably compelled to participate.
21 So those are some of the thoughts. I think at
22 the end of the day, one of the things that's striking is

1 that we are no longer in the world of, hey, we're starting
2 out for the first time implementing A-APMs. Many
3 organizations and clinicians have been in A-APMs for a very
4 long time. I think of Commissioners around the table, like
5 Paul, who have led organizations year after year after
6 year, through these programs.
7 I think it's a much harder case, I think, to
8 argue now, that this all about uncertainty or even perhaps
9 startup costs. Those arguments, to me, start to become a
10 lot less compelling.
11 So I think kind of two other big points in my
12 mind are I think this is piggybacking on comments from
13 other Commissioners. Specialist engagement is a place
14 that's been very challenging, particularly in the
15 population-based models. It seem like an area to
16 prioritize. And then also simplicity. If we make these
17 very complicated it's going to be very hard for clinicians
18 to know what it looks like when they join an A-APM versus
19 what it looks like if they don't.
20 And that brings me to, I think, for me, the kind
21 of governing point, in some sense, is I think the
22 importance of the A-APM bonus, at a high level, because

1 we're now in Year 13, 14, 15, whatever, or Year 10, 11, 12,
2 whatever we want to call it, of this experience. It's a
3 lot less compelling to need this bonus. A lot of this
4 should happen through the design of the model. But I don't
5 think we necessarily want to create a system where there is
6 that counterincentive or we're undermining the incentive to
7 participate.
8 So the symmetry to the reference point of MIPS,
9 for me, looms very large, and I think it's very helpful,
10 the analysis that you have done and you have reflected to
11 us, about how the impact of MIPS is likely much smaller
12 than it would have been, based on what CMS has articulated
13 recently.
14 So I would support approaches kind of like
15 Approach 1, which are a little bit more tilted towards
16 engaging specialists, keeping things, if we can, as simple
17 as possible, but at the same time calibrating magnitude to
18 the extent that we can to be very similar to what
19 clinicians might experience from MIPS. So we're not
20 necessarily bonusing them per se, but we're also trying to
21 prevent a disincentive from joining an A-APM.
22 So that's kind of my conceptual musings. Thanks.

1 MS. KELLEY: All right. I have a comment from
2 Larry.
3 Larry agrees that, on average, the APM programs
4 have not been very successful. He's concerned that their
5 main effect so far has been to encourage consolidation
6 rather than to improve care. However, he thinks that APMs
7 have the potential to improve care and that it may take
8 more than a few years for any given organization, an ACO
9 for example, to succeed in improving care.
10 He doesn't think we have a great alternative.
11 There are some ACOs that provide really good care, but most
12 don't yet have the structure or culture to function like a
13 Kaiser or a Geisinger, for example.
14 He sees ACOs' potential to be a way to begin to
15 create organizations that really could improve care.
16 He adds that there's a lot of support in Congress
17 for the Medicare Advantage program, even though it has
18 never saved money for Medicare. A charitable view of this
19 support would be that MA has the potential to save money,
20 even though it hasn't yet, just as APMs have the potential
21 to save money, even though they haven't yet. He sees this
22 as a parallel argument to the argument for being supportive

1 of APMs and is not clear why one would support MA but not
2 APMs.
3 He's basically in accord with the conclusions on
4 the takeaway slide. His high-level opinion is that there
5 should continue to be for a few years some financial
6 incentive, perhaps around 3 percent, for clinicians to be
7 in A-APMs, but that CMS should not put its thumb on the
8 scale too heavily.
9 At some point within the next five years, A-APMs
10 need to make money through improving care rather than
11 through bonuses paid to clinicians simply for being in an
12 APM.
13 We're talking about relatively small amounts of
14 money, especially when analyzing the difference between
15 bonuses and MIPS versus bonuses paid to A-APMs. So it may
16 also be worth considering that, at least for individual
17 clinicians, bonus payments may function more as a signal, a
18 symbol. That is, things are moving in the direction of
19 value-based care than as an important source of income.
20 Two other points. First, as Greg and Robert have
21 mentioned, for many clinicians, the decision to participate
22 in an A-APM is made by their organization, not by the

1 individual clinician.

2 Large organizations are probably more interested

3 in bonuses per clinician, even when they are small enough

4 that they would not influence an individual's decision to

5 participate in an A-APM, But an aggregate might be of

6 interest to the organization.

7 Organizations may also participate for other

8 reasons; For example, to learn how to function in value-

9 based care. The materials and today's presentation do

10 mention that organizations rather than individual

11 clinicians are the decision-makers for many clinicians, but

12 this point might be made more visible.

13 Second, statements like this -- statements like

14 the one on page 13, he has problems with -- he doesn't

15 believe that individual clinicians or even organizations

16 care much about what's going to happen in 2035, to say

17 nothing about 2045, even if one adopts the unlikely

18 assumption that no policy changes will be made in the

19 intervening years.

20 It's important to include this estimate in the

21 chapter, but it makes us look unrealistic if it's not

22 heavily qualified; That is, if we don't point out that

1 things are unlikely to play out this way over such a long
2 time span.
3 Wayne, I think you had a question?
4 DR. RILEY: Yeah. Apologies, Luis and Rachel,
5 for a Round 1 question at the end of Round 2, but I may
6 have missed this. What's the cost differential between
7 approach one and two?
8 MS. BURTON: I don't have that for you.
9 MS. KELLEY: Gina?
10 MS. UPCHURCH: I'm going to follow on Wayne. I
11 think the first one might be a Round 1 question.
12 So when we compared what Medicare -- and this is
13 building on Larry's comment -- what we pay Medicare
14 Advantage plans versus fee-for-service Medicare and we have
15 that 22 percent differential, does that include the bonus
16 payments and the alternative payment model? Okay. So
17 that's even including those. Okay. Just clarifying,
18 making sure that's clear.
19 I am a little baffled by the beneficiary autonomy
20 concern because consumers -- in my mind, if you're in fee-
21 for-service Medicare, you're getting standard of care or
22 improved coordinated standard of care with an ACO or any

1 sort of alternative payment model. It's not telling you
2 that you have to have a narrow network or you have networks
3 of providers or that you have different cost sharing or
4 anything like that. None of that changes. You're just in
5 a plan that's hopefully standard of care or better
6 coordinated care. So I don't understand. Beneficiaries
7 don't even know they're in ACOs. So I don't really
8 understand that concern necessarily.
9 The last thing I just would say is that I wonder
10 about -- and I know it would be hard for us to figure out -
11 - if you're changing sort of how providers interact with
12 each other, how they share electronic health records, I
13 don't like the consolidation that it's led to. But I
14 wonder if it has positive effects on other, like, employer
15 care or Medicaid or -- because you're getting providers to
16 work more closely together in an idealistic way. I don't
17 know if we have any data on that, how ACOs impact outside
18 of Medicare.
19 Thanks.
20 MS. KELLEY: Brian, did you have something on
21 that?
22 DR. MILLER: Yeah, I have an on-point response.

1 So, in every other part of social sciences, psychological
2 research, when you're involving human subjects, you get
3 their consent to changing things. And we've said -- the
4 policy community has said many times that CMMI is doing
5 experiments and payment innovation. And, as we've said,
6 that 45, I believe, of the 50 models have not improved
7 quality or cost. So we've changed care delivery with not
8 improving quality or cost without a beneficiary's consent.
9 I think it's really important for Medicare
10 beneficiaries to have the choice to participate or not,
11 right, because we need to respect their autonomy, and
12 that's a basic human right and part of research. And I
13 think that with the current APM framework, we are not
14 respecting that.
15 MS. KELLEY: Tamara.
16 DR. KONETZKA: So, first, I just want to echo
17 what Scott, Betty, Amol, a few others articulated very
18 well, and that is despite some lukewarm evidence about
19 alternative payment models, I don't think of it as a one-
20 time establishment of a new system. I think of it as sort
21 of like quality improvement. It's a process, and it's part
22 of this sort of grand transition in mindset from paying on

1 volume to paying on quality. And it's sort of an ongoing
2 work in progress.
3 And I really don't think -- as I think Amol was
4 mentioning, I really don't think there are great other
5 alternatives out there to follow. I think it's our best
6 hope for moving in that direction. So I think it's well
7 worth pursuing as we improve those models, right?
8 That said, I'm going to disagree a little bit
9 with people. I don't know how strongly I feel about this,
10 but I'm going to disagree a little bit with some of the
11 other comments about maintaining the bonus, because when I
12 read the evidence in the chapter, I just wasn't convinced
13 that it's actually making any difference in participation,
14 right?
15 There was the qualitative work, which I found
16 super interesting. That said, it's really perhaps not
17 about the bonus, but people are very interested in getting
18 referrals, and that's why they join these models. They're
19 interested in data, and there are other good reasons for
20 joining an APM, and then that coupled with the evidence
21 that, you know, it's actually not a big amount for most
22 physicians.

1 So, to Greg's point, there might be some
2 heterogeneity, and maybe that's too much of a
3 generalization, but I wasn't convinced that we -- and it
4 also -- sorry. The third part of that is it seemed like a
5 temporary problem, right, where, like, MIPS as an
6 alternative is going to look worse and worse over time. So
7 it seemed like a temporary problem that I wasn't sure
8 existed, that if this bonus goes away, that we're going to
9 see less and less participation in ACOs or not the level
10 that we want.
11 So I wasn't really sure that continuing the bonus
12 was the right way to get more people in APMs, but I'm
13 strongly supportive of sort of continuing the experiment
14 and making sure across a broad range of options that people
15 have incentives to join APMs.
16 Thanks.
17 MS. KELLEY: Paul.
18 DR. CASALE: Thank you.
19 Great, great work.
20 I'm going to repeat a few things that others have
21 said, but I think some of it bears repeating and then a few
22 other comments.

1 So, as others have said, I think for most
2 specialists, I'll say, particularly in health systems, they
3 have no idea they are in an APM, absolutely no idea. And I
4 think that's just sort of factual, you know, not -- and
5 having run an ACO where I've tried to make the specialists
6 aware, they're just generally, you know, busy clinicians,
7 and it's just not on their radar.
8 And you mentioned that, you know, if you think of
9 sort of smaller independent groups of specialists, they're
10 probably more in an episode bundle, and they're less likely
11 to qualify, right, for the APM bonus.
12 Comments that I agree with around the size of the
13 bonus and timing can -- again, generally don't -- I'm
14 thinking about the specialist -- don't generally resonate
15 with them.
16 And then to Amol's comment about, you know, we've
17 been doing this a long time, I remember when it started,
18 when this work all started. And, again, I was on PTAC
19 then. And, you know, the clinicians, specialty clinicians
20 brought models to PTAC. And, you know, several of the
21 specialists were bringing models because they wanted the 5
22 percent bonus. That's what they were -- yeah, yes, they

1 wanted to redesign care. They wanted to get payment. But
2 some of them and some of the specialties really didn't have
3 a capacity to take on total cost of care. But that 5
4 percent, again, early on, I think was a real incentive.
5 And I bring that up to say, you know, we're down
6 the road quite a bit, and for many MSSPs, they require to
7 move to risk over time, regardless of their choice. And so
8 I think we are further down the road as to whether that has
9 really incentivized more, and, again, I'm thinking around
10 the specialists', in particular, participation.
11 However, I do think, as others have said, even if
12 this incentive is small, whether it's 2 or 3 percent, I
13 think it signals a direction, as others have said, as to
14 moving from fee-for-service that there's -- you know, I
15 don't think it's necessarily going to cover a lot of
16 infrastructure costs, et cetera. But it's a signal that
17 there is, you know, sort of additional payment for you to,
18 you know, participate.
19 And in the final, I'd say, you know, as CMMI
20 continues their work, as you know, they have an out-for-
21 comment, the ambulatory specialty model, which they'd like
22 to, you know, again, anticipate becoming mandatory. So I

1 think there's a lot of moving pieces now, that we're many
2 years down the road.
3 So, having said all that, I do think having some
4 small incentive, I think, is helpful as we continue down
5 this journey of APMs.
6 MS. KELLEY: Mike, that's all I have for Round 2.
7 DR. CHERNEW: Okay. Paul, thank you. Everybody,
8 thank you. I very much appreciate this.
9 A few general reactions before we take a quick
10 break and then come back to discuss Part D.
11 The first one is there is a new one -- well,
12 actually, the first one is I am not sure where we are going
13 to go with this, if we -- how it plays out. I'm just not
14 sure. We're going to have to debrief based on this whole
15 discussion and decide. So we may do more; we may not do
16 more. I just don't know. So that -- and I'll say this at
17 the end, but for those of you at home,
18 MeetingComments@MedPAC.gov if you want to weigh in on
19 whether you think we should pursue this and how much we
20 should or shouldn't pursue this.
21 I do hear a very wide range of views that I think
22 broadly are supportive of APMs with some concerns about

1 APMs. So, again, I'll just make some follow-up comments on
2 what I said in the beginning.
3 The first point is there is wide heterogeneity
4 amongst APMs. A statement, APMs work, APMs don't work.
5 They work. That's just an average. It is complicated to
6 decide what they are and how they work.
7 And I think we know in a number of cases that
8 there have been meaningful design concerns around things
9 like how benchmarks are set, the ratchet effect, how we do
10 regionalization, selection and participation. There's a
11 lot of general concerns around APMs, and there's a lot of
12 room to try and design them better. That's not a bonus
13 comment. That's just a general comment about APMs. But I
14 take Brian's point that some aspect of a lit review in some
15 way about where we think they are is an extremely
16 reasonable request. And I think that can be done, and I
17 think that's going to show. Having worked in this area, I
18 think it's going to show some places where things didn't
19 work and some places where there's great promise. But we
20 will actually do the work before I describe what I expect
21 and will find.
22 The second thing I will say is there is another

1 nuance between having a bonus versus maintaining this
2 bonus, right? And so there is a version of the way this
3 bonus is structured about exactly what's going on, and
4 there's a question of was it impactful, could it be
5 designed better, blah, blah, blah, blah. That is a
6 different question than if we were going to ask how would
7 we get folks to participate in these models, what would we
8 do, why would we do it, how would we structure it.
9 I do not think we as a group are going to get to
10 that level of detail in how we do that, but I do appreciate
11 at least what I heard around the table with some interest
12 in at least speculating or raising issues or discussing
13 that if you thought that APMs -- I'm not sure who I'm
14 channeling here, Maybe it's Amol, but I just say that
15 because he just walked in. If you believe that there is a
16 role for alternative payment models and you believe that
17 there's a role for transitioning to them or balancing them
18 with MIPS or doing some other thing in a particular way,
19 you might think about how you could structure a bonus or
20 not or some other program parameter for those types of
21 models in a range of ways that doesn't tie the ACO bonus to
22 the specialty bonus or the structures that we have, some of

1 those approaches we did. So I don't know if we're going to
2 do this work, but at least we'll think about that issue.
3 The last point, which I actually think is a
4 really important point -- and we don't have time to really
5 delve into it now, but I do take it quite seriously -- is
6 Brian's point about we're experimenting on people. What
7 are they consenting to in a range of ways? And that does
8 matter, because I think at the end of the day, we're all
9 motivated by making sure that people have access to high-
10 quality care in general.
11 And I'm concerned about the fiscal ramifications
12 of the program, but honestly, I'm really concerned that
13 beneficiaries have access to high-quality care, just a
14 general point.
15 But I would say that CMMI aside, that is a
16 concern that spans everything we do. It spans site
17 neutral. We don't ask, "Oh, we're going to change the way
18 we pay this. What do you think about that?" It spans when
19 we did DRG, someone mentioned. It will span our update
20 discussions. It will span our Part D discussions.
21 Everything we do, every change in the program, everything,
22 whether we do it or someone else, has real ramifications

1 for people's lives, how they're dealing with their family,
2 what we do for hospice payment, how we do post-acute, how
3 we integrate the long-term services and support work we're
4 doing. These are fundamental program design decisions that
5 affect people and how they're living their lives and how
6 their families are living their lives.
7 And while I very much accept Brian's point that
8 CMMI has issues of what folks are consenting to, I wouldn't
9 assume that every other thing we do is going through some
10 elaborate consent process. So what that means is I think
11 we are beholden in everything we do to think through, are
12 we promoting access to high-quality care just in general?
13 And we maintain that. And, again, there are limits.
14 There's challenges. It's a complicated program. We're
15 about to talk about the structure of Part D, and my head
16 almost exploded. It might explode again. This is a
17 difficult, challenging program.
18 But the general point that when we make
19 recommendations, CMMI or otherwise, that we have to make
20 sure that we are improving quality, I think, matters and,
21 in part because in all these, CMMI aside, we don't have a
22 really easily consensual way for all these other people to

1 say, yes, I would prefer this. We have to make decisions.
2 The program has to be run, from Betty's point, in a -- we
3 have to design a program in ways that are just going to
4 have that feature, and so that's why I think we're going to
5 spend this attention to understanding what the program is.
6 Betty, I'm going to give you the last word
7 because I -- Amol is timing me. So count this on Betty.
8 DR. RAMBUR: I just really feel strongly about
9 saying this. Autonomy and self-determination requires that
10 you can really see and understand what you're deciding
11 between, and we know that the lack of transparency is
12 throughout the health care system. People don't really
13 understand the different Medicare Advantage plans. They
14 don't understand that they're over-treated in the health
15 care system, right? And so -- and there are other ethical
16 models that include autonomy, but Ruth Faden and others
17 have talked about one, about the ethical obligation to
18 improve the system for all.
19 So I think we're, I mean -- so I just have to say
20 that, because I think the idea of people really being able
21 to choose and understand the options is impossible in our
22 health care system. A worthy goal, but very, very

1 difficult.

2 DR. CHERNEW: So add this back to my time,

3 because I'm at, like, 35 minutes by now. I think it's

4 three

5 But, yeah, that's true, and there's sort of real

6 choice and effective choice, and we get people into MA

7 plans, and how they get back, we'll talk about that in

8 networks. There's a whole slew of areas where we struggle

9 with how to make this work, and so I think our guiding --

10 our North Star principle has to be that we try and find

11 ways to promote quality just writ large because I don't

12 think -- again, I'm a reasonably free market economist

13 person. I believe in choice, in general, but I don't think

14 we can fundamentally believe that just because there is

15 choice or there's some aspect of choice that it's working

16 in a way that's going to do things or that we could have a

17 policy world in which every policy change we, you know,

18 contemplate requires someone to choose to opt into or not

19 into it in a range of something. I don't think that's

20 realistic.

21 So I've run out the clock. We are going to take

22 a five-minute break. I very much appreciate this

1 discussion. We will take all of it back to digest and
2 decide sort of the way we think we can go forward,
3 understanding there's a lot of competing things that we
4 have to deal with and a lot of competing that the staff
5 does. But the one area I think we can agree is that Rachel
6 and Luis did a phenomenal job in this chapter, and we very
7 much appreciate it.
8 So, on that note, we'll take a break for about
9 five minutes.
10 [Recess.]
11 DR. CHERNEW: Welcome back.
12 There are many, many complicated parts of the
13 Medicare program. There may be none more complicated than
14 Part D. I don't know if that's true. I realize that
15 Stacie understands it stunningly well, and it may seem
16 simple to her. I don't know, but at least for me, it is
17 particularly complicated, so for so many reasons, several
18 of which are going to be discussed in this chapter.
19 So I'm going to let Tara jump in as we talk about
20 the structural difference between the Part D market and the
21 MA-PD market, and we are then going to just go from there.
22 Buckle up.

1 MS. O'NEILL HAYES: Thank you, Mike, and good
2 afternoon, everyone.
3 Shinobu Suzuki, Andy Johnson, and I are here to
4 talk about structural differences between the PDP and MA-PD
5 markets in Part D.
6 The audience can download a PDF version of these
7 slides from the menu on the right-hand side of your screen,
8 and we would like to thank our colleagues Stuart Hammond
9 and Luis Serna for their helpful insights as we prepared
10 this work.
11 The Part D program relies on competition among
12 private plans, which vary by premium, cost sharing,
13 formulary, and pharmacy network. There are two distinct
14 markets within the Part D program -- standalone
15 prescription drug plans, or PDPs, that offer only drug
16 coverage for fee-for-service beneficiaries and no medical
17 coverage; and Medicare Advantage prescription drug plans,
18 referred to as MA-PDs, which provide both medical and
19 prescription drug coverage for MA enrollees.
20 As the program has evolved through numerous
21 policy changes since its inception nearly 20 years ago, so
22 too have plan offerings, which has implications for

1 enrollment choices, beneficiary costs, and access to
2 medications.
3 Today we will discuss the role of structural
4 differences between the MA program and the fee-for-service
5 environment that may be contributing to trends that raise
6 concerns about the long-term stability of the PDP market.
7 Today we will start with a background on the Part
8 D payment system and show shifts in enrollment and plan
9 offerings in the two markets. Next, we will discuss trends
10 we see in the PDP market that give rise to concerns. Then
11 we will walk through how some of the structural features of
12 the program may be affecting the PDP and MA-PD markets and
13 their plan offerings. Finally, we will talk about the
14 upcoming changes in 2025, including the redesign of the
15 Part D benefit and the PDP demonstration being implemented
16 by CMS. We will end with a few details of our next steps,
17 and, of course, we welcome your discussion.
18 Part D benefit costs are shared by multiple
19 stakeholders, as you can see here in this depiction of the
20 standard benefit design for 2025. Note that most plans
21 offer enhanced or supplemental coverage and thus use a
22 benefit design that varies from this, but all coverage for

1 basic benefits must be actuarially equivalent to this.
2 Starting next year, plan sponsors, whose
3 liability is highlighted by the orange boxes, will be
4 responsible for a majority of costs above the deductible,
5 increasing significantly from historical levels.
6 Medicare's cost-based reinsurance payments, shown
7 in gray in the catastrophic phase, will fall to 20 percent,
8 down from 80 percent, and the program subsidy will largely
9 shift to capitated risk-adjusted premium subsidies, which
10 will increase significantly.
11 We will discuss these changes and their expected
12 impact more later in this presentation, but it is the shift
13 in liability effective next year that led many to wonder
14 what the effect would be and particularly whether the
15 changes would affect PDPs and MA-PDs differently. Thus,
16 throughout this presentation, we examined trends in the two
17 markets and notable differences between them.
18 Based on that standard benefit design, plans
19 submit bids reflecting their expected cost for providing
20 basic benefits for an enrollee with average costliness.
21 The enrollment-weighted nationwide average of the bids
22 submitted determines the base beneficiary premium, which is

1 about 25.5 percent of the average bid, and Medicare's
2 direct subsidy, which covers the remaining 74.5 percent.
3 Beneficiaries' actual premium paid depends on
4 plan choice. Beneficiary premium equals the base
5 beneficiary premium plus or minus the difference between
6 their plan's bid and the nationwide average. So if the
7 plan's bid is less than average, the beneficiary pays less
8 and perhaps nothing. If the plan's bid is greater than
9 average, the beneficiary covers the excess. Beneficiaries
10 also must cover the full cost of supplemental coverage
11 provided in an enhanced plan.
12 Medicare's program subsidy consists of multiple
13 parts. First, plans submit bids, as discussed on the
14 previous slide, estimating their cost of providing basic
15 benefits to an enrollee of average cost. That bid is then
16 risk-adjusted based on a selection of diagnoses, as well as
17 demographic characteristics, including age, sex, disabled
18 status, low-income status, and whether the beneficiary
19 resides in a long-term institution.
20 After subtracting the enrollee premium, you have
21 the Medicare direct subsidy. Other payments from Medicare
22 include subsidies for low-income individuals, reinsurance,

1 and risk corridor payments. Shinobu will discuss the risk
2 corridor payments in more detail in a moment.
3 These payments are all part of Medicare's overall
4 program subsidy and are intended to support a robust Part D
5 program by encouraging enrollment among all beneficiaries
6 by defraying a significant share of the cost and encourage
7 plan participation through multiple risk-sharing mechanisms
8 that limit the amount of financial losses or profits a plan
9 may experience.
10 So what have we seen over the past few years?
11 Unsurprisingly, just as in the broader Medicare program,
12 enrollment is shifting away from PDPs available to fee-for-
13 service beneficiaries, shown in dark blue in both charts,
14 and toward MA-PDs for beneficiaries choosing to enroll in
15 MA, shown in orange.
16 As you can see, trends in plan offerings, charted
17 on the left, and enrollment, charted on the right, have
18 followed similar paths.
19 This chart digs deeper to show enrollment by both
20 plan type and low-income status. Starting at the bottom of
21 the chart, with PDP enrollment in blue, you can see that
22 enrollment among non-low-income beneficiaries has fallen

1 from 54 percent in PDPs in 2012 to 45 percent in 2023.
2 Most of these individuals have moved into conventional MA-
3 PDs open to all beneficiaries, shown in darker orange.
4 Among low-income enrollees, the top section of
5 the chart, 76 percent were enrolled in PDPs in 2012. But
6 that share has dropped significantly, down to 40 percent in
7 2023. Most of these individuals have moved to special
8 needs plans, shown in light orange at the very top, which
9 are a type of MA plan open only to certain individuals.
10 One such type plan is known as a D-SNP for
11 beneficiaries dually eligible for Medicare and Medicaid
12 because of their low-income status. These individuals
13 account for 90 percent of all SNP enrollees.
14 Shinobu will now talk about the importance of the
15 PDP market and some of the emerging trends that are raising
16 concerns.
17 MS. SUZUKI: While there are still many PDPs
18 participating in the market, we're seeing trends that may
19 raise concerns about the long-term stability of the PDP
20 market.
21 PDPs have a unique role in Part D. They provide
22 options for fee-for-service beneficiaries to receive Part D

1 drug coverage, and they ensure that premium-free options or
2 benchmark plans are available for beneficiaries with low-
3 income and assets.
4 However, there are some concerning trends in the
5 market. PDPs, on average, have higher premiums than MA-
6 PDs. There are fewer PDPs qualifying as premium-free to
7 LIS beneficiaries. They have higher gross costs but lower
8 risk scores than MA-PDs, and they are more likely to incur
9 losses than MA-PDs.
10 While any one of these trends alone may not by
11 themselves raise immediate concerns about the stability of
12 the PDP market, all of these trends combined suggest that
13 there may be underlying issues.
14 In the next few slides, we'll go over each of
15 these trends in more detail.
16 Trend number one is that, on average, premiums
17 charged by PDPs exceed that of MA-PDs. We compared
18 premiums charged for basic benefits separately for plans
19 that are primarily competing for enrollees with and without
20 the low-income subsidy. PDPs are shown in dark blue, and
21 MA-PDs are shown in orange.
22 On the left, we compared premiums for non-

1 benchmark PDPs with conventional MA-PDs. Those are MA-PDs
2 excluding SNPs. Most of the enrollees in these plans do
3 not receive the low-income subsidies. As you can see,
4 premiums charged by PDPs exceeded those of MA-PDs in every
5 year between 2014 and 2024. The difference in the premiums
6 ranged between $8 and $16 per month.
7 On the right, we compared premiums for benchmark
8 PDPs with D-SNPs. Both are premium-free for LIS enrollees.
9 D-SNPs exclusively enroll LIS beneficiaries, while
10 benchmark PDPs enroll both LIS and non-LIS beneficiaries.
11 Between 2014 and 2024, PDPs, on average, had
12 higher premiums than D-SNPs, though that difference is
13 relatively small and have narrowed over time.
14 Trend number two is that fewer PDPs are
15 qualifying as premium-free to beneficiaries with LIS.
16 Benchmark PDPs are PDPs with premiums at or below LIS
17 benchmarks, which were calculated separately for each of
18 the 34 PDP regions based on plan bids and LIS enrollment.
19 LIS enrollees can enroll in other plans, but
20 they're typically not premium-free, because the low-income
21 subsidy only pays for basic premium up to the benchmark
22 amount. These benchmark plans are also the only plans into

1 which LIS beneficiaries may be automatically enrolled,
2 which ensures that no LIS beneficiary goes without a drug
3 coverage.
4 As we detailed in your mailing material, the
5 number of benchmark plans has declined over the past
6 decade. For example, in 2025, on average, there will be 4
7 benchmark plans per region, down from, on average, 10 per
8 region in 2014. In 2025, there will be five regions that
9 will have just two benchmark plans.
10 Before turning to the third trend, let me provide
11 a quick background on Part D's risk adjustment model, the
12 prescription drug hierarchical condition category, or the
13 RxHCC model.
14 As Tara mentioned earlier, it's used to risk-
15 adjust capitated direct subsidy payments to plans. We'll
16 come back to how this works later. For now, we'll focus on
17 the key features of the RxHCC model.
18 It's similar to the CMS-HCC model used in the
19 Medicare Advantage Program in that they both use
20 demographic and diagnostic information to predict
21 enrollees' costs. Diagnoses are grouped into condition
22 categories, ranked into hierarchies for similar conditions,

1 and diagnoses come from physician and inpatient and
2 outpatient hospital records, including chart reviews and
3 health risk assessments in MA encounter data or fee-for-
4 service claims data.
5 There is a substantial overlap in the diagnosis
6 codes used in the two models. For the models used between
7 2019 and 2023, we found that about 82 percent of diagnoses
8 used in the RxHCC model were also used in the CMS-HCC
9 model.
10 There are some differences between the two
11 models. First, the RxHCC model uses gross drug costs,
12 which differ from actual benefit costs in that it does not
13 account for post-sale rebates or discounts.
14 Second, it is normalized across all Part D
15 enrollees, meaning that an average Part D enrollee has a
16 risk score of 1.0. The CMS-HCC model, on the other hand,
17 is normalized across fee-for-service beneficiaries, meaning
18 that the average risk score for MA enrollees would reflect
19 the differences in demographic characteristics and
20 diagnoses recorded for beneficiaries in MA relative to fee-
21 for-service.
22 Trend number three is that PDPs, on average, have

1 higher gross costs for basic benefit but lower risk scores
2 than MA-PDs. Given that Part D's risk adjustment model is
3 based on gross plan costs for basic benefits for enrollees
4 in both PDPs and MA-PDs, we would expect the trends for
5 average risk scores to reflect the relative expected costs
6 of enrollees in the respective market, but that is not what
7 the data show.
8 The figure on the left shows the gross cost
9 trends, and the figure on the right shows the risk score
10 trends. PDPs are shown in dark blue and MA-PDs are shown
11 in orange.
12 Even though PDPs, on average, had higher costs
13 than MA-PDs in every year between 2012 and 2023, since
14 2016, the average risk scores for MA-PD enrollees have
15 exceeded that of PDP enrollees. The difference has widened
16 over time, and by 2022, the difference was close to 15
17 percent.
18 In contrast, as you can see on the left, the cost
19 trends for PDPs and MA-PDs have grown closer during this
20 period.
21 Taken together, these two trends imply that, over
22 this period, PDPs had higher gross benefit costs, despite

1 enrolling a population that had lower expected spending
2 relative to MA-PDs based on their risk scores. This could
3 be because PDPs have a comparatively ineffective management
4 of benefit costs, differences in coding patterns that
5 affect risk scores, or some combination of both.
6 Trend number four is that PDPs are more likely to
7 incur losses compared with MA-PDs. For this analysis, we
8 looked at risk corridor payments.
9 As Tara mentioned earlier, Part D has symmetric
10 risk corridors that limit each plan's overall losses or
11 profits. Plan incurs losses, which is Medicare's payments
12 to plans -- Medicare makes payments to plans when actual
13 spending is greater than 105 percent of the plan's target
14 amount, and when plan makes a profit, plan makes a payment
15 to Medicare when actual spending is less than 95 percent of
16 the plan's target amount.
17 The risk corridors are depicted in the figure on
18 the left. As shown in the figure, plans are fully at risk
19 for average benefit costs within the range of 95 percent to
20 105 percent of the expected benefit costs that was included
21 in their bids. This is the target amount.
22 If the actual benefit spending is between 105

1 percent and 110 percent of the target amount, Medicare
2 splits the losses evenly with the plan by making payments
3 to plans to cover 50 percent of the losses in this range.
4 Beyond 110 percent, Medicare covers 80 percent of the
5 losses. Similarly, if the actual spending is lower,
6 Medicare shares in the profits. So plans pay Medicare a
7 portion of the excess profits.
8 This figure shows the aggregate amount of net
9 risk corridor payments. Note that risk corridor profits or
10 losses do not account for profit margins included in their
11 bids. Positive amounts shows that on net, a given type of
12 plan -- MA-PD, PDP, or SNPs -- made profits. So, in total,
13 Medicare's payments to plans to cover the portion of the
14 losses plans incurred were lower than the payments from
15 plans to Medicare. This is Medicare, on net, recouping a
16 portion of the excess profits plans made in the risk
17 corridors.
18 Negative amounts shows that, on net, plans had
19 losses. So, in total, Medicare's payments to plans were
20 greater than payments from plans to Medicare.
21 As you can see, plans, on net, incurred losses in
22 the risk corridors after 2018, as reflected in the negative

1 net risk corridor payments from Medicare to plans. Most of
2 the risk corridor payments were for losses incurred by
3 PDPs.
4 There are likely multiple factors, some outside
5 of Part D, that are contributing to the trends we just
6 discussed. There are certain structural features of the MA
7 program that may directly affect plan offerings and
8 payments under Part D.
9 First feature is that MA-PDs have an additional
10 funding source, MA rebates, to enhance their Part D
11 offerings or to buy down Part D premiums.
12 Second feature is that MA-PDs may adjust premiums
13 after CMS publishes national average bid and subsidy
14 amounts to achieve their intended premiums.
15 Third feature is that MA-PDs can more effectively
16 segment the market by enrollees' LIS status using D-SNPs
17 that are only available to dual eligible enrollees.
18 Fourth, MA plans have tools that are not
19 available in fee-for-service to document additional
20 diagnosis codes which may contribute to their higher Part D
21 risk scores. We'll discuss each of these in more detail
22 next.

1 First feature is that MA-PDs have an additional
2 funding source, MA rebates, to enhance Part D offerings,
3 including buying down Part D premiums. The premium trends
4 you saw earlier reflect premiums after the application of
5 the MA rebates. These rebates have helped to keep premiums
6 charged by MA-PDs below those of PDPs for both conventional
7 MA-PDs and D-SNPs.
8 For example, without these rebates, average
9 premiums charged by D-SNPs would have been higher than
10 those of benchmark PDPs in every year between 2014 and
11 2024.
12 MA-PDs can also use those rebate dollars to
13 subsidize the cost of supplemental Part D benefits. PDPs,
14 on the other hand, do not have additional funding source
15 and cannot buy down premiums. Their bids and full expected
16 costs of any supplemental benefits determine their
17 enrollees' premiums.
18 While MA-PD'S ability to lower premiums benefit
19 individuals who pay the reduced premiums, it also distorts
20 the price signals by disconnecting premium amounts from the
21 actual benefit costs just for MA-PDs, which in turn may
22 affect beneficiaries' chosen plans.

1 Second feature is that MA-PDs have an additional
2 opportunity to adjust their premiums through reallocation
3 of MA rebates after CMS publishes national average bid and
4 subsidy amounts. This feature may help stabilize MA-PD
5 premiums across years, ensure premium-free status for those
6 targeting the LIS benchmarks, and maximize LIS premium
7 revenues by adjusting MA rebates so that their enrollee
8 premium is at or very close to the benchmark amounts.
9 PDPs do not have the same opportunity, which
10 could, again, affect beneficiaries' choice of plans and
11 plans' revenues. For example, PDPs that miss the LIS
12 benchmarks may lose LIS enrollees or may have to waive
13 excess premium amounts if their bids are too high. If
14 their bids are too low, they would receive lower payments,
15 potentially foregoing additional LIS revenue.
16 Third feature is that MA-PDs can segment the
17 market by enrollees' LIS status using D-SNPs. LIS and non-
18 LIS enrollees face different financial incentives, because
19 for LIS enrollees, Medicare's low-income cost-sharing
20 subsidy pays all or nearly all of LIS enrollees' cost-
21 sharing liability.
22 This can affect how plans design their

1 formularies and benefits, which can affect plans' ability
2 to manage benefit spending. Because LIS enrollees are not
3 generally concerned with cost-sharing amounts, D-SNPs use
4 defined standard benefit structure, which uses co-insurance
5 for all covered drugs rather than co-pays, as nearly all
6 other plans do.
7 PDPs cannot perfectly segment the market. Even
8 benchmark PDPs serve both LIS and non-LIS beneficiaries.
9 Because of this, they may face greater challenges in
10 balancing the need to offer an attractive benefit to both
11 types of enrollees while managing spending to keep premiums
12 low.
13 Fourth feature is that MA plans' ability to
14 document additional diagnoses may contribute to their
15 higher risk scores. Since 2012, the average risk score for
16 MA-PD enrollees has risen more rapidly than for PDP
17 enrollees, and as we saw in the earlier slide, these trends
18 in risk scores for MA-PDs versus PDPs are not consistent
19 with the trends in gross costs.
20 Because the RxHCC model is normalized across all
21 Part D enrollees, more intensive coding by MA plans that
22 results in higher risk scores for Part D would increase

1 payments for MA-PDs offset by lower risk scores in payments
2 for PDPs.
3 For 2025, CMS is applying separate normalization
4 factors for MA-PDs and PDPs. This policy would adjust for
5 the projected average discrepancy between risk scores and
6 costs in the two markets but would not improve the accuracy
7 of the model coefficients.
8 Now, we want to step back and walk you through
9 mechanically how plans may be impacted by differential
10 coding and risk scores using a hypothetical example. Note
11 that figures shown in black in the table are assumptions.
12 Calculated amounts based on Part D rules are shown in
13 orange.
14 In this example, there are just two plans, Plan A
15 and Plan B, and they each have a 50 percent market share.
16 We assumed that the average expected basic benefit costs
17 are the same, $50 for both plans, and that the difference
18 in coding results in a higher average risk score for plan
19 A: 1.10 for Plan A and 0.90 for plan B. The overall
20 average is 1.0, because this is how the normalization works
21 in Part D.
22 As shown on the right, risk scores affect plan

1 bids and enrollee premiums through the formula used to
2 calculate the risk standardized plan bid, or RSPB.
3 The formula produces the RSPB of $45 and $56, for
4 Plan A and Plan B, shown in the Table. CMS then calculates
5 the national average bid amount weighted by enrollment,
6 which comes out to $51.
7 Enrollee premium is base beneficiary premium plus
8 the difference between the RSPB and the national average
9 bid. So, when RSPB, or the plan bid, is lower than the
10 national average, enrollee premium is reduced by the amount
11 of the difference, and vice versa. Accordingly, Plan A has
12 lower premium, $25, and Plan B has higher premium, $35,
13 both reflecting the amount their bid differed from the
14 national average.
15 Medicare's direct subsidy is RSPB adjusted for
16 plan's average risk score minus the enrollee premium. In
17 this example, they come out to $25 for Plan A and $15 for
18 Plan B. So, in this example, for two plans with the same
19 expected cost, Plan A with the higher risk score has lower
20 bid, lower enrollee premium, and higher direct subsidy
21 compared with Plan B.
22 However, understanding the effects of higher

1 coding intensity in Part D is complicated. This is just
2 one example used to illustrate the mechanical aspect of how
3 risk score might impact plan bids and premiums. Different
4 assumptions would result in different outcomes.
5 Tara will now talk about plans bid for 2025 and
6 describe the new premium stabilization demonstration CMS is
7 implementing.
8 MS. O'NEILL HAYES: The redesign of the Part D
9 benefit, noted at the beginning of our presentation, may
10 amplify these effects of the structural differences between
11 PDPs and MA-PDs. As more insurance risk will shift to
12 plans in 2025, a higher share of plans' payments for basic
13 benefit costs will be capitated payments rather than cost-
14 based, as they are now. Thus, accurate risk adjustment
15 will become much more important.
16 The increased liability also translated, as
17 expected, to significantly higher bids, increasing from $64
18 in 2024 to $179 in 2025, an increase of nearly 180 percent.
19 The average subsidy, based on those bids, would increase
20 nearly fivefold to $143, up from just under $30 in 2024.
21 The base beneficiary premium, now allowed to
22 increase by no more than 6 percent from one year to the

1 next, would increase to $36.78. Without the 6 percent cap
2 included in the BRA, the base premium would be almost $56.
3 Remember, though, that simultaneously, Medicare's
4 monthly reinsurance payments will decline significantly
5 from approximately $90 down to $40. When CMS revealed
6 these bid and premium amounts, they also announced a
7 voluntary demonstration for PDPs only.
8 This new Premium Stabilization Demonstration is
9 voluntary, though virtually all plan sponsors opted to
10 participate. Its intent, as stated by CMS, is to moderate
11 the effects of the large and varied premium increases
12 revealed in plans' bid submissions this year.
13 There are three components. For each
14 participating plan, enrollees' base beneficiary premium is
15 reduced by $15, the total premium increase can be no more
16 than $35 from the year prior, and plans will receive more
17 generous risk corridors. The standard risk corridors,
18 which Shinobu discussed earlier, is depicted in the graphic
19 on the top. The risk corridors that will be applied for
20 plans participating in the demonstration is on the bottom.
21 Note that the risk corridors for the
22 demonstration are asymmetrical, with lower thresholds for

1 sharing plan losses when spending is greater than a plan's
2 target amount. However, the thresholds on the left, when
3 spending is below the target amount, will not change. Also
4 note that the share of losses Medicare will cover above the
5 highest threshold will increase from 80 percent to 90
6 percent.
7 CMS noted that even after the additional premium
8 subsidy provided by this demo to the PDPs, the average
9 premium for PDPs will still be higher than that of MA-PDs.
10 CBO estimates this demonstration will cost $5 billion in
11 2025.
12 Over the coming months, we plan to further
13 analyze Part D data focused on two main areas: how
14 differential coding patterns in MA and fee-for-service may
15 affect Part D risk scores, and how different incentives and
16 funding sources may affect the generosity of drug coverage
17 and formulary design in the two markets. Findings from
18 those analyses will be presented in the spring.
19 And now we turn it back over to Mike for your
20 questions and discussion.
21 DR. CHERNEW: Okay. That was a lot, so I think
22 there's a lot of stuff for us to all dig in on. But I

1 guess we're going to start. So I think the first person in
2 Round 1 actually is Gina. Is that right, Dana? Yeah,
3 okay. Good. Gina.
4 MS. UPCHURCH: Thank you guys so much. Great job
5 with the information that you shared. I've got three
6 questions for you in Round 1.
7 The Figure 10, and it's also shown in your next-
8 to-last slide, showing all the risk corridors that Shinobu
9 explained to us, it says, "Plan bids are based on expected
10 benefit costs net of expected post-sale rebates and
11 discounts." Does that include DIR fees that come from the
12 pharmacies?
13 MS. SUZUKI: Yes, although in 2024, they
14 eliminated the retrospective DIR fees and made it post-
15 sale, essentially.
16 MS. UPCHURCH: That's right. Point of sale.
17 MS. SUZUKI: Point of sale. And so beginning in
18 2024, you do not technically have pharmacy DIR, but it's
19 shown as a price at the point of sale.
20 MS. UPCHURCH: Yeah, that's one of the things I'm
21 getting at, because pharmacists are getting paid much less
22 for the medicines, from the insurance companies, but, you

1 know, they can't compare it to the previous when they were
2 getting these DIR fees on the back end. They just know
3 they're getting a lot less this year. So call it DIR fees
4 or whatever, they're losing money off a lot of dispensing
5 here. So that was one of my questions if that's included
6 in this calculation.
7 The second one is, well, if you're saying there
8 are no pharmacy DIR fees now, because they're certainly
9 also not seeing bonuses. You remember, this whole thing
10 was built upon you help with the star ratings, you're going
11 to get bonuses at pharmacy. As far as I know, pharmacies,
12 you know, they were getting things taken from them with DIR
13 on the back but when it's now at point of sale they're not
14 getting bonuses, that I know of. Is that what you all are
15 hearing?
16 MS. SUZUKI: So we'll have to see what the data
17 shows, but technically if there are bonuses, there should
18 be a payment from the plan to the pharmacies
19 retrospectively. So the positive amounts are allowed
20 retrospectively. But the amounts at the point of sale
21 should be the lowest amount the pharmacy could receive.
22 MS. UPCHURCH: Okay. So if we can just keep an

1 eye on that, because I haven't heard anybody getting those
2 bonuses that were promised if pharmacists were part of the
3 solution there.
4 And then my question was, if those funds are
5 coming, is there differences? You know, you're talking
6 about a stable market here. Are there any differences in
7 DIR fees with pharmacists, between standalone drug plans
8 and Medicare Advantage plans? If we start seeing some of
9 those payments come it would be interested to see if
10 they're different among the two, if they come.
11 And then my last Round 1 question is the
12 aggregate net payment, so the risk corridors, shifted in
13 2018, and I'm just curious, before plans were paying
14 Medicare and now Medicare is having to pay plans more
15 commonly. Is that because biosimilars were added in 2018,
16 and biologics, to this formula? Or what happened in 2018?
17 MS. SUZUKI: So I don't think we know for sure
18 what is causing some of the trends. I think it's more of
19 how does your expected cost relate to your actual spending.
20 And how much you miss the actual spending amount by is
21 what's reflected in the net losses, mostly for PDPs.
22 MS. UPCHURCH: Mm-hmm.

1 MS. SUZUKI: And just to clarify for the risk
2 corridors, it is an aggregate amount. So for the plan it's
3 all of their enrollees' claims and payments that are made,
4 that against the capitated payments that they receive. So
5 it's all aggregate, the bids or expected amounts. So the
6 expected amount includes what they expect to pay and
7 receive in DIR fees or rebates and discounts.
8 MS. UPCHURCH: Okay. Thank you so much.
9 MS. KELLEY: Robert.
10 DR. CHERRY: Yes, thank you, and I appreciate you
11 taking a really complex subject and making it digestible
12 for all of us to understand.
13 My question actually picks up on one of Gina's
14 comments, which has to do with biosimilars, because buried
15 in the report there's this interesting comment around how
16 the MA programs, at least the beneficiaries, are able to
17 get biosimilars actually faster, with fewer restrictions,
18 which I found kind of fascinating, because a lot of people
19 chose fee-for-service because of the flexibility around
20 choice. But if they don't have choice around biosimilars
21 that may drive them to an MA program. And I can see the MA
22 programs being able to handle this a little bit better,

1 given the subsidies and everything.

2 So my question, given the interest in this group

3 around biosimilars, because it comes up from time to time,

4 the costs involved and their prominence I think regarding

5 future therapies, is, are you planning on doing some sort

6 of analysis around biosimilars in relation to the Part D

7 analysis that's going to be happening over the coming weeks

8 and months?

9 MS. O'NEILL HAYES: Yeah, thank you for your

10 question. We are doing formulary analysis, and we are

11 working on selecting various categories of drugs, and still

12 selecting which drugs, in particular, to focus on, because

13 we obviously can't assess every drug there is. So we will

14 certainly keep that in mind, that we might want to pick

15 some where there are, well, we have picked some where there

16 are biosimilars, but we will certainly keep that in mind,

17 that you're interested in that.

18 MS. SUZUKI: And one thing I'll add is last year

19 we did look at the 2024 plan formularies on biosimilar

20 coverage, at the Humira product, and that was one of the

21 first major launch of biosimilars in Part D. And we found

22 that the vast majority of plans kept the reference products

1 on their formulary, and that very little had biosimilar
2 options that were preferred.
3 DR. CHERRY: That's helpful. Thank you.
4 MS. KELLEY: Amol.
5 DR. NAVATHE: Shinobu and Tara, thank you so much
6 for this. I have, well, it will be hopefully three
7 reasonably quick questions.
8 The first one is, we commented multiple times
9 that one of the challenges for the PDP market, say relative
10 to MA-PDP, is the lack of ability to segment, if you will,
11 or the fact that PDPs often have both LIS and non-LIS. And
12 I was wondering if you could give us a sense of the
13 magnitude, like what share of the enrollees are non-LIS
14 benes, and how that might vary across the distribution of
15 different benchmark plans.
16 MS. SUZUKI: So off the cuff I only have average
17 for benchmark plans, and it is higher than the overall PDP
18 share of the LIS. And for benchmark plans I think it's
19 over 60 percent LIS, so that leaves about 30-plus percent
20 for non-LIS.
21 DR. NAVATHE: Okay. Great. Thank you.
22 Second question is on the RxHCC score, just to be

1 clear, in terms of the diagnoses that count versus don't
2 count. So diagnoses that are collected by HRAs or home
3 visits, are those also included here in the RxHCC? They're
4 allowed, basically?
5 DR. JOHNSON: Yeah. The risk adjustment eligible
6 rules are the same for Part C and Part D, so health risk
7 assessments and chart reviews are also allowed.
8 DR. NAVATHE: Okay, great.
9 And then the last question is, if we were to look
10 at PDP market share, what share would actually accrue to
11 plan sponsors who are also sponsoring MA-PD?
12 MS. SUZUKI: We did not have that information off
13 the top. We can certainly look into this. This is an area
14 where we are planning to focus on for our status report and
15 for some of the next spring presentation on this topic, as
16 well.
17 DR. JOHNSON: But it's going to be very high.
18 DR. NAVATHE: Great. Thank you.
19 MS. KELLEY: Brian.
20 DR. MILLER: Thank you for this chapter. A
21 little more sparse with compliments so I hope this hits
22 home when I say I really liked it. This is a very hard

1 topic to parse, and I don't think anyone else has written
2 in this type of detail with this clear of a structure. So
3 I think that this will be helpful for everybody in
4 Washington and beyond in laying out the differences between
5 PDPs and MA-PDs, so thank you for doing that.
6 Three very small technical things. One, on page
7 23, Figure 11, of aggregate net payments and risk
8 corridors, I think it's a really important figure, and I
9 haven't really seen it anywhere else laid out so
10 eloquently. I do recognize that I have reading glasses,
11 but my vision is pretty good. It's a little small. I'd
12 put it on its own page, because I think it's really
13 important, and when the chapter is eventually published, I
14 think there will be a lot of discussion about that.
15 Two other small things. One, we talked about the
16 Budget Reconciliation Act. I think we should call it the
17 IRA, because that's what it's commonly known as. That's
18 not a political comment. I think that's just the name that
19 most folks use.
20 On pages 13 and 14 we talked about PDPs and
21 standalone and MA-PD markets and market concentration. You
22 denoted that five firms cover 89 percent of the standalone

1 PDP market, and the MA-PD space we noted that five firms
2 cover 69 percent. I think that we can't say, based upon
3 that sentence, whether it's concentrated or concentrated.
4 We'd have to do HHIs and look at what the DOJ ATR Division
5 cutoffs are for HHI. I suspect that looking at that,
6 that's not moderately concentrated, but we should probably
7 do that work. And I suspect that work has already been
8 done somewhere and can be recycled.
9 Overall, amazing chapter, and I really appreciate
10 you guys putting this together.
11 MS. KELLEY: Greg.
12 MR. POULSEN: Thank you. Actually, I would've
13 taken my name off because Amol asked the same question I
14 was going to. But I kept it on because I wanted to
15 reiterate what a great chapter this was and how effective
16 it was in clarifying some really complicated issues. So
17 thanks.
18 MS. KELLEY: Scott.
19 DR. SARRAN: I'll add to the compliments.
20 Excellent work making this intelligible.
21 Quick question, and I apologize if I missed it.
22 But the Part D premium stabilization process, is that

1 ongoing, or does it sunset?

2 MS. O'NEILL HAYES: So currently it will be

3 implemented for next year, 2025, and for two subsequent

4 years, so through 2027, and then we don't know after that.

5 DR. SARRAN: And is baked into that a formal

6 evaluation of its impact?

7 MS. O'NEILL HAYES: No, there is not an

8 evaluation. The parameters of the demonstration could

9 change over the next two years. CMS says that they may

10 adjust, as needed, but there weren't details provided as to

11 how they would make those determinations, what the

12 adjustments should be.

13 MS. KELLEY: Last, I have a question from Larry.

14 He wants to know if you have any sense for why risk scores

15 for PD went down so abruptly from 2021 to 2022.

16 DR. JOHNSON: So we see a similar thing in the

17 Part C risk scores, and in Part D it is a difference in the

18 relative rates of risk scores for MA-PDs and PDPs because

19 the normalization factor is based on both MA-PDs and PDPs.

20 So as MA-PDs are going up, PDPs are going down, and in the

21 Part C risk scores, we also see those two years, from 2020

22 to 2021 and 2022 as being big differences in coding

1 intensity between MA and fee-for-service. So we're seeing
2 that spill over into MA-PDs and PDPs.
3 MS. KELLEY: That's all I have. Oh, I'm sorry.
4 Kenny, go ahead.
5 MR. KAN: Yeah. I have a question and also an
6 observation and a suggestion. Can we please go to the
7 slide that has the graph that shows the gross cost and the
8 risk score, please?
9 [Pause.]
10 MR. KAN: Yeah. So my question is if the
11 proposed normalization factor achieves its intended outcome
12 and the premium stabilization program, likewise, how could
13 this actually impact at least the divergence between the
14 two lines?
15 MS. SUZUKI: I think to the extent that the
16 projection that CMS made to make the adjustment is fairly
17 close to what actually happened, the correction will
18 account for the divergence we're seeing, on average. I
19 think it's a question of how does it affect the individual
20 plans, because it's not adjusting for the coefficients.
21 MR. KAN: So if it achieves its intended outcome
22 over time, do you think it would be possible to just

1 footnote it on this slide for future iterations of this
2 slide, and in the chapter, that we'll be monitoring the
3 impact. But to the extent that, you know, the desired
4 normalization factor and the premium stabilization demo
5 achieve its intended impact it could help to mitigate the
6 divergence. That would be helpful. Thank you.
7 MS. KELLEY: Okay Are we ready for Round 2,
8 Mike? I have Stacie first.
9 DR. DUSETZINA: Thank you all so much for this
10 incredibly important work and clear chapter. This is a lot
11 to digest for even somebody who's really in the weeds on
12 this, so kudos to all of you for making it as clear as you
13 have.
14 I'll try to keep this as condensed as possible,
15 but I'm taking the whole rest of the time that I haven't
16 taken in prior comments. So, Amol, turn the timer off.
17 [Laughter.]
18 DR. DUSETZINA: So, you know, I guess one global
19 comment, it just really struck me when you said 41 percent
20 of Part D enrollees are in standalone Part D plans, and I
21 think that's just contextually really interesting
22 information, knowing that that might -- the standalone

1 plans are probably going to look less and less attractive
2 over time. If we didn't have the stabilization
3 demonstration project going on right now, they would look
4 very unattractive this year, relative to even in prior
5 years. And I worry that the way that things have been
6 going, we're not going to have an affordable and attractive
7 option for people who want to stay in traditional Medicare,
8 and I think that that makes this work very urgent and
9 important. So I'm glad we're going down this path.
10 So I think one of the overarching comments I'd
11 have is I think it would help us a lot to know more about
12 the firms that are offering these plans. Maybe going to
13 Brian and to Amol's points and questions, if we could get a
14 little bit better of an overlay of how that market looks
15 and that these are actually the same companies, largely,
16 that offer both types of plans, which I think does inform
17 then some of the weird things that we see later on in your
18 analysis of, you know, their bidding processes and also the
19 segmentation issues. So having that be front and center
20 and how that's changed over time -- because I know from
21 work from KFF, for example, that's gotten really a small
22 number of firms that are -- you know, have most of the

1 beneficiaries.

2 That brings me to a question about the

3 presentation. You mentioned the plans that were

4 experiencing losses, and I wondered if there would be some

5 way to understand what firms those were and if those are

6 actually some of the smaller firms, if that's at all

7 possible. I think that would be useful to know.

8 We know, at least in the standalone market, that

9 there are a smaller number of plans offered each year and

10 fewer firms. So, if that's what's happening, I think that

11 would be fairly disappointing, right, that, you know, those

12 are the ones experiencing losses.

13 I think in the chapter with the discussion about

14 bids and rebates, it just made me think about, you know, if

15 I were a plan sponsor, like a firm, and I had both

16 standalone and MA-PD plans and I have the ability to rebid

17 my MA-PD plan after I see the average, like, if I make more

18 money on MA-PD -- and I don't know for sure that's true for

19 those plans, but if I did, that could create some weird

20 gaming of, you know, how I was bidding for both of those

21 markets. And so I think that that was a really helpful bit

22 of analysis.

1 The thing that I was left scratching my head
2 about was, like, how often do the MA-PD plans rebid, and by
3 how much? Like, do we have a sense of how much those bids
4 change after the fact, and what percent are doing that?
5 I also found it incredibly helpful, the piece
6 about LIS enrollees and the segmentation of the market and
7 how having plans that are specific to LIS beneficiaries
8 allows you to do something really different than if you are
9 trying to capture both LIS and non-LIS beneficiaries, and I
10 had never thought about it before. So it was very, very
11 useful to see that.
12 And I think the thing that struck me is, you
13 know, if you have a plan that markets to LIS beneficiaries
14 and you know they are not going to pay any of the cost
15 sharing, the entire benefit structure can look very
16 unfavorable to someone who had to pay that cost. So it
17 doesn't create a level playing field between standalone and
18 MA-PD plans, and I think all of this makes me think, why
19 are we combining the two of them when we're doing bids?
20 You know, is it worth thinking about? Should standalone
21 PDPs and MA-PDs be separately bidding and treated kind of
22 in those separate ways? Because they're feeding off of

1 each other in ways that don't appear to have, like, you
2 know, again, a level playing field.
3 Okay. I'm almost done.
4 So I think the issue -- and, Shinobu, thank you
5 for clarifying for me earlier about the low-income
6 subsidies and the benchmark plans and that there is a floor
7 to how many plans would be available. I think that
8 including that information in the chapter would be really
9 helpful.
10 I got really tripped up in the risk adjustment
11 parts on page 20, and I think maybe a little bit more
12 detail in there and clarity would help. I kept thinking,
13 okay, wait, it's gross spending, but then it wasn't totally
14 clear to me that the other kind of factors could come in
15 and adjust the MA parts.
16 Okay. Almost done.
17 Let's see. I wondered if we could actually -- we
18 -- you guys could do the analysis that you talked about
19 around the net spending, net gross drug costs. Like, we
20 have rebate data. There's a bit in the chapter that talks
21 about the gross spending, but since we have the rebate
22 data, I wondered if there was a way to use that to figure

1 out, like, is that really problematic to use the gross
2 spending instead of net spending? It may be that there's
3 just so many things to do that that's lower on the priority
4 list, but it struck me that that's one use of the rebate
5 data that we could make.
6 And, yeah, I think that that's it. I got to the
7 end.
8 MS. SUZUKI: So just two things. On the rebid, I
9 think it's resubmission, and that they're only allowed to
10 make certain modification. And it's really just
11 reallocation of rebates to hit the intended premium.
12 So, if you said I want to be a free LIS plan and
13 you did not get the premium to be zero for LIS, you can
14 reallocate the rebates, but those are limited amounts. So
15 it's a little bit different than resubmitting bids.
16 They're not allowed to change anything else.
17 On the net cost, I think you're talking about the
18 model, and we did look into this a little bit a few years
19 ago. I can forward the chapter on -- or section on this in
20 the presentation we gave.
21 I think there are a couple things that we came
22 out from looking at just two classes with fairly large

1 rebates, and that it does affect individual risk scores,
2 that it was not clear how big the effect at the plan level
3 would be because the coefficients are sort of giving up the
4 effects on spending. And so, as you may shift across the
5 HCCs, but we did not see as big of an effect in our sort of
6 test case with just two therapeutic classes.
7 Another thing to keep in mind is that there are
8 pretty large differences in how much rebate plans get on a
9 particular therapeutic class, and that may be another issue
10 to think about.
11 MS. KELLEY: Gina?
12 MS. UPCHURCH: To honor Larry, I brought my
13 props. This is Medicare helping people. We're in the
14 middle of the open enrollment period, obviously, and
15 helping people with Part D as well as Medicare Advantage
16 plans, and we've seen some stark differences this year in
17 the drug benefit. So I don't know if some of my comments
18 here are for this work or for the update chapter, but I do
19 want to put them out there as concerns that we're seeing.
20 First of all, this idea of direct and indirect
21 remuneration fees at point of sale for the pharmacists, I
22 mean, my pharmacy closed down since we last met. My

1 independent pharmacy has closed down, and now it's just
2 more and more, you're seeing it in the news. So I just
3 feel like on some level, we have to pay attention to what's
4 happening to access to pharmacies. So I hope that's
5 somewhere in our mix.
6 Secondly, and it's very odd. So because plans
7 are, as you've pointed out well, plans are more responsible
8 for the plan costs, the overall costs now than they had
9 been in the past, plan sponsors are more responsible.
10 We've noticed that. So, for example, if somebody's on
11 three inhalers, three brand inhalers -- or they're generic
12 or brands, it's hard to find a plan that covers that
13 combination of inhalers. If they're on one, I could find a
14 plan. If they're on two, maybe. But finding that exact
15 combination.
16 So I was helping somebody the other day, and to
17 get to the three, what was ironic is I had to move all the
18 inhalers. I put them in as generic. I had to move them
19 all to brand to get the lowest price for the person for the
20 year. So just we need to watch that. So I'm having to
21 move people to brand-name drugs to get their overall plan
22 prices down, and I don't think that's what we intended with

1 this benefit.
2 Another thing that I would just add that we've
3 seen is that -- and I understand it. I think insurance
4 companies, "firms," as she's calling them, or plan
5 sponsors, I think they see that pharmacists are hurting.
6 They're trusted in the community. So they are being hired
7 in many ways to do risk assessment. They have the pharmacy
8 technicians calling people that are their patients, doing
9 health risk assessments over the phone. Not that
10 pharmacists know how to intervene on that, but you have to
11 know that it's affecting risk scores. So insurance
12 companies are paying some pharmacies to do these risk
13 assessments. So it's not just the nurses going into the
14 home doing the risk assessments. It's now using the
15 trusted pharmacists to do it. So I just want us to be
16 aware of that and tracking that and what that means for
17 people.
18 And Lord, gracious knows, I want pharmacists to
19 be able to stay open, right? So I'm not -- I don't want to
20 kill that if that's what, you know, is needed, but we need
21 to pay them for doing what they're trained to do in
22 pharmacy school.

1 And that's my last piece here. Unless CM -- what
2 I'm hearing on the street is these drug prices that have
3 been negotiated that won't start to 2026, a lot of
4 pharmacists are saying that they will not carry the drugs
5 because they don't know how much they're going to get paid
6 to dispense the drugs. And they're thinking they're
7 getting it from the wholesaler here. They're going to get
8 reimbursed below that. They can't do it. So I think we
9 need to keep our eyes wide open because this is the
10 pharmacy talk right now. They cannot carry these expensive
11 meds, even though they have negotiated prices, if they're
12 not going to be paid more than it costs to hold it in
13 pharmacy. So I just think we need to keep an eye on that
14 because it is sort of out there right now. It's a real big
15 concern.
16 But just thank you so much for this work, and
17 we've got to keep our eyes on it. Thanks.
18 MS. KELLEY: Brian.
19 DR. MILLER: Thank you.
20 So a couple things sort of caught my attention on
21 this. One is I think we buried the lead a little bit
22 because, as I interpreted this chapter, we're talking about

1 standalone PDPs and MA-PDs, not just as a matter of
2 intellectual policy interest but as a practical application
3 and study, because fee-for-service, if it's any willing
4 provider network and the standalone PVP plan at a gap is an
5 important option for beneficiaries to have. And for many
6 beneficiaries, that is going to always remain their
7 preferred or best option. So that should be preserved.
8 Whether it's the best option, that, or an MA-PD plan or
9 something else is the best option for any one particular
10 beneficiary, I don't think any of us can determine that,
11 which is why we have these choices.
12 But, on page 37, we noted that the national
13 average bid rose quite a bit. The numbers I saw were
14 $64.28 to $179.45, which the chapter tells me is a 179
15 percent increase, which is pretty nuts just as a number,
16 and that's a direct result of the Inflation Reduction Act.
17 I think we all agree that Part D redesign needs to happen.
18 Donut hole still would be nonsensical for Medicare
19 beneficiaries.
20 But the fact of the matter is, is that the IRA
21 made a very rich standalone PDP benefit, and then to
22 finance that, it transferred the cost to the plan, doubling

1 their liability. And plans have choices, right? They can
2 tighten networks. They can tighten formularies. They can
3 increase tiering. They can increase utilization review
4 and, incidentally, torture pharmacists, physicians, and
5 patients. And many of us have been subject to utilization
6 review, either directly as clinicians or as patients, and
7 we tend not to enjoy it.
8 All of this is to say is that they have those
9 tools, but those tools only go so far when you double their
10 liability. So we doubled their liability, and we're
11 surprised that premiums went up a whole lot.
12 I think that that broader policy discussion needs
13 to be at the beginning of the chapter, instead of on page
14 36, not to necessarily criticize or support any one piece
15 of legislation, but that is the primary rationale for us to
16 be exploring this space at this detail, because we are now
17 confronted with a problem that collectively we need to
18 solve in order to make sure that fee-for-service Medicare
19 with a standalone PDP remains a viable option for Medicare
20 beneficiaries as one of their choices.
21 I think that we had a discussion about the
22 standalone PDP demo, which was incomplete, because I know

1 that there are letters from some of the people that we
2 advise aka Congress questioning the legality of that demo.
3 So we should mention that there's debate about the demo.
4 We don't have to opine one way or the other.
5 And I think that including that broader policy
6 conversation will help us as the Commission and then also
7 Congress and their staff think sort of about this challenge
8 in that structured way, and that Medicare beneficiaries
9 have choices. And I think we all agree that they need
10 better information about those choices and perhaps some
11 more unbiased sources of how to get that information, but
12 that whether they want an MA-PD plan or a fee-for-service
13 plan with a standalone PDP plan and a Medigap plan, having
14 that choice is important, because the Medicare population
15 is very diverse. It's a very diverse combinatorics of
16 diseases, cultures, lifestyles, demographics, et cetera.
17 And so we want that customization for them.
18 And we want them to have the choice of getting
19 their Medicare benefits, which they earned, through a form
20 that works best for them. We should be agnostic about what
21 we think that best form is. And so I think when I look at
22 this chapter, that's what I see this as about, and I think

1 that we should really strive to include that.

2 One thing I think that would be helpful to
3 include is looking and framing it as the MA-PD plan is a
4 choice, again, about tradeoffs. So when the bene gets fee-
5 for-service with any willing provider network, they get a
6 standalone PDP plan. The alternative is an MA-PD plan,
7 which seems to have, based upon our data, somewhat richer
8 Part D benefits in terms of coverage. And we noted, I
9 think, on page 40 that out-of-pocket costs are 24 percent
10 lower in MA-PD than standalone PDP, and that that's part of
11 that tradeoff, where the beneficiary gets -- you are in a
12 provider network, and then they get less -- they get more
13 benefits included in that single premium, and there's that
14 tradeoff where they take access to fewer folks in exchange
15 for more insurance protection. And so I think that that is
16 a theme that we should weave on early.

17 I think another theme that is not in here, but we
18 should probably push, is that both PDPs and MA-PDs need to
19 focus more on value-based contracting and thinking about
20 how we pay for high-cost drugs, right? We're going to have
21 a lot more that we want. People have access to innovative
22 therapies. None of us knows if we're going to get cancer,

1 heart failure, some rare autoimmune disease, whatever the
2 condition is. At some point, all of us are going to need
3 medical care and prescription drugs, and so we want to make
4 sure that there are ways to pay for those in a way that's
5 sensible. And so I think including an emphasis that we
6 need more work on value-based contracting for high-cost
7 drugs is something that we should add in here.
8 But overall, I really enjoyed this chapter. I
9 appreciate the detailed amount of analysis, which I don't
10 think most people would have been able to do. So thank you
11 all for doing it.
12 MS. KELLEY: Scott.
13 DR. SARRAN: Just a very brief comment. I think
14 this is very important work, because I think probably most
15 of us are concerned that if we're not careful to support
16 standalone PDP plans, whether it's via the demonstration
17 approach or some other approach, we will, in effect, be
18 sort of backdooring an accelerated growth in MA that isn't
19 necessarily what, you know, we want to do. Or if we want
20 to do that, it should be a more explicit, I think,
21 direction we take rather than sort of back into it because
22 the PDP program has some structural disadvantages in their

1 abilities to compete with MA-PD.

2 MS. KELLEY: Cheryl.

3 DR. DAMBERG: This was a great chapter, and I

4 appreciate all the work that went into it. It was quite

5 substantial.

6 I'm by no means a PDP expert, but I certainly

7 learned a lot. And I guess I came away with the conclusion

8 that this is a pretty uneven playing field.

9 And I would probably plus-one Stacie's comment

10 about whether the bidding process should be separate in the

11 two markets.

12 I also am concerned about, you know, the fact

13 that the same entities are bidding in the MA and the PDP

14 space. I don't know whether this is the appropriate word

15 to use, but is there some information sharing -- I don't

16 want to use the word "collusion," but structuring their

17 bids in such a way that it really is driving traffic to the

18 MA side, you know, without some explicit rationale for what

19 we as a policy community want to see happen in this space

20 and putting at risk those people who opt to stay in

21 traditional Medicare.

22 And I think that, you know, what's happening in

1 this space, there was a line in the chapter about rebates
2 distorting price signals, and I think that that is really
3 spot on. And I was happy to see you highlight that.
4 And I guess one thing -- and maybe this was a
5 Round 1 question -- I wasn't exactly sure what the
6 rationale is for CMS allowing the MA plans to do a rebid.
7 That seems just odd to me. So I don't know if there's
8 additional information that you could add for what was the
9 underlying rationale for doing that, because it just seems
10 to me to be giving them another chance. And I realize you
11 described there are guardrails around what they can do in
12 that space, but it just seems to create another opportunity
13 for them to price in a more attractive way and drive
14 traffic toward MA.
15 DR. MILLER: I have a quick on-point comment.
16 I think that I would -- we should not -- it would
17 be imprudent to separate standalone PDP and MA-PD bidding
18 in this space. That is precisely the problem that we have
19 in the fee-for-service and MA market, where MA benchmarks
20 are not set in competition with fee-for-service, which has
21 resulted in lots of problems that we have spent a lot of
22 time discussing. So I don't think we should look to

1 replicate the medical benefit side challenges in the
2 prescription drug benefits side.
3 MS. SUZUKI: Cheryl, to your question about the
4 rationale, we can certainly add more information. I think
5 the general understanding is that there are MA rebates that
6 are available for plans to use to benefit their enrollees.
7 And to the extent that their bids are -- bids are
8 not what you expected and they -- I think CMS wants to make
9 sure that the rebates are used in a way that benefits the
10 enrollees. And so some of the rationale that I've seen is
11 that if your bid relative to the overall national average
12 ends up being lower and so your premium is already lower
13 and you have allocated X dollar to buying down that rebate,
14 you don't want that rebate to create a negative premium,
15 which would just be set to zero. So you're wasting that
16 extra rebate that was allocated. So I think there's
17 something about the correction to -- that they are able to
18 make, but in a limited capacity to make sure that the
19 rebates are used to benefit their enrollees.
20 DR. DAMBERG: Thank you for that explanation.
21 MS. KELLEY: Amol.
22 DR. NAVATHE: I'm going to time myself, too.

1 Thank you, all of you, for, you know, I very much
2 echo my fellow Commissioner comments about just how
3 complicated this is and how wonderful a job you did in
4 making it intelligible.
5 I have a few comments. One is I wanted to really
6 plus-one -- I guess, I don't know, maybe it's a plus-two or
7 plus-three now -- to Stacie's original points about it's
8 really striking to just see the trends, as I think we've
9 described them, kind of in a descriptive fashion, that
10 highlight this question of stability in the standalone PDP
11 market.
12 And I think the other thing that is really
13 striking to me is other pieces that in some sense we could
14 look at and say, hey, maybe these are features of the
15 market. Maybe to some extent they are. They end up
16 becoming very complicated by the issue with ownership, that
17 the MA-PD plans also are likely, at least from what you
18 were saying, Shinobu, most likely covering a lot of market
19 share on the PDP side. Or I guess Mike is the one who said
20 that. And so that creates a much more complicating
21 dynamic.
22 So for example, I think in the world of value-

1 based care we have said, hey, maybe we should find a way to
2 get Part D spending or prescription drug spending together
3 with medical spending under the same benchmark or under the
4 same incentive structure. In some sense, MA and MA-PD have
5 that. So by using rebates to buy down premiums and then
6 maybe having more advantageous formularies, because they
7 can reap some beneficiaries and the plans can reap some
8 benefit in terms of lower medical costs and lower
9 utilization, in some sense that's great. I mean, that's
10 aspirational.

11 I think what you've pointed out here is that,
12 well, there is some complexity in that. That would be a
13 wonderful story, and maybe that, in part, is what's
14 happening. But because of this potential ownership on both
15 sides of that equation, that gets tricky, and that gets
16 tricky fast because there might be some conflicting
17 incentives there.

18 To some extent, I think the coding piece of this
19 is also similar. We talked about how the normalization --
20 I think Kenny kind of pointed this out -- maybe the
21 normalization is really going to address a lot of our
22 concerns. At the end of the day, however, there's still

1 going to be some asymmetry across MA versus standalone PDP,
2 just like there is across MA and fee-for-service. That, in
3 itself, introduces some complexity if the same
4 organizations are playing on both sides of this, and
5 therefore, one side of the market is better, more
6 profitable, or what have you. And that can really create a
7 bit of a spiral, and I think that's the big concern.
8 So I really appreciate this work. I would say to
9 the extent, in the future, stuff that we're doing, and
10 Shinobu, you highlighted how there's more work coming down
11 the road, if we can be a little bit more emphatic, almost,
12 about that point, or at least make that front and center, I
13 would strongly support that, because I think that would be
14 very helpful to highlight to policymakers and others.
15 So that's sort of my big point. I have a smaller
16 point, and to some extent the fact of the normalization
17 factor is going to be different in 2025 onward maybe makes
18 us a little bit less high yield. So I would not be
19 offended at all if these next comments are completely
20 ignored, but I'll make them anyway.
21 Which is I'd be curious on the coding side. You
22 know, in the same way that we did the MA work, where we

1 took out HRAs and take out chart reviews, and see what is
2 the impact, I'd be kind of curious what that impact would
3 be.
4 And then there's also an Rx risk score, which is
5 basically, I believe it's only using the diagnoses that are
6 attached to the prescriptions themselves. And Shinobu is
7 shaking her head, so you can correct me.
8 But I was curious if there are diagnoses on the
9 pharmacy claims or something like that, that we could use
10 more readily, or use the prescriptions themselves to infer
11 the comorbidities and see if that would give us a better
12 sense of sort of across the standalone PDP and MA-PDP, what
13 the coding differences, quote/unquote, "authentically"
14 might look like.
15 DR. JOHNSON: I think there has been some
16 academic work using prescriptions to create a risk
17 adjustment model, but not something that CMS has formally
18 done.
19 DR. CHERNEW: The academic work that I'm familiar
20 with uses the class of drug and the disease associated with
21 the class. It doesn't use a diagnosis code attached to a
22 prescription.

1 DR. NAVATHE: Correct. There's a therapeutic
2 mapping.
3 DR. CHERNEW: There is --
4 DR. JOHNSON: We've used that in our work. It's
5 a therapeutic class mapping diagnosis, basically.
6 DR. CHERNEW: Right. But no one's writing down a
7 diagnosis. You're just deciding that this is how the --
8 DR. NAVATHE: Right. Thanks for clarifying. So
9 I agree that CMS is not saying we should do this. I was
10 just curious, if we did do that, what would that look like.
11 Thank you.
12 DR. CHERNEW: That was terrific. We are at the
13 beginning of this work and the beginning of this mountain.
14 There's a lot of interest here and a lot to do here. So
15 let me just try and broadly summarize before I say thank
16 you to everybody and we refresh ourselves and come back
17 tomorrow.
18 The first thing I think I'm hearing, and this
19 echoes somewhat with what Amol just said, and many of you
20 all said, I don't consider the choice between a Part D plan
21 and a PD portion of MA. I consider the choice between the
22 MA program and the traditional Medicare program, and if you

1 choose the traditional Medicare program, you're going to
2 want drug coverage, and that's going to put you in a Part D
3 plan. And of course, when you have organizations that are
4 spanning both, you've already got a lot of competition
5 issues, and incentives, and balancing a bunch of things. I
6 think you did a great job about lining that.
7 Related to that, and maybe because of that, we've
8 done a lot of work on the Medicare Advantage program and
9 the ability to use the rebate dollars to buy down the Part
10 D program, at least in terms of salience, creates part of
11 an imbalance, which you talked about in the chapter. Just
12 to be clear, if they couldn't do that, they could take that
13 same rebate dollars and put it into some other bunch of
14 things, right. So that money's sort of fungible. But I
15 think we have to think about how all that works, and it
16 really shows that there's just a connection between sort of
17 MA and TM, there's a connection between these markets and a
18 Part D plan, is kind of one vehicle for which that
19 connection is made.
20 The part that I find hardest, and honestly, I
21 really need to spend more time pondering and sleep on it
22 and wait to hear people who tell us what to do at

1 meetingcomments@medpac.gov, to think about is there are a
2 lot of sub-themes that flow through here, and figuring out
3 how to weave them together and which to emphasize is hard.
4 So I'm just going to enumerate the ones that I see.
5 One of them is the structure of the markets that
6 I just mentioned -- the number of carriers, the number of
7 plans, how they're changing, who owns what. And to Brian's
8 point, there's a national version, and as our MA work shows
9 there's also local versions, and they can move in different
10 ways, and I think that's clear, and I very much appreciate
11 the work you've done there.
12 The second is issues with benefit design and how
13 we think through what's happening to the premiums because
14 we've changed the benefit. And my general sense there is
15 there have been big changes. There's been a lot of
16 uncertainty about what's going on there. And hopefully,
17 and maybe I'm too optimistic here, more -- and I'm not sure
18 all -- but more will be revealed over time, and luckily
19 we're in this sort of long haul.
20 But it's conceivable that a lot of the
21 uncertainty associated with the benefit design is affecting
22 what's happening, as opposed to just some of the other

1 clearly actuarial things that were clearly going on, as
2 well. And separating out all of that is hard, but luckily
3 we don't have to sort that all now, but it's certainly
4 important.
5 Then there are issues that we have dealt with in
6 the past. In fact, I think it was my first time around
7 with MedPAC, the LIS and how the LIS works, and
8 segmentation in the LIS, and how we protect LIS and the
9 associated stuff in LIS, and of course, how that plays out
10 is just a very complicated thing. And we have to think
11 through how to worry about the existence of benchmark plans
12 and how these other issues sort of impact the LIS market,
13 because that may behave differently than the non-LIS
14 market. So we're just stuck with what to do there.
15 And lastly, we've been interested in a whole
16 bunch of coding issues, and Andy here, so I don't have to
17 tell anybody. And those, of course, as you pointed out,
18 transcend things. But we could spend more time thinking of
19 some of Amol's comments, coding in general and what it is.
20 And I think -- and I'll let Andy tell me
21 separately -- we've done a ton of work on coding in the AB
22 side, and we're in sort of an earlier phase, I think, in

1 our analysis of coding in this, both the coding here and
2 the connection between some of those things, and I think
3 that's also interesting.
4 So the good news is there's a lot to do. The bad
5 news is there's a lot to do. So we're going to have to
6 give some thought to how we do this. But I have to say,
7 you did an amazing job of presenting voluminous,
8 complicated issues. And as Part D changes, as it is, and
9 as the importance of having access to medications, for
10 people with chronic conditions, people with serious
11 illnesses, like making sure people have access to
12 medications turns out to be a really important thing to
13 keep people healthy. Figuring out how to do that and
14 encourage innovation and stuff is hard.
15 So I look forward to hearing more about where
16 this goes, and obviously we'll take all of these comments
17 under advisement, to figure out what we parse and how we
18 emphasize things. So I very much appreciate all the
19 comments of the Commissioners and the engagement, the
20 tremendous work and materials that you guys presented.
21 And to the folks at home, I sort of said it under
22 my breath before, but I'll say it more explicitly now,

1 please let us know your thinking, any comments you have.
2 You can reach us at meetingcomments@medPAC.gov. We do take
3 them seriously. Or you can reach out in a number of other
4 ways, to the stuff or to me or through letters and such.
5 Anyway, thank you all for really engaging in this
6 topic, both from the beginning of the day through now. We
7 had three really meaty discussions of three really
8 important and challenging topics, and again, it illustrates
9 how wonderful the MedPAC staff is. And we'll be back
10 tomorrow to talk about networks in Medicare Advantage and
11 inpatient psych facility stay limits.
12 So again, for those at home, join us tomorrow
13 morning, and otherwise have a wonderful night.
14 [Whereupon at 4:41 p.m., the meeting was
15 recessed, to reconvene at 9:00 a.m., on Friday, November 8,
16 2024.]
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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC SESSION

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

Friday, November 8, 2024
9:00 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
PAUL CASALE, MD, PhD
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
KENNY KAN, FSA, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
BETTY RAMBUR, PhD, RN, FAAN
SCOTT SARRAN, MD, MBA
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AGENDA PAGE

Workplan: Assessing Medicare Advantage provider networks
- Katelyn Smalley......................................3

Recess..67

Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities
- Betty Fout, Pamina Mejia............................67

Adjourn..109

1 P R O C E E D I N G S

2 [9:00 a.m.]

3 DR. CHERNEW: Good morning, and happy Friday.

4 We had a great day yesterday, at least in my

5 opinion, and we have two terrific sessions this morning.

6 We have spent a lot of time thinking about the Medicare

7 Advantage market and how beneficiaries experience it and

8 what's going on with MA plans, and one of the important

9 aspects of MA plans is that they use networks, which I

10 think we acknowledge the value of having networks. But, on

11 the other hand, there's a range of issues with networks

12 that we're sometimes concerned about, and just measuring

13 them is hard.

14 So we are going to let Katelyn tell us about

15 that. So, Katelyn?

16 DR. SMALLEY: Thanks, Mike.

17 Good morning. I'd like to remind the audience

18 that they can download a PDF version of these slides in the

19 handout section of the control panel on the right-hand side

20 of the screen.

21 This presentation follows on from our chapter in

22 the June 2024 report to the Congress. Last cycle, we began

1 work on Medicare Advantage provider networks by reviewing
2 CMS's network adequacy criteria and other regulations
3 governing how networks are used in MA. Today we'll discuss
4 our plan for analytic work to assess various aspects of MA
5 networks over the next several cycles. This work will not
6 be included in a 2025 report chapter, but we plan to return
7 with the first phase of findings in the fall of 2025.
8 Today we will first provide some background on
9 key points of how CMS assesses network adequacy in MA and
10 review the literature on network breadth. We will then
11 turn to our planned analyses. We will discuss the
12 available data sources for analyzing MA provider networks,
13 our immediate next steps for analysis, and possibilities
14 for future work analyzing provider networks in MA. Then we
15 will turn to your discussion. We are interested in your
16 feedback on the plan presented here today as well as your
17 analytic priorities in this area.
18 In the June 2024 report to the Congress, the
19 Commission reviewed CMS standards and processes for
20 ensuring that MA enrollees have adequate access to
21 providers through their plan's networks. In brief, CMS has
22 network adequacy requirements for 14 facility types and 29

1 specialty types, requiring plans to contract with a minimum
2 number of each type of clinician and facility within a
3 maximum time and distance from potential enrollees. MA
4 plans are also required to provide access within maximum
5 wait times for each of these facility and specialty types.
6 Some of these standards vary by rurality. For
7 example, the percentage of beneficiaries who must reside
8 within the maximum time and distance thresholds is lower in
9 non-urban counties than in metropolitan areas.
10 All new plans and proposed service area
11 expansions must demonstrate network adequacy as part of the
12 CMS application process. In addition, CMS verifies that
13 plans continue to be compliant with network adequacy
14 criteria using a three-year review cycle. Reviews can also
15 be triggered under special circumstances, including when an
16 enrollee files an access complaint. However, the data used
17 in these reviews is plan-supplied and not independently
18 verified.
19 While CMS has the authority to impose sanctions
20 for noncompliance with the network adequacy standards, it
21 has never done so. However, applications for new plans and
22 service area expansions have been denied on this basis.

1 Accurate directories of in-network providers are
2 important so that beneficiaries can ensure that their
3 existing providers are covered when choosing a plan, and in
4 cases where a new provider is needed, that they can find
5 one that is in-network. Beneficiaries typically have to
6 pay higher cost sharing for out-of-network providers or
7 their services may not be covered at all.
8 However, the current system for generating and
9 maintaining provider directories is costly and inefficient.
10 Plans maintain their own directories, and provider groups
11 must submit their information to every plan they contract
12 with, leading to inconsistencies and inaccuracies. This is
13 not a problem unique to MA, but a 2018 CMS evaluation found
14 that roughly half of MA directories had at least one
15 inaccuracy, and inaccurate listings comprised up to 93
16 percent of one directory. CMS has been exploring the
17 utility and feasibility of a national provider directory to
18 address these issues.
19 Obtaining accurate information about provider
20 networks is further complicated by the fact that plans and
21 providers are allowed to terminate their contracts at any
22 point in the year. By contrast, most beneficiaries are

1 only allowed to change plans during open enrollment. When
2 a major contract change happens, CMS has the discretion to
3 declare a special enrollment period for affected
4 beneficiaries, but this is not guaranteed.
5 Much of the existing literature on MA provider
6 networks has focused on characterizing the extent to which
7 plans have narrow provider networks, which are usually
8 defined as those composed of fewer than 25 or 30 percent of
9 the available providers in a given service line in a given
10 area.
11 In general, MA networks have been found to be
12 broader than ACA, commercial, and Medicaid networks in the
13 same market, and the narrowness of MA networks is not
14 evenly distributed across specialties. For instance, some
15 specialties, like OB/GYN and allergy, appear to be more
16 restrictive than others, like cardiology and urology. The
17 impact of networks seems to also vary with geography.
18 For instance, rural beneficiaries have been found
19 to disproportionately experience difficulties finding
20 providers, delays in care, or financial challenges related
21 to network restrictions.
22 The impact of narrow networks is not

1 straightforward, however. On the one hand, a narrow
2 network could benefit enrollees by weeding out poor-
3 performing providers or negotiating more favorable rates,
4 but it could also cause access problems by constricting
5 supply. On the other hand, a broad network could provide
6 better access, but it could also expose enrollees to low-
7 quality providers and reduce a plan's ability to negotiate
8 prices in the long run.
9 MA networks have been found to include less
10 costly providers than the regional average, but differences
11 in quality are less clear. Some studies have found
12 positive associations between quality indicators and narrow
13 networks. Others have found a negative relationship
14 between narrow networks and quality, and still others have
15 found no clear association.
16 Networks may be particularly salient for
17 beneficiaries with chronic, complex illnesses who need
18 access to a specific provider or set of providers. For
19 example, studies have found that MA enrollees with ESRD may
20 be likelier to travel longer distances to a dialysis
21 facility and to be seen at a facility of lower average
22 quality than fee-for-service beneficiaries living in the

1 same area, and that narrow dialysis facility networks may
2 be more likely to impact dual eligible beneficiaries.
3 Other studies, not unique to Medicare Advantage,
4 suggest that narrow networks disproportionately affect
5 people with disabilities.
6 In contrast to other specialty types highlighted
7 above, MA has been found to have much narrower networks for
8 behavioral health care than other markets, potentially
9 leading to care delays. Networks are consequential for
10 surgical procedures as well.
11 One study of access to high-volume cancer centers
12 in MA found good in-network coverage for certain types of
13 cancer surgery but little or no in-network coverage of
14 others.
15 Now we'll turn to the work we have planned for MA
16 networks. Broadly speaking, our aims for this work are,
17 first, to understand the characteristics of MA plans and
18 the providers that do and do not participate in MA
19 networks. We also aim to understand how MA provider
20 networks are used by enrollees. For instance, we'd like to
21 know if MA enrollees use certain in-network providers more
22 often than others and the extent of out-of-network service

1 use in MA. And, finally, we aim to understand the impact
2 of CMS's network adequacy standards on access to care in MA
3 by measuring actual provider networks relative to the
4 standards.
5 I'll speak in more detail about the work we have
6 planned to address each of these aims in a few moments.
7 First, though, I'd like to introduce you to the
8 data we'll be using for these analyses. As I mentioned
9 earlier, MA plans are responsible for maintaining their own
10 provider directories. Many MA plans use third-party
11 vendors to compile and maintain details of their in-network
12 providers, including their addresses, specialties, cultural
13 competencies, and ability to take on new patients.
14 Ideon is one such private company that collates
15 provider network information for insurance carriers,
16 including MA organizations. Several studies of MA provider
17 networks have been published using this data, and we have
18 recently obtained extracts consisting of some high-level
19 plan and provider information, along with a list linking
20 plans to their in-network providers.
21 This data can be combined with various CMS
22 sources to help us understand how aspects of MA networks

1 are constructed and used. For instance, we can link with
2 MA enrollment data to analyze by plan size, type, and
3 location. We can link with provider registries like NPPES
4 and PECOS to confirm provider specialty types, locations,
5 and organizational affiliations, and we can link with MA
6 encounter data to analyze utilization of in-network and
7 out-of-network providers by MA enrollees.
8 We are in the process of validating some elements
9 of Ideon's MA data. For instance, we are using CMS
10 enrollment data to verify that the contract IDs provided by
11 Ideon represent real CMS contracts that were active at the
12 time of the study. Similarly, we are comparing Ideon's
13 provider IDs to the NPIs that have billed fee-for-service
14 Medicare in the same year, those associated with an
15 encounter record in that year, and those registered in
16 NPPES and PECOS.
17 Matching provider IDs to fee-for-service data can
18 indicate that a given provider was treating Medicare
19 beneficiaries at the time they were listed in an MA
20 provider directory. Further, matching these same IDs
21 against MA encounter data can indicate that a provider is
22 seeing MA enrollees generally or beneficiaries enrolled in

1 a specific MA plan.

2 We also plan to cross-reference a subset of
3 Ideon's plan and provider details, such as names, specialty
4 types, and locations with CMS sources to assess their
5 accuracy.

6 To manage the scope of this work, we propose to
7 limit our analyses to local coordinated care plans, that
8 is, HMOs and local PPOs, in the 50 states and D.C., and to
9 providers of Medicare-covered services; that is to say, not
10 drugs or devices at this time.

11 We propose to begin our empirical work on MA
12 networks with two sets of analyses that characterize
13 provider participation.

14 The first would characterize the breadth of
15 provider participation in MA and fee-for-service. While
16 many providers participate in both programs, some may
17 participate in only one. Among those who participate in
18 MA, some may contract broadly with all plans in their
19 market, while others may only work with a small number. To
20 better understand the types of providers that MA enrollees
21 have access to, we plan to summarize the percent of
22 providers that participate across MA and fee-for-service

1 and how that varies across local markets and provider
2 types.
3 The second line of work would characterize how MA
4 provider networks change over time. The extent to which
5 providers enter and exit MA networks is an indicator of the
6 stability of those networks. To characterize the extent of
7 churn, we could summarize the percent of providers that
8 exit MA networks each year along with the percent of new
9 providers entering plan networks each year. Beyond
10 quantifying the scope of this phenomenon, we could assess
11 the feasibility of conducting qualitative research to
12 further understand the drivers of contract terminations and
13 the impact of provider network changes on beneficiaries.
14 For the next block of work, we plan to link Ideon
15 on data with MA encounter data to better understand how MA
16 networks are used in practice. In this line of work, we
17 would compare the list of in-network providers and Ideon on
18 data, what we are calling the "nominal networks," to
19 providers that MA enrollees have used as evident in
20 encounter data, which we are calling the "effective
21 networks."
22 We could explore concordance between nominal and

1 effective networks along various plan and provider
2 characteristics. We could also explore using the Ideon and
3 encounter data to measure the extent to which MA enrollees
4 receive care from out-of-network providers, as this would
5 be an indicator of access to care in MA plans.
6 This may be challenging to implement since some
7 providers may not submit claims for out-of-network care,
8 especially to HMOs, if it is known in advance that the plan
9 will provide no coverage for those services. On the other
10 hand, it would still be important to know what share of MA
11 encounter records represent out-of-network care, since this
12 would have implications for understanding the extent to
13 which coding and risk adjustment payments result from out-
14 of-network services.
15 Another potential line of work relates to
16 assessing plans' empirical provider networks in the context
17 of CMS's network adequacy standards. These analogies would
18 be on a longer time horizon because it would take time to
19 construct a dataset that could apply CMS's network adequacy
20 rules to the provider networks of each plan.
21 However, such a dataset would allow us to explore
22 the association between MA network design and indicators of

1 access. For instance, we would be able to report the
2 percent of plans with provider networks that substantially
3 exceed CMS's thresholds for network adequacy and the
4 percent of plans with networks that are closer to the
5 required threshold for each specialty and facility type.
6 If the numbers of in-network providers hover at
7 or just above the minimum standards, this may indicate that
8 the network adequacy standards are compelling plans to
9 contract with more providers than they otherwise would. On
10 the other hand, if MA networks actually include many more
11 providers than the minimum required, this could indicate
12 that CMS's standards are not a driving factor in how MA
13 plans design their networks.
14 This data would allow us to conduct analyses
15 where we relate network size to other access indicators,
16 potentially including the rates of switching out of MA
17 plans, the average distance enrollees travel to providers
18 of different specialties in different areas, or the share
19 of enrollees with a particular condition who have a visit
20 with a relevant specialist.
21 We could also identify types of providers who are
22 not subject to CMS's network adequacy standards and measure

1 the extent to which plans are meeting hypothetical
2 standards for those providers.
3 Now this brings us to your discussion. We would
4 welcome any questions or feedback you have about the
5 proposed analyses, and we'd like to know your priorities
6 for analytic work on MA networks.
7 With that, I'll turn it back to Mike.
8 DR. CHERNEW: Katelyn, thank you.
9 And I think apart from the importance of this
10 issue, just the novelty of the data is fun. So I know
11 there's a lot of work there.
12 Anyway, that aside, let's start with the Round 1
13 questions, and I think, if I am right, Brian is first in
14 Round 1.
15 DR. MILLER: Thank you for doing this. This is
16 fun. I think this is really important for beneficiaries.
17 Two small things. On page 4, we talk about out-
18 of-network care. Going to be honest, I think many of our
19 readers and staff, policy analysts, et cetera, are going to
20 be confused about how out-of-network care works in MA, and
21 so it would probably be helpful to add the notion that
22 emergency care is covered and then also talk about PPO

1 versus HMO out-of-network care, because that's different.
2 Most of us sitting around the table probably
3 understand that. Many of the people reading this probably
4 don't.
5 And noting that the out-of-network Medicare
6 Advantage is set at the fee-for-service rate -- and I say
7 this because I probably get this question about once a
8 week. So that, I think will add some color that will help.
9 I'm also the first to admit that provider
10 directories need to be improved and that the technology
11 infrastructure appears to be functionally behind other
12 decades -- or decades behind other industries looking at
13 its performance.
14 I also, at the same time, think that we need to
15 be a little cautious and not get over our skis. At one
16 point in there, we said that the 2018 CMS evaluation found
17 that rough of half of the directories had at least one
18 inaccuracy. Trust me, I'm 100 percent on the same page
19 that provider directories are very out-of-date. I hear
20 these stories. Probably, every day somebody texts me about
21 it.
22 There are also 900,000 physicians and 6,000 --

1 over 6,000 acute care hospitals. So, if we say that the
2 CMS evaluation found that roughly half of every directory
3 had at least one inaccuracy, that actually sounds good. So
4 we may want to denote the types and numbers of "providers"
5 -- and apologies to my clinical colleagues for using that
6 term -- that are in the Medicare network, like, maybe a
7 little footnote that says number of LTCHs, number of acute
8 care hospitals, number of SNFs, number of doctors. And
9 then note that there's still a lot more work to do on
10 improving provider directories, because the CMS data, that
11 actually looked good. And we should denote that, but we
12 should also denote that that's probably very much
13 incomplete and that there's a lot of work to do to improve
14 provider directories.
15 So I think that CMS -- I'm trying to say that
16 that CMS survey made the plans look better than they
17 actually are. So we should give them credit for what that
18 survey showed, but also to note that we all know and all
19 the beneficiaries know that there's a lot of work to still
20 be done.
21 Hopefully I parsed that well. But thank you
22 again for doing this chapter. It's very important, I

1 think, for beneficiaries.

2 DR. SMALLEY: Thanks. We'll definitely be

3 careful about both of those points.

4 DR. MILLER: Thanks.

5 MS. KELLEY: Betty.

6 DR. RAMBUR: Thank you.

7 Very, very interesting and very important.

8 In a way, I think my question kind of follows on

9 a piece of Brian's, and it relates to the HMO-MA and the

10 PPO-MA. So I just want to make sure I understand how the

11 chess pieces work.

12 We hear of all these organizations leaving MA,

13 and I think 30 were reported in October or something like

14 that. So I want to understand -- make sure I understand

15 this correctly. If a person has an HMO plan and they no

16 longer are accepted, they pay everything out-of-pocket

17 until they can switch to a different plan, and that can

18 only happen during open enrollment. Is that correct?

19 DR. SMALLEY: So, in an HMO, beneficiaries are

20 responsible for it. They must stay within the network.

21 DR. RAMBUR: Right.

22 DR. SMALLEY: And if they choose to go to an out-

1 of-network provider, they are on the hook for --

2 DR. RAMBUR: But what if their network, the place

3 they've been going, leaves or no longer accepts HMO-MA?

4 They would be responsible for everything. Is that correct?

5 DR. SMALLEY: So when that happens, CMS does have

6 discretion to offer a special enrollment period to the

7 beneficiaries of those plans. The extent to which that

8 happens is something that we're still trying to tease out,

9 but there is a mechanism for that.

10 DR. RAMBUR: And then in the PPO plan, people

11 would just have to pay up to the MOOP or -- and does CMS

12 have the discretion on that as well?

13 DR. SMALLEY: I believe that those contract

14 changes are for HMO plans and PPO plans.

15 DR. RAMBUR: I think just a small piece on that,

16 because I think it's actually confusing, and I think it's

17 really important that we all understand what happens when

18 organizations exit.

19 DR. SMALLEY: Yeah.

20 DR. RAMBUR: Thank you.

21 MS. KELLEY: Greg.

22 MR. POULSEN: Thanks. I, like everybody else,

1 thought this was really, really interesting work and
2 fascinating information.
3 A couple of thoughts or a question, one. You
4 mentioned a much narrower network for behavioral health.
5 Do we know what percentage of the behavioral health
6 participants are also choosing not to participate in
7 traditional fee-for-service Medicare?
8 MS. SMALLEY: I don't have numbers for you
9 offhand, but I think that's an important point, that a
10 certain degree of that in behavioral health is the decision
11 not to participate in Medicare at all.
12 MR. POULSEN: Yeah. In my part of the country a
13 lot of behavioral health providers don't participate in
14 Medicare/Medicaid broadly, including MA, so that would be
15 one thought.
16 There is one other point. We talked about
17 quality in narrower networks, and I think we capture part
18 of the reason for the quality differentiation but I don't
19 think we gave appropriate recognition to the fact that
20 sometimes narrower networks provide quality simply because
21 the relationships exist. It's not necessarily that the
22 provider is a better provider. It's that they're more

1 connected with the other providers and they work as a team
2 more effectively. And it seems to me that would be a point
3 worth capturing. That is particularly true when they share
4 electronic medical records, they share practice
5 philosophies, they may share treatment protocols, and so
6 forth. So just to throw that in I think would be good.
7 Thanks.
8 MS. SMALLEY: Thanks. Yeah, I think that could
9 be an interesting thing, if we're going to do qualitative
10 work, to kind of understand the mechanisms of how these
11 things work. That's an important point. Thank you.
12 MS. KELLEY: Gina.
13 MS. UPCHURCH: Yeah. Thank you so much for this
14 chapter. Really great work. A couple of things, and I'm
15 not clear about this. But an HMO, if you have something
16 that's an emergency, you're always in network. I think
17 some Medicare Advantage plans also assume that about urgent
18 care, but do you know about urgent care?
19 MS. SMALLEY: I believe it is both urgent and
20 emerging, yeah.
21 MS. UPCHURCH: Okay. That would be great to make
22 clear in defining this. And I think what happens a lot of

1 times is the individual thinks it's emergent or they feel
2 like it's urgent, and then the plan doesn't believe that to
3 be true. What happens in those cases?
4 MS. SMALLEY: That's definitely something that we
5 can look into.
6 MS. UPCHURCH: Yeah. That would be a tremendous
7 problem. And then last, Ideon -- never heard of it. Is
8 that something that just researchers would pay for, or is
9 it something that the plans themselves pay for to help keep
10 their network, you know, up to date?
11 MS. SMALLEY: So Ideon primarily, their role
12 primarily is to help plans keep their networks up to date
13 and to help them understand which providers are in their
14 network and out of network. Because they have this
15 repository of data, they have also made it available to
16 researchers to use.
17 MS. UPCHURCH: So if I'm an insurer and I pay
18 Ideon, does that go on my medical loss ratio somehow? I
19 just think of all this money we put into health care,
20 that's not about delivering care, but I would be interested
21 to know if that's part of the medical loss ratio, or it's
22 considered administrative, or is it considered --

1 MS. SMALLEY: We can look into that.
2 MS. UPCHURCH: That would be good. Thank you so
3 much.
4 MS. KELLEY: Okay. I think we're ready for Round
5 2, Mike. Am I right? Stacie, you're first.
6 DR. DUSETZINA: Thank you so much. I was very
7 excited to see this workstream because I, like Brian, I
8 agree this is incredibly important for beneficiaries and
9 thinking about their access to care. So very excited about
10 this. Also new data -- yay. That's always great.
11 I really wanted to just say I think it's
12 wonderful that you're going to be creating some of the
13 similar estimates for fee-for-service, thinking especially
14 about local areas and how much variability there would be
15 in different places around the country.
16 A couple of things that just stood out to me as I
17 was reading. One is when you do the comparison of the NPIs
18 in Ideon that like had fee-for-service but not MA, that
19 seemed really high to me, the gap there. And I wondered if
20 when you're doing that if there should be some sort of
21 threshold for you have to have at least this many
22 connections to be included in the denominator in the first

1 place. So that was just one thing that I think would be
2 helpful contextually.
3 I think the issue of plans and providers being
4 able to change networks at any point in the year is
5 horrible. Just for beneficiaries it's very bad. And I
6 know Gina has educated me on what that means for people and
7 their out-of-pocket spending. So at the very least it's a
8 penalty for someone, you know, even if they successfully
9 transition into a new plan, I really don't think that
10 should be allowed. Like if you should sign up for a
11 contract and then have the whole year and changes are made
12 it should be on the next year. So that's a little
13 preaching to the choir, maybe.
14 But I think documenting the churn in those
15 networks is incredibly important. I'm glad to see that as
16 part of the work plan.
17 The one thing I wasn't sure is can you tell when
18 it's a big system leaving and be able to give us some color
19 around that, not just how many providers are moving? But
20 like did you lose the big system in your area which may
21 have differential effect on both specialty care and primary
22 care access, which I think is important.

1 In Table 1 you mentioned focusing on the local
2 coordinated care plans, and I definitely appreciate the
3 need to have some scope limit here. But one of the things
4 I wondered about was, is there any chance that leaving out
5 the regional plans actually masks some of the kind of worse
6 situations for beneficiaries, maybe like the local might be
7 more sensitive to the people in their area, like you're
8 more in the community versus maybe regional is less likely
9 to have good access or more likely to have exits. I just
10 don't know the answer to that. So it was the only thing
11 that made me be a little bit concerned about giving that
12 piece up.
13 But also knowing the magnitude of how people are
14 sorted among those different plan types would help to know
15 like, okay, that's not that many people relative to the
16 group that would help to make that feel better.
17 MS. SMALLEY: Yeah, on that point, the number of
18 beneficiaries in our PPOs is very small. I think it would
19 be a great idea to do that kind of sensitivity analysis to
20 make sure that those are not substantially different from
21 what we're finding.
22 DR. DUSETZINA: Right. And even just having that

1 like this is a small percentage relative to the overall I
2 think is great to add.
3 I don't know if probably qualitative work is not
4 necessarily going to be part of this, but it seemed to me
5 that when you have large systems that are leaving or large
6 plans that are leaving, that having some digging in on the
7 why. Anecdotally, I've heard when there is one of these
8 bigger moves that the prior authorization and like the
9 number of personnel just to get claims paid, and I think
10 that's the good and the bad. That's maintaining the lower
11 cost, but that's also burdensome.
12 Okay. And then I think the one thing, and when I
13 was thinking about what you could pull back on, on scope,
14 because it is a big scope. I was a little bit less
15 concerned about the out-of-network piece of this, and part
16 of my thinking here is that if we find that there are
17 substantial challenges in like the consistency of your
18 network, a lot of providers leaving, the directories aren't
19 correct, for all the in-network care you're supposed to
20 get, you know, that's kind of a big red flag. And out-of-
21 network care, yes, I'm concerned about, but in a lot of
22 ways I think it's a secondary piece. So I'd say

1 prioritizing the in-network care pieces first would be
2 great. Thank you.
3 DR. SARRAN: I think I was next. Thanks,
4 Katelyn, for excellent work in this succinct presentation,
5 and I support all the proposed next steps in the work plan,
6 and no surprise, I have suggestions for some additional
7 bodies of work.
8 So one of the lenses that I think it's really
9 important we look through is the potential for beneficiary
10 harm to occur via how MA plans manage their networks. And
11 there are three points in that, I think, where beneficiary
12 harm can occur, and I think we need to get at all of those,
13 to at least some extent.
14 The first is that in-network is not necessarily
15 synonymous with accessible to the member, to the
16 beneficiary, right. They can be two completely different
17 things. In-network is necessary but not sufficient to
18 create access, and we care about access at the end of the
19 day.
20 Number two, there is sort of a truism that you
21 don't always know what you need until you need it. I'm
22 sure there are better ways to say it. If you don't have

1 cancer and you're not facing some really critical
2 decisions, you're not going to think about that when you
3 shop.
4 Third is that there are times where quaternary
5 care does make a different in outcomes, and I think there's
6 some reasonable evidence in the oncology space that that
7 is, in fact, the case. I think that evidence may be less
8 clear in other clinical spaces, but not denigrating expert
9 cardiologists, Paul. But I think it's proven, I think, in
10 the cancer space.
11 So with those as background, what I'd suggest is
12 we do some qualitative interviews focused on two of the
13 areas that you mentioned, behavioral health and oncology,
14 and two additional ones. So behavioral health, that's the
15 space where there is a ton of, I think it's more than
16 anecdotal evidence, that there are a lot of providers who
17 are, quote, "in-network," even in the most updated
18 directories, but they're just not accessible. And there
19 are some that are in-network and clearly, they never
20 thought they were in-network. I mean, that is a well-
21 documented problem, so I think we really need to highlight
22 that, and I think the best way to get at that is

1 qualitative interviews.

2 In oncology, I think we need to look at what
3 centers of excellence -- and I think NCI designated centers
4 as probably the right parameter for that. But we need to
5 look at how many cancer centers of excellence are in and
6 not in network, because there I think we do, again, I think
7 there's evidence that quaternary cancer care can make a
8 difference, does make a difference at times, and I think we
9 have some operational definitions of what a quaternary
10 cancer center looks like. So I think highlighting that.

11 And that, by the way, that should be highlighted
12 to members when they're shopping. I mean, I think that
13 should be very clear when a beneficiary is choosing an MA
14 plan.

15 The two other areas where I think we should do
16 some qualitative interviews, because I hear this a lot from
17 beneficiaries and families, SNFs, lots of choice about
18 challenges in accessing geographically feasible and high-
19 quality, and there are some now, of course, CMS definitions
20 of high-quality SNFs, and dialysis. I hear that all the
21 time. And we know we have essentially a duopoly in most
22 areas, so one of them may be in-network with adequate

1 geographic access, but they don't have a chair available,
2 and then what's somebody to do and they're having to go a
3 much further distance.
4 So I think those four areas will benefit from
5 some ongoing qualitative interviews with beneficiaries.
6 Thanks.
7 MS. KELLEY: Tamara.
8 DR. KONETZKA: Thanks, Katelyn, for this great
9 work and for your willingness to dive into these new data
10 sources, which are very exciting. I want to start by just
11 sort of doubling down on this idea that networks can change
12 midyear, and it's hard to fathom how anybody thought it
13 would be a good idea to put that risk entirely on
14 consumers. Like we know that providers and plans may sort
15 of split for various reasons in midyear, but why that
16 should all fall on consumers is just kind of crazy.
17 But my main point is sort of reinforcing things
18 you're already planning to do. I'm not adding to your
19 list, but I want to point out the things that I think are
20 particularly important.
21 As Scott kind of mentioned, I think next to
22 behavioral health, where we've seen perhaps the most

1 concern in access to providers is in the post-acute sector.
2 And so just anecdotally we hear this all the time. Just
3 personally I was in a SNF with my mother the beginning of
4 this week for three days, and I have to say when she was
5 getting discharged from the hospital, before they talked
6 about her care plan, before they talked about rehab, the
7 first question was about insurance. I asked about care
8 plan in the SNF. The first question was about insurance.
9 Like it's really driving what kind of post-acute care
10 people get, in addition to length of stay and other things
11 you're not going to look at in this chapter.
12 So I think it's really important to look at post-
13 acute care, because I think it's one of the main areas
14 where this probably has an effect.
15 But related to that, you're planning to look at
16 quality. I think for good reason, the sort of network
17 adequacy requirements don't include quality because that
18 would be sort of, I think, hard to do across all the
19 different sectors. But I think in the post-acute care
20 sector it's really important, and there's certainly
21 evidence that people on MA end up going to lower-quality
22 facilities.

1 And so I'm really excited to see that you're
2 going to include quality in your assessment and that you're
3 going to compare that to fee-for-service, because I think
4 that's a really important part of access to good post-acute
5 care is whether or not you actually can choose a higher
6 quality provider.
7 And I think that's also related to this sort of
8 official network versus effective network, because on both
9 sides of it you may have, if you're on one of these plans
10 you may have a limited choice of SNFs, for example, that
11 might be low quality, but even if there is a high-quality
12 SNF in your network it may be that that SNF, if it has a
13 high occupancy rate, also may just not accept you. So
14 that's sort of effective if you have access to the higher-
15 quality SNF, even if it's in your network, I think it's a
16 really important distinction.
17 Yeah, I think the whole issue around quality, you
18 know, it's framed several times in the chapter as like this
19 may be a mechanism for plans to rule out low-quality
20 providers, which I think is sort of the ideal that actually
21 doesn't happen. It's the opposite. And so I just want to
22 reinforce that looking at quality is going to be really

1 important, and I'm glad that's in the work plan. Thanks.

2 MS. KELLEY: Brian.

3 DR. MILLER: So I really appreciate this work
4 because for beneficiaries provider directories matter. I
5 think there is some level set that we should think about as
6 a Commission which is also probably important for this
7 work.

8 So Medicare fee-for-service is the best of
9 insurance by 1965, no interlock brakes, no airbags, right.
10 Totally different era. Any willing provider network
11 without meaningful utilization review or network design was
12 best in 1965.

13 Today, 2024, heading into 2025, almost everybody
14 in the country has a provider network. If you're in an ACO
15 plan, if you're in a Medicaid managed care plan, you're in
16 an ESI plan, you have a network. Probably more likely a
17 POO than an HMO. Most everybody has a network. So fee-
18 for-service Medicare with an any willing provider network
19 stands apart from the entire rest of the insurance markets
20 in the entire country. So I think we should denote that in
21 this chapter, and I think that's important for us to think
22 about.

1 Again, I feel strongly that fee-for-service in
2 Medicare is an important option for beneficiaries. I also
3 think we need to be realistic and constructive about MA. I
4 think that the provider directories definitely need to be
5 updated. This work is a way to force that to happen, help
6 shed some light on it. A lot of the anger I hear, and
7 assertions that MA is having lower quality providers as
8 opposed to higher are not necessarily true.
9 And there is a lot of heterogeneity around the
10 managed care market. Not all plans are equal. Maybe for
11 some plans that's true. Maybe for some plans that's not.
12 But I think that we should be very cautious about making
13 assertions that an entire marketplace is including lower
14 quality providers, because that doesn't make us look
15 credible.
16 I think using this work as a way to be
17 constructive and improve the Medicare Advantage program for
18 beneficiaries is the ethos that we should have instead of
19 just bashing the Medicare Advantage program. Because our
20 collective goal, I think, as a Commission, should be to
21 make the program better for beneficiaries, and this is a
22 huge positive lever.

1 I think the other thing that we need to think
2 about is what this data shows us is the opportunity for
3 tech and automation to improve the administrative
4 processes. I realize many of us are policy people, but not
5 everything is going to be solved with law and regulation.
6 I used to have Geico insurance. I don't anymore. My wife
7 made me switch, but I still love Geico.
8 I remember I had a car accident 10 years ago, a
9 fender bender. I had to get a fender replaced. And I went
10 online to the Geico website, and I typed in my ZIP code,
11 and it gave me repair shops within a certain number of
12 miles of my house. It was great. Did I like what the
13 repair shop did? Not exactly. They were not perfect. But
14 I knew what the prices were. I knew what the costs were.
15 And it was pretty clear where I could go and what I could
16 do.
17 When I need to book flights, I'm very organized
18 about my work but I'm very disorganized about travel.
19 Luckily there are lots of websites that help me sort that
20 and forget which airline and where I'm going, paying for
21 hotels, paying for using credit card miles. We have all
22 kinds of technological systems that can solve the problems

1 that the Medicare Advantage marketplace is with provider
2 networks.
3 My suggestion for us as a Commission, as I said,
4 I think our goal should be constructive rather than to take
5 a baseball bat. You'd say that there is a problem with
6 provider directories. This work -- and I think our staff
7 are doing a great job getting started on -- is to enumerate
8 what that problem is. And I think one of the advice that
9 we have, instead of saying it's law and regulations, like
10 law and regulations often don't solve everything in health
11 care. We have lots of laws and regulations in health care
12 and we create more laws and regulations every year, and we
13 continue to face the same problems year after year, despite
14 more laws and regulations.
15 So I view this work as a way to highlight a
16 problem that technology can solve, and I think one of the
17 things that I'd love to see added in this work is how all
18 those other industries have solved this problem. That's
19 not necessarily a data-crunching issue. That might be just
20 talking to companies, like calling up Geico, asking them
21 what they do and how it works. And I use that example
22 because it's just that it's a personal one that I know.

1 But there are many companies that have solved the problem
2 of I have many people who have contracted rates for a
3 service, and the consumer can only go to certain places,
4 those contracted places. And if they don't go to those
5 contracted places, they have different rates.
6 So I think we need to look at those other
7 insurance industries, and frankly, other consumer-facing
8 industries, and talk to them for solutions, because I think
9 that as a Commission you want to be in the business of
10 helping Congress solve problems for beneficiaries, pointing
11 out the problem and then solving the problem, because
12 that's going to make things much better.
13 There are some of us on the Commission that are
14 on Medicare. I'm quite a ways away from Medicare so I
15 really want it to be there, and I want it to be there in an
16 even stronger, better form that it currently is. And I
17 think provider directories are one thing that will
18 massively improve the beneficiary experience, and it's
19 something that we all have been complaining about for a
20 long time, rightfully so. I think some of the papers I
21 read were from when I was in elementary school. So I think
22 we should work towards solving this problem. Thank you.

1 DR. CHERNEW: So let me just jump in and make a
2 quick comment for those at home, and first of all, I think
3 the folks viewing this will realize I am much closer to
4 Medicare than Brian, unfortunately.
5 But, in any case, we are not planning on
6 publishing the material that we've seen. It is really just
7 to understand the analysis we're doing, and I don't take
8 any of the comments around the table as trying to draw a
9 normative conclusion about Medicare advantage one way or
10 another or the existence of networks one way or another.
11 I think right now where we are is trying to just
12 understand aspects of the networks and their stability.
13 Once we get through that work, which turns out to be a lot
14 of work -- and it needs this new data -- then we will have
15 many more discussions about the relative implications of
16 that for quality and how we feel and what the expectations
17 should be.
18 And so the extent to which -- it is true that we
19 would like to help folks solve a problem, but we are right
20 now just trying to understand if there is a problem and
21 what it is, and at least for me and I think the -- right
22 now, I'm not presupposing there is a problem that we've got

1 to jump right at it. There are certainly some things that
2 one worries about.
3 Ninety-three percent of networks, you know, not
4 being right seems a problem, you know, but in any case, I'm
5 not going to assume that now. We're just trying to outline
6 this work that we're doing, and I think, to Brian's point,
7 that's right. It is actually quite important because, as
8 there are networks, we need to figure out how people are
9 experiencing and what the implications of them are. And
10 that's where we are.
11 But I don't take any of the comments now as sort
12 of presupposing what we're going to find. But we will be
13 reporting back before we -- when we publish things, you'll
14 actually have information as opposed to just an outline of
15 where we're going. This is just to explain where we're
16 going.
17 Anyway, I hope that was clear, but thank you.
18 And I think we now -- who's next, Dana?
19 MS. KELLEY: Amol.
20 DR. NAVATHE: Thanks, Katelyn, for this really
21 important work. I share the sentiments of my fellow
22 Commissioners that this is really important, and I'm glad

1 that we're embarking upon this analytic piece.

2 I will try to keep my comments fairly structured
3 here. So, first, I just wanted to agree with Stacie and
4 Tamara about this point that it is it's seemingly unfair
5 for beneficiaries to be the ones responsible or accountable
6 for network disruptions or for changes in the network and
7 especially if we think about it in the context of the sort
8 of MA lock-in issue, which is, you know, in most states,
9 potentially challenging access to supplemental coverage in
10 the Medigap market. This whole thing seems challenging.
11 It could place certain -- you know, certainly outsized
12 burden on beneficiaries, and one could contemplate ways in
13 which plans could be sort of shared, have a greater shared
14 responsibility or more responsibility for that, and I think
15 that would be good to explore further.

16 Three other points that I hope are shorter. So
17 you have done a very nice job of laying out future work. I
18 think one of the pieces around the ownership element that I
19 think would be nice to make sure we focus in on is a
20 vertical integration where we have plans that are owning
21 physician groups or providers. So I didn't see that
22 articulated, but that's great if we can do that.

1 I really agree with many of the points that Scott
2 and others have made about concerns around specific types
3 of services, and I thought in this analysis of the nominal
4 versus effective networks, if we can look at this from the
5 perspective of beneficiaries who have conditions that may
6 require specialized services.
7 So Scott mentioned oncology. You know, you could
8 look at things like conditions that require bone marrow
9 transplant where there has to be a certain volume and a
10 center also for them to really be able to do it well.
11 I think I'll also comment on cardiology. I think
12 Paul will hopefully be happy about that. So advanced heart
13 failure is another condition that requires a lot of
14 advanced technology and capital investment. So I think
15 it's unlikely that we're going to have widespread advanced
16 heart failure care. So that would be another condition to
17 look at.
18 And I think other procedures, for example, where
19 there's strong relationships between volume and outcomes,
20 so heart bypass surgery. CABG certainly pops to mind.
21 Another one that's been more emerging where CMS themselves
22 actually placed restrictions on volume requirements would

1 be TAVR, or aortic valve replacement, and so there's
2 increasing evidence about the benefits of TAVR, for
3 example, and so having access to TAVR, if you have even --
4 I think there's recent evidence -- Paul will correct me --
5 that even if you have asymptomatic but severe aortic
6 stenosis, TAVR actually has benefit. And yet those centers
7 that provide that are actually necessarily constrained
8 based on volume. So I think that would be nice to
9 incorporate some illustrative examples that are kind of
10 bene-focused but focused on these highly specialized
11 services.
12 And then the last point I wanted to make is
13 really a plus-one to Stacie again on this notion of the
14 exit or churn and focusing. I think it would be ideal if
15 we could either kind of weight the analysis by the number
16 of members served by a provider who's exiting or based on
17 the encounter volume, something like that, because I think
18 that would be a much better reflection of the sort of
19 degree of disruption, if you will, from that exit.
20 You could also imagine a very, like, relatively
21 innocuous and strategic approach by plans to prune the
22 network if their providers -- if their beneficiaries aren't

1 actually seeing somebody. And so I think we don't want to
2 confuse the two things. I think kind of pruning in a
3 rational way is very different than disruption. So that's
4 why I was highlighting that.
5 So otherwise, a really wonderful sort of set of
6 work, and I look forward to seeing it. Thank you.
7 MS. KELLEY: Betty.
8 DR. RAMBUR: Thank you again, and I plus-one on
9 all of these comments. This is fabulous.
10 And I know you're wanting us to help you focus,
11 and so I'm going to try to not repeat things that I've
12 heard but just a couple of additional points.
13 Stacie talked about focusing in-network, and I
14 totally support that. At the same time, I'm very concerned
15 about out-of-network by service type, particularly in the
16 HMO, because those people would be accountable for the
17 cost.
18 And my overall greatest concern is that do
19 beneficiaries know what they are getting and what they're
20 giving up, the difficulty with getting back in? And since
21 this is a longer piece of time, I would be very
22 enthusiastic about some qualitative exploration in that

1 area, because just speaking from personal experience in
2 trying to help a neighbor, I thought it was impossible. I
3 just, you know, so -- and maybe it's not. Maybe it's not,
4 but I think the qualitative piece would be really
5 important.
6 I certainly agree with what's been said about
7 oncology, heart failure, the comments on post-acute,
8 vertical integration, and so there was a lot of work here
9 to do, so I'm not sure we're helping you prune.
10 The final thing I would say, it seems to me that
11 the network adequacy that -- or information that Brian
12 talked about really isn't, in a -- our calling for is
13 important, but this seems like a solution somebody with AI
14 genius should be able to come up with. This just seems
15 like it should not be that hard.
16 So the fact that that hasn't happened is very
17 curious to me, and so I think it really, you know, behooves
18 somebody in this country to make that happen, and it may
19 not be these organizations, because maybe they don't have
20 the incentive.
21 But very supportive. My biggest push would be to
22 do qualitative with beneficiaries. Thank you.

1 MS. KELLEY: Gina.
2 MS. UPCHURCH: Again, Katelyn, thanks so much for
3 this work. I'm very excited about it, and I'm excited
4 about it because I really do -- I work with consumers a lot
5 as a SHIP counselor, and I think this work is just really,
6 really critical to being able to offer a benefit that works
7 for people.
8 So three major comments. Totally agree that
9 provider directories -- I know we have something that says
10 "pay for reporting." Can we have something that says
11 "don't pay if not reporting correctly"? It seems insane
12 that we do not have directories that are working well for
13 people.
14 You all have seen the spreadsheets I pull out.
15 We can't even put that on a spreadsheet. It's all
16 electronic in an Excel spreadsheet, and we call providers
17 every year, and we can't just speak to the front desk
18 person. You have to call and speak to the contracting
19 people, and so this takes an inordinate amount of time to
20 figure out who's in network, who's not in network.
21 You call 1-800-Medicare. You call the Department
22 of Insurance in your state. They don't know networks

1 necessarily if they're depending on these directories. So
2 it's really important that directories get it right, so
3 whatever we need to do to make that happen, and again, not
4 paying for not reporting is not a bad idea.
5 We've had the Battle of the Titans in Durham, and
6 it's been very insightful to have a major -- the largest
7 insurance company fight with the largest health care
8 provider, and a miracle happened at midnight the night
9 before that it was supposed to happen.
10 So, just a family of three that I met, she has
11 pancreatic cancer. Her father has cancer. Her husband has
12 end-stage renal disease. They come to me before -- meet
13 with them the week before that's supposed to happen, these
14 two terminating their contract. The anxiety and the stress
15 that it creates for people is ridiculous, okay?
16 So for the health of people, we have to take care
17 of this. So I am plus-one-ing Tamara, Stacie, Amol. We
18 need to not allow networks to end in the middle of a
19 contract year, okay?
20 Let me tell you some things you may not know. We
21 were able to use a five-star rated plan to get people to a
22 five-star, because they were so anxious. We said, "Here's

1 your opportunity. We can put you in a five-star plan for
2 November, December." But we had to tell them, "You lose
3 your maximum out-of-pocket. So, all this you've paid
4 through the year, you don't lose your TrOOP, your drug
5 carryover, but your medical carryover, you're going to have
6 to start again," okay? They're okay with that.
7 What we didn't tell some people -- and now I got
8 an email from occupational therapists this morning asking
9 me about it. People that had vendors for their oxygen, for
10 their DME, were in process of, you know, renting and
11 leasing these things. You got to redo that whole thing for
12 the next two months, okay?
13 So you're going to a different insurance company.
14 The headache for consumers needs to be fixed. So don't
15 allow it.
16 If we do allow it, we need two special enrollment
17 periods, one that need to be handled by the plan finder.
18 The SEP that is there now that CMS can allow only goes into
19 effect after the break, after the termination. So it
20 doesn't give it anybody help to plan. It's just after the
21 termination, CMS can do it, and it's case-by-case. So you
22 have to call each person and get it approved. We don't

1 have enough time and energy to do that to help all the
2 people that were calling us.
3 So we use the five-star SEP and move people to a
4 five-star rated plan. We cannot get them back. Once they
5 figure it out at midnight on October 31st, we cannot put
6 them back in that company they were in to keep their move
7 and to keep their contracts for their DME supplies. We
8 can't. So we take the hit for trying to help people get
9 the coverage that they need.
10 So the last thing I'd say, we need a SEP. We
11 don't need to do this case-by-case. We need a special
12 enrollment period to go on the plan finder to switch them
13 with the threat, if there's a threat, so people can plan,
14 and we also need one -- if it gets worked out, we need a
15 way to get them back easily.
16 So, if it's allowed, we need two SEPs. For
17 people who do make the switch, we need to get it back and
18 to get your MOOP back and to make it retroactive to the
19 beginning. I hope we don't allow it to continue, that they
20 could break contracts in the middle of the year. If we do,
21 we have to have something that's more consumer friendly
22 than it is now.

1 This is such a critical issue for consumers, and
2 I hope -- I know it's not going to be a chapter or shared,
3 but I really do hope we pursue this because it is really
4 not consumer friendly.
5 Thanks.
6 MS. KELLEY: Cheryl.
7 DR. DAMBERG: Katelyn, thank you for this work.
8 I was really excited to see it, and I very much support the
9 direction of the work laid out in the document.
10 And I say this because -- so full disclosure. My
11 team runs the annual MA Part D Disenrollment Survey, and
12 the main reason people cite for disenrolling is coverage of
13 doctors and hospitals. So we know that this is a critical
14 problem for beneficiaries.
15 I want to plus-one on many of the comments that
16 were made, particularly Tamara's comment about looking at
17 post-acute care providers and maybe separating out
18 different types of providers that are in the network.
19 I also want to plus-one what Amol said. I know
20 you referenced ownership, but I think it will be really
21 important to unpack the types of providers that are in
22 these networks and the extent of inclusion of the

1 vertically integrated groups within a plan that has VI
2 groups.
3 I also am really interested -- and I know it's
4 going to be difficult to try to better understand
5 differences in the quality of care of these different
6 provider networks. And one of the things -- and this is
7 kind of relatively new in the literature, but I was
8 wondering. So there are some folks at Dartmouth -- Erika
9 Moen and colleagues -- who've been looking at network
10 vulnerability and looking at what they refer to as
11 "linchpin providers." And I think this kind of relates to
12 what Amol was saying about, you know, looking within
13 certain market conditions.
14 They specifically looked at oncology to see how
15 much disruption would be if a particular provider exited
16 and so kind of how vulnerable are these networks, and do
17 they disproportionately, you know, affect low-income
18 individuals in low-socioeconomic areas of the plan's
19 network area?
20 And let's see. I want to plus-one on everything
21 that Gina said. This termination issue is really critical
22 right now. It's not just, you know, one, two doctors here

1 and there leaving the MA plan networks. It's very large
2 provider systems. And I think it would be really helpful
3 to do some longitudinal work. I don't know how many years
4 you're planning on looking and what your data supports, but
5 I think the critical thing here is what these year-over-
6 year changes have been. And I think they're escalating.
7 And I hope that this is going to be sort of a kind of long
8 trajectory of work and so that we may be able to
9 incorporate multiple years to really get some sense of
10 that.
11 And then one of the things -- and again, this is
12 future-looking because I realize you are constrained in
13 time and resources -- is whether there would be any value
14 in the future of comparing within region the providers used
15 by fee-for-service beneficiaries to those used by MA.
16 I fully support the qualitative work with
17 beneficiaries. I think that in the near term could give
18 you some sense of what these market disruptions have looked
19 like, and I would, you know, specifically pick, you know,
20 as you're looking for where to conduct those focus groups,
21 at particular markets. I'm sure Gina could point to some.
22 I could point to some other ones.

1 And then, lastly, I wasn't sure whether you were
2 planning on looking at variation in the different networks
3 based on the extent of competition within a given market.
4 Thank you.
5 MS. KELLEY: Robert?
6 DR. CHERRY: Yeah. Thank you very much for
7 teeing up this work plan. I do like it, and I think it's
8 generated a good discussion.
9 I just have two modest suggestions for the work
10 plan, one qualitative, one quantitative.
11 The qualitative piece has to do with, you know,
12 the conundrum around the provider directory. Why is it
13 always inaccurate, it seems like? And you can't find the
14 right provider to the right plan.
15 You know, as I think about it a bit more, there
16 is a step that occurs before provider directory is
17 generated, and that's health plan credentialing. So it
18 works very similar to, you know, hospital credentialing and
19 privileging in the sense that providers need to submit, you
20 know, their licensure, their board certification, training,
21 et cetera, so that the health plan can credential them as
22 meeting the minimum expectations, you know, for their

1 members. And so you can generate off of these databases, a
2 provider directory.
3 So I wonder if states develop statewide
4 credentialing databases so that health plans can manage
5 their credentialing process. Then you can update that in
6 real time, because as providers come and go, you can
7 basically update your directory daily, weekly, monthly, and
8 you'd always have an accurate, you know, provider
9 directory, because it's directly linked to the health plan
10 credentialing. So I wonder if that's a potential solution,
11 something to kind of look into, you know, the feasibility
12 of whether something like that can work on a state-to-state
13 basis.
14 The other quantitative piece has to do with, you
15 know, the quality indicators and this idea of, you know,
16 whether a narrow network or not is better in terms of
17 quality. I wonder if there's also another way of looking
18 at it, too, because in prior discussions, we have talked
19 about market competition. And I wonder, however we define
20 market competition, whether or not market competition
21 actually generates better quality or not, and that could be
22 another sort of lens at looking at how health care is

1 delivered and whether we should encourage more market
2 competition if that, I think, hypothesis turns out to be
3 the case.
4 So thank you. Otherwise, I really like the work
5 plan.
6 MS. KELLEY: Okay. I have a comment from Larry
7 next. Larry has five quick points.
8 First, he strongly supports the plan to compare
9 nominal versus effective provider networks.
10 Second, he also supports the ideal of working
11 with a contractor to construct a database that would apply
12 CMS's network adequacy rules to the provider networks of
13 each plan.
14 Third, except for four states, it can be
15 prohibitively expensive to leave MA for traditional
16 Medicare. When we look at rates of beneficiaries leaving
17 MA, could we analyze both by network size and by whether
18 beneficiaries are in one of those four states?
19 Fourth, when describing plan characteristics, how
20 they vary and how that variation correlates with X,
21 consider including the following plan characteristics:
22 plan ownership category, for example, national for-profit,

1 regional not-for-profit; plan size and market share
2 nationally and in the region being analyzed; plan network
3 characteristics, for example, narrow versus broad.
4 One of the factors to be considered in
5 characterizing a plan network as being broad or narrow
6 might be whether the plan includes at least one clinical or
7 comprehensive cancer center and at least one academic
8 medical center in the region being analyzed.
9 Another correlation factor could be the extent to
10 which the plan employs, for example, Optum or is closely
11 integrated with, for example, Kaiser physicians.
12 His fifth point is, are there differences in plan
13 provider relationships in narrow versus broad networks, for
14 example, by differences in payment rates, prior
15 authorization requirements, and/or denial rates or claims
16 denials? And he asks if we can see these.
17 That's all I have from Larry.
18 And I think, Greg, did you have a comment?
19 MR. POULSEN: Yeah, thank you.
20 I think it's certainly true that MA plans vary
21 across a broad spectrum of different capabilities, quality,
22 and so forth. And although I'd love to go on another "I

1 love MA, I love capitation diatribe," I won't do that, so
2 relax.
3 But I will reiterate that there is tremendous
4 variability between MA plans, and with that, I would bring
5 up just a couple of points that have been brought up that I
6 think are worth either reiterating or maybe challenging.
7 One is the thought that was brought up that
8 there's evidence that MA plans tend to have lower-quality
9 post-acute care facilities. I don't know what studies -- I
10 haven't seen any studies one way or the other, but it goes
11 against my experience. My experience is that MA plans tend
12 to find the best of the post-acute care facilities for a
13 simple reason, and that is good-quality post-acute care
14 facility saves money by treating people effectively and
15 moving them on to a lower cost care setting. And so,
16 again, I haven't seen that data, and it goes counter to
17 what I've seen, at least in the western part of the United
18 States.
19 We also talked about access to behavioral health,
20 and I think that that's really an important one, too,
21 because, again, my experience has been -- and again, I
22 haven't seen data, and I don't know if there is data that's

1 broad -- is that MA plans, in general, have better access
2 to behavioral health than does traditional fee-for-service
3 because of relationships that have been created within the
4 networks that are created within MA or that are utilized by
5 MA, and that having those relationships in place leads to
6 access that is differentially better.
7 The other thing that I think is very, very clear
8 if we look at the cost data is untreated behavioral health
9 problems are very expensive, and so there's motivation, I
10 think, irrespective of what we might try and do from an
11 external perspective. There's internal motivation to
12 provide rapid and effective behavioral health.
13 So, again, I think in both the cases of post-
14 acute care and behavioral health, it's not to say that MA
15 does it well. It's just to say that I think it doesn't do
16 it less well than other mechanisms that are available.
17 MS. KELLEY: Tamara, did you want to add
18 something here?
19 DR. KONETZKA: Yeah. I put this in the chat, but
20 I wanted to bring up some research about the quality of
21 SNFs that MA plans contract with. And I haven't done a
22 full literature search. This is just a study I know, so

1 there's probably more written on this.
2 But David Meyers and colleagues at Brown, who do
3 a lot of work on Medicare Advantage, published a study a
4 few years ago that showed that basically people in MA end
5 up going to lower-quality SNFs than people in traditional
6 Medicare, and that that's true for highly rated MA plans as
7 well as for poorly rated MA plans.
8 So I think there is some evidence, and I totally
9 acknowledge there is certainly heterogeneity, right. But I
10 think that's why I think it's so important to just include
11 this, as you pointed to in the workplan, and dig into that
12 issue a little bit more. Thanks.
13 MS. KELLEY: Stacie, did you also want to add
14 something here?
15 DR. DUSETZINA: Yeah. Greg's comment made me
16 think that if we get to the phase of qualitative and
17 digging in a little bit more where things are kind of
18 happening, that either seem the worst or the best or just
19 counter to the average experience, those might be really
20 great places for case studies. Because it could elucidate
21 examples where, you know, this is a smaller network but a
22 very well-functioning network that's getting everything to

1 the beneficiaries, and I think those cases will be also
2 helpful for how do we make this a great experience for
3 people and make the program as good as it can be.
4 MS. KELLEY: Paul.
5 DR. CASALE: Adding my thanks for this work,
6 Katelyn, really terrific, and anticipating the work ahead.
7 Plus-one to a lot of the comments. Just a couple of
8 things.
9 One was you mentioned the plan supplies the data
10 and often it's not verified. I don't know if there's more
11 around that, like how often CMS actually tries to verify
12 that data. It always raises, at least for me, a concern
13 when it's sort of not audited in some way. So I don't know
14 historically how often they do that, but it would be
15 interesting to know.
16 And then on the MA networks there was a
17 statement, "Less costly providers are included compared to
18 the regional average." And understanding what less costly
19 providers, understanding how that's defined and what
20 represents I think would be helpful.
21 And then I just wanted to add to everyone else's
22 comments around centers of excellence. Thanks for

1 including cardiology in that, Amol. But, you know, there
2 are many, and as we look at this data -- and again, this is
3 not discounting the primary care piece of it -- but I think
4 specialists, in general, particularly geographically, there
5 are other specialties that are really critical but may or
6 may not be included in network. So as you look at the
7 adequacy of the network, sort of looking at a variety of
8 other specialists, besides what's already pointed out
9 around oncology and cardiology, I think would be
10 interesting. Thanks.
11 MS. KELLEY: Mike, that's all I have, unless I
12 missed someone.
13 DR. CHERNEW: Is anyone feeling missed?
14 [No response.]
15 DR. CHERNEW: So this is really exciting work,
16 and as I sort of said earlier, we are at the beginning of
17 this work, and I appreciate all of the directions and
18 suggestions. And I think as MA becomes more and more a
19 part of the Medicare program, understanding how it
20 functions for beneficiaries matters.
21 So I'm just going to say sort of three quick
22 things, maybe four, and leave it at that, and then we'll

1 take our break and come back. And for those at home we're
2 going to probably come back at, say, 10:25 instead of
3 10:30, since we're a little bit ahead of schedule.
4 One issue is just the accuracy of the
5 directories, and I think we all agree we would like
6 accurate directories, and anything we can do to make
7 directories more accurate is good. And frankly, I think
8 people are trying to figure out how to do that. That's not
9 a huge insight, but it seems to be a general policy
10 challenge. I think that's true.
11 The second point, which Scott mentioned, and I
12 don't know if it got enough attention, is even if the
13 directories were perfect, it is hard to know what you need
14 when you're choosing a plan. So you just can't shop and
15 say does this have my best oncologist in it, because you
16 just might not know you need that type of oncologist, or
17 whatever it is. So there's just a general question about
18 how that's going to play out. That's not an accuracy
19 issue. It's a broad shopping issue. And I think it's just
20 something to sort through.
21 Then there's a whole series of things that Gina
22 raised about the changes in the directories over time and

1 how beneficiaries experience that. Of course, we have a
2 model of Medicare Advantage that's based on choice and
3 competition, and broadly speaking -- and I will say this to
4 economists watching me -- I am in favor of choice and
5 competition. But there are challenges associated with
6 that, for a bunch of reasons. The story that Gina gave
7 about a change in network in the middle of the year, for a
8 very vulnerable family, is, of course, hopefully not
9 replicated very much because the things are shocking. But
10 just to point out, even if the change was at the end of the
11 year, the care continuity issues would not be horribly
12 easier. And because there aren't a huge number of plans,
13 it is hard to match everything you would want with any type
14 of network.
15 The alternative of no networks, as Brian pointed
16 out, has its own other set of limitations. We all live in
17 networks in a range of ways.
18 So we are stuck right now sort of trying to
19 understand where we are and what the issues are. There are
20 going to be some important choices about how we run and
21 regulate the Medicare Advantage program. We are not, and I
22 am not, going to presuppose where we will come down on

1 that. But certainly the implications of this for access to
2 care, quality of care, the experience, I will say something
3 that Gina said earlier because it's been a great interest
4 of mine. Just the administrative burden, let alone the
5 cognitive and stressful burden of doing all of this, is
6 something at a minimum we need to acknowledge.
7 Cheryl's going to acknowledge something right
8 now, and then we're going to take our break. Cheryl, go
9 ahead, because I was basically done.
10 DR. DAMBERG: No, no, no. I just wanted to note
11 something that's kind of peculiar, and maybe this has been
12 going on for many years and I just didn't understand it, is
13 that we're in the midst of open enrollment, and these
14 provider networks are not settled for 2025. And I think
15 that's hugely problematic for beneficiaries.
16 DR. CHERNEW: Yeah, right. Yeah, I think the
17 spirit of having plans using networks is sensible, as
18 everyone does, because there are reasons why you want to
19 have networks. The notion that people should know what's
20 in the networks is reasonable so people can choose. The
21 idea that you have to choose when you don't know what the
22 network is, as you say, is actually sort of problematic.

1 So again, I'm not going to presuppose how we make
2 this work better.
3 And actually, I'm going to leave this on an
4 optimistic note, which is seldom for an economist, and then
5 we're going to take our break. Luckily, there are a lot of
6 ways for us to do better. Thankfully, there's room for us
7 to add value, and we should feel good about that. I don't
8 know if that was all that soothing.
9 Actually, and I said this before, it is actually
10 -- and I said this yesterday and I'll say it again, and
11 sort of when we hear it sometimes it's easy to miss. And
12 Gina, thank you for your sort of example, because it is
13 true that these are real people facing real problems and
14 real challenges and very stressful situations, and our sort
15 of North Star is how to make sure beneficiaries have access
16 to high-quality care when they need it, at a reasonable
17 price, in a bunch of ways. And it's easy to forget that in
18 sort of conceptual conversations about how we leverage
19 competition to make the Medicare program better, which is
20 an important conceptual conversation. But we can't forget
21 the experiences that people are having when they do that.
22 And so this chapter, some of our work on prior

1 auth stuff, how we're going to think about brokers, is very
2 high on our agenda. And it is challenging because while it
3 is easy to come up with problems, some of which are
4 horrific, there are reasons why the solutions, some of
5 those things, are actually valuable in a world where, you
6 know, just letting things go without any sort of oversight
7 is also equally problematic, or maybe not equally
8 problematic, also problematic. Well, I'll defer to people,
9 not to you all to decide.
10 But in any case, this was a really rich
11 discussion. And, you know, Katelyn, usually there's like
12 three or four people there, and now, we've just got you on
13 this important topic. I'm joking because I know there's a
14 lot of other support. But really, thank you. I think
15 you're hearing a lot of enthusiasm for what you're doing,
16 and not just the quantitative work but also the qualitative
17 work of understanding. So thank you.
18 We're going to take a break now. We're going to
19 come back at 10:25. It's about seven minutes. So for
20 those at home, please come back and join us. And if you're
21 not going to join us, meetingcomments@medpac.gov -- I need
22 it on like a tee-shirt or a tie, just so I won't have to

1 always say that.

2 But anyway, we'll be back in a minute.

3 [Recess.]

4 DR. CHERNEW: Welcome back. We had a really good

5 discussion a moment ago about networks in Medicare

6 Advantage, and one of the themes of that was how important

7 behavioral health was just in general. And I think,

8 broadly speaking, we have been concerned about people's

9 access to behavioral health care. There's a lot of issues

10 there, but one of them turns out to be inpatient -- access

11 to inpatient psychiatric care.

12 So this is a place where actually had past

13 discussions. We're reasonably far along in where we're

14 going to go. So we are going to, hopefully, have a

15 discussion about a potential recommendation.

16 And, Betty, I think you're going to take us

17 through that -- oh, sorry.

18 MS. MEJIA: Good morning. In this session, we

19 will present on Medicare's coverage limits on stays and

20 freestanding inpatient psychiatric facilities.

21 The audience can download a PDF version of these

22 slides in the handout section of the control panel on the

1 right-hand side of the screen.

2 This presentation is organized as follows:

3 background on Medicare and inpatient psychiatric

4 facilities, or IPFs; beneficiaries affected by Medicare's

5 limit on care in freestanding IPFs; improving access to IPF

6 care by removing the 190-day limit; illustrative changes in

7 Medicare spending from removing the limit in 2023. And,

8 lastly, we will present language for the Chair's draft

9 recommendation.

10 We start with some background for this

11 presentation. In response to a congressional request, we

12 previously conducted an analysis of Medicare beneficiaries'

13 utilization and spending on behavioral health services

14 provided by clinicians and outpatient facilities. This

15 analysis also covered trends and issues in IPF services,

16 including information on Medicare's 190-day coverage limit

17 on stays in freestanding IPFs. These analyses were

18 published in the June 2023 report to the Congress.

19 During our March 2024 meeting, we followed up

20 with new findings on the types of care beneficiaries

21 receive as they approach and exceed the 190-day limit. At

22 that meeting, Commissioners expressed interest in a

1 recommendation to eliminate the 190-day limit.
2 Today we discuss the impact of the 190-day limit
3 on beneficiaries' access to care and the implications of
4 removing it.
5 Medicare beneficiaries experiencing an urgent
6 mental health or substance use-related crisis may be
7 treated in IPFs. These facilities can be freestanding IPFs
8 or hospital-based IPFs. IPFs provide 24-hour care in a
9 structured, intensive, and secure setting. Amongst other
10 treatments, patients may receive individual and group
11 therapy, psychosocial rehabilitation, and drug therapy in
12 the form of psychotropic medications and electroconvulsive
13 therapy. The goal of IPF care is to stabilize the
14 individual's condition and enable safe return to the
15 community.
16 IPF stays are covered under Medicare Part A and
17 payments for fee-for-service beneficiaries are made per
18 diem under the IPF prospective payment system. Services
19 from clinicians received during the stay are covered by
20 Part B.
21 Inpatient psychiatric services can also be
22 provided in general acute care hospitals, referred to as

1 "scatter-bed stays." These stays were discussed more in
2 depth during our March 2024 presentation. Our presentation
3 today focuses on Medicare-covered IPF use, though we
4 account for the use of scatter-bed stays as an alternative
5 setting for inpatient psychiatric care.
6 There are two limits of Medicare's coverage of
7 treatment in psychiatric hospitals under Part A.
8 The first is a 190-day lifetime limit on days in
9 freestanding IPFs. Inpatient psychiatric stays in
10 hospital-based IPFs or general acute care hospitals do not
11 count towards this limit.
12 The second is a reduction of inpatient
13 psychiatric days available during the initial benefit
14 period if the beneficiary is a patient in a freestanding
15 IPF on the first day of Medicare entitlement.
16 The number of IPF days available during the
17 initial benefit period are reduced by the number of IPF
18 days used in the prior 150 days. As this reduction applies
19 to beneficiaries' first benefit period only, it likely
20 affects a very small number of beneficiaries, and we do not
21 analyze the effects of this limit during this presentation.
22 These provisions were established in 1965 with the

1 implementation of Medicare when the majority of inpatient
2 psychiatric care was in state and locally-run freestanding
3 facilities.
4 The limitations were intended to restrict
5 Medicare's coverage to the active phase of psychiatric
6 treatment and to prevent states from shifting financial
7 responsibility for long-term custodial care to the federal
8 government.
9 The psychiatric hospital sector has undergone
10 dramatic changes since Medicare's implementation in 1965.
11 A de-institutionalization movement began in the 1960s that
12 was partly in response to concerns about the quality of
13 care received by long-term patients in public psychiatric
14 hospitals.
15 This resulted in the downsizing enclosure of many
16 state and locally-owned psychiatric hospitals. From 1970
17 to the early 2000s, the nationwide share of psychiatric
18 beds at state and county psychiatric hospitals declined
19 from 80 percent to 30 percent. The total number of
20 residents in state psychiatric hospitals declined by nearly
21 90 percent over the same time.
22 Capacity shifted instead to private, non-

1 government, freestanding, and hospital-based IPFs. In
2 fact, currently, most Medicare beneficiaries who receive
3 inpatient psychiatric services obtain them from private
4 entities. In 2023, 16 percent of Medicare-covered IPF days
5 were with government-run hospitals. The remaining 84
6 percent of Medicare beneficiaries received inpatient
7 psychiatric care in non-governmental private hospitals.
8 This graph shows the share of Medicare-covered
9 IPF days that were in freestanding IPFs from 2011 to 2023,
10 broken down by ownership. In 2023, about 40 percent of all
11 Medicare-covered days were in freestanding IPFs. The
12 remaining 60 percent of Medicare-covered days were in
13 hospital-based IPFs and are not shown in the graph.
14 In 2011, 8 percent of Medicare-covered days were
15 in freestanding government-run IPFs, as shown in the orange
16 portion of the left-most bar. This share declined to 4
17 percent in 2023.
18 Over the same time, the share of Medicare-covered
19 days in freestanding for-profit IPFs, shown in the dark
20 blue part of the stacked bars, rose from 23 percent to 29
21 percent. The share of Medicare-covered days in
22 freestanding non-profit IPFs was steady over the time

1 period.

2 I'll now hand the presentation to Betty to talk

3 about beneficiaries affected by Medicare's 190-day limit on

4 care in freestanding IPFs.

5 DR. FOUT: As of January 2024, about 814,000

6 Medicare beneficiaries had used at least one day in a

7 freestanding IPF since their initial enrollment in

8 Medicare. Of these, 39,000 Medicare beneficiaries had

9 reached the limit and exhausted their coverage in

10 freestanding IPFs. Another 10,000 were within 15 days of

11 the 190-day limit, and about 1,300 beneficiaries nearly

12 reached the 190-day limit in 2023.

13 Medicare beneficiaries at or near the limit were

14 among the most vulnerable. This figure shows the share of

15 Medicare beneficiaries with certain social risk factors

16 stratified by their use of freestanding IPFs. The left-

17 most navy bar shows that among Medicare beneficiaries who

18 are at or near the limit, 75 percent were disabled. The

19 orange bar shows that this share was 61 percent among

20 beneficiaries with a history of freestanding IPF use but

21 who are not near the limit. The light gray bar shows that

22 among all other Medicare beneficiaries, the share was 11

1 percent.

2 The pattern was similar for the share of

3 beneficiaries who were low-income and non-white. Eighty-

4 four percent of Medicare beneficiaries at or near the limit

5 had low incomes compared to 22 percent among other Medicare

6 beneficiaries, and 37 percent were non-white, while this

7 share was 27 percent among other Medicare beneficiaries.

8 Some beneficiaries may have other sources of

9 insurance coverage to assist with the cost of IPF days past

10 the 190-day limit. In 2023, about 9 percent of MA plans

11 offered coverage of additional IPF days as a supplemental

12 benefit.

13 For dual eligible Medicare beneficiaries,

14 Medicaid may provide additional coverage. However, the

15 Congress prohibited federal matching funds for some

16 Medicaid beneficiaries in hospitals that have 16 or more

17 beds and primarily treat mental health conditions or

18 substance use disorders. This is referred to as the "IMD

19 exclusion."

20 The IMD exclusion only applies to non-elderly

21 adults ages 21 to 64. However, many states have made use

22 of exceptions, such as Section 1115 demonstration waivers,

1 to provide some coverage for non-elderly adults and IMDs.
2 Given this, many Medicare beneficiaries at or
3 near the limit may lack alternative coverage for services
4 beyond the 190-day limit and freestanding IPFs.
5 Among Medicare beneficiaries at or near that 190-
6 day limit, 5 percent were enrolled on an MA plan with
7 supplemental IPF benefits, as shown in the far left dark
8 blue portion of this chart. Another 17 percent were dual
9 eligible beneficiaries aged 65 and older who would likely
10 have Medicaid coverage of additional IPF days, shown in
11 orange. Together, these 22 percent were likely to have
12 alternative coverage beyond the limit.
13 The middle gray section of this bar shows that 60
14 percent of these Medicare beneficiaries were dual eligible
15 and younger than age 65 and therefore subject to the IMD
16 exclusion. The 18 percent teal "all others" category is
17 composed of non-dual eligible Medicare beneficiaries who
18 were not enrolled in the MA plan with IPF supplemental
19 benefits. Together, these 78 percent of Medicare
20 beneficiaries at or near the limit may lack coverage for
21 additional IPF days. This is an approximation, as some
22 dual eligible beneficiaries may live in a state with

1 exceptions to the IMD exclusion.

2 We now discuss improving access to IPF care by

3 removing the 190-day limit.

4 Patients who need long-term inpatient psychiatric

5 services may have difficulty accessing IPF care. Private

6 IPFs typically care for patients needing shorter stays,

7 while public IPFs often serve patients needing longer-term

8 care and patients without coverage, and demand for public

9 psychiatric hospitals exceeds supply.

10 Private psychiatric hospitals serve as an

11 alternative place of care but may be less willing and able

12 to take patients who have reached the 190-day limit and

13 lack coverage.

14 In interviews conducted with a small set of IPFs

15 last year, most interviewees considered the 190-day limit

16 to be insufficient coverage, especially for patients with

17 chronic mental illness. They noted that the limit

18 increased the difficulty of finding suitable post-discharge

19 placement options.

20 Beneficiaries may obtain inpatient psychiatric

21 care from hospital-based IPFs, since they are not subject

22 to the limit, but the number of hospital-based IPFs has

1 declined over time.

2 To better understand how the use of inpatient
3 psychiatric services is affected by the 190-day limit, we
4 compared service utilization by beneficiaries at or within
5 15 days of reaching the limit, referred to as
6 "beneficiaries affected by the limit," to a comparison
7 group of similar beneficiaries who had 16 to 90 days
8 remaining and therefore would be less or not affected by
9 the limit.

10 To enhance comparability of the two groups, we
11 examined only fee-for-service beneficiaries with at least
12 one freestanding IPF stay in the prior five years.

13 We found the two groups to be relatively similar
14 in shares of beneficiaries who are disabled, have low
15 incomes, or are non-white.

16 We found that Medicare beneficiaries who are
17 affected by the 190-day limit appear to substitute
18 freestanding IPF care for psychiatric services in hospital-
19 based IPFs and general acute care hospitals.

20 As shown in the first row of the table,
21 beneficiaries affected by the limit had an average of 2.4
22 covered days in a freestanding IPF, compared with 7.6

1 covered days for the comparison group, suggesting an
2 increase of 5.2 freestanding IPF days on average if the
3 limit were removed.
4 On the other hand, the second and third rows of
5 the table show that beneficiaries affected by the limit had
6 more covered psychiatric days in hospital-based IPFs and
7 general acute care hospitals than what the comparison group
8 had, indicating there could be some substitution away from
9 these types of care if the limit were removed.
10 The last row of the table shows that the
11 comparison group had an overall average of 2.2 more days of
12 covered inpatient psychiatric care than those affected by
13 the limit, which indicates an overall increase if the limit
14 were removed.
15 We now show an illustrative change in Medicare
16 spending from removing the 190-day limit in 2023.
17 We start with the calculated changes in
18 psychiatric hospital covered days per beneficiary shown in
19 the prior slide, which are copied to the first column of
20 this table.
21 We then computed the average per diem Medicare
22 payment for beneficiaries not affected by the limit for

1 each type of inpatient psychiatric care, as shown in the
2 second column.
3 We multiplied the two columns to obtain the
4 average change in the fee-for-service Medicare payment per
5 beneficiary for each setting. By totaling the resulting
6 amounts in the third column, we calculate that Medicare
7 would spend an additional $1,260 per beneficiary at or near
8 the 190-day limit if they were to change their psychiatric
9 hospital use to be like those beneficiaries in the
10 comparison group.
11 Multiplying this illustrative $1,260 per
12 beneficiary by the total number of fee-for-service Medicare
13 beneficiaries at or near the limit yields approximately $40
14 million in increased spending on inpatient psychiatric
15 services from eliminating the 190-day limit.
16 Payments to MA plans would also increase,
17 reflecting the additional care plans would be required to
18 cover for their MA enrollees.
19 The actual change in federal spending could be
20 higher or lower depending on a variety of considerations.
21 Medicare spending on other services such as Part D
22 prescription drugs and Part B clinician services might also

1 be affected by removing the limit, though the direction of
2 the impacts is unclear. Freestanding IPFs may change
3 behavior in terms of accepting more Medicare patients and
4 keeping them for longer periods of time if the limit were
5 removed, which would increase spending.
6 Eliminating the 190-day limit would decrease
7 federal Medicaid matching payments for dual eligible
8 beneficiaries who exceeded that 190-day limit and received
9 coverage through Medicaid. However, because of the IMD
10 exclusion, the extent of the rejection would depend on
11 whether states have exceptions to the IMD exclusion.
12 The existing Medicare criteria and benefit
13 structure for IPF and Part A hospital services would not
14 change if the 190-day limit were eliminated. Two relevant
15 components are the IPF active treatment eligibility
16 criteria and the hospital benefit period.
17 The eligibility criteria for Medicare IPF
18 coverage requires that Medicare patients have a psychiatric
19 principal diagnosis and need active treatment of an
20 intensity that can be provided appropriately only in an
21 inpatient hospital setting.
22 The Medicare Part A covered hospital benefit

1 period is limited to 90 days with deductible and copayment
2 and 60 non-renewable lifetime reserve days. A new benefit
3 period starts only when the beneficiary has been discharged
4 for at least 60 consecutive days. Even in the absence of
5 the 190-day limit, beneficiaries using IPFs would still be
6 subject to the structure of the benefit period and total
7 lifetime reserve days.
8 We now present the Chair's draft recommendation.
9 The Chair's draft recommendation reads: "The Congress
10 should eliminate the 190-day lifetime limit on covered days
11 in freestanding inpatient psychiatric facilities and the
12 reduction to the number of covered inpatient psychiatric
13 days available during the initial benefit period for new
14 Medicare beneficiaries who received care from a
15 freestanding inpatient psychiatric facility on and in the
16 150 days prior to their date of Medicare entitlement."
17 The implications of the Chair's draft
18 recommendation is an increase in spending relative to
19 current law. We expect this recommendation would increase
20 Medicare beneficiaries' access to inpatient psychiatric
21 care at freestanding IPFs by increasing freestanding IPFs'
22 willingness to treat beneficiaries with chronic and severe

1 behavioral health conditions.

2 Eliminating the 190-day limit would improve

3 access to IPFs for some of the most vulnerable Medicare

4 beneficiaries. However, more work is needed to ensure that

5 Medicare beneficiaries are receiving high-quality inpatient

6 psychiatric care, especially in light of recent

7 investigations by the Department of Justice on care

8 provided by some of the facilities owned by two large IPF

9 chains.

10 Allegations included improperly detaining

11 patients who are not eligible for inpatient care; billing

12 for services not provided; inadequate staffing, training,

13 and supervision of staff; and the improper use of

14 restraints and seclusion.

15 IPFs serve vulnerable patients with complex

16 needs, and greater transparency is needed to understand the

17 services provided at IPFs, how they should vary based on

18 beneficiary characteristics, and the quality of care

19 provided.

20 In particular, we have noted in the past that

21 there is little information on the mix and types of staff

22 employed by IPFs and how staffs spend their time across

1 tasks. Staffing data could provide essential insights into
2 the variation in costs and quality of care across
3 providers, enabling CMS and Medicare beneficiaries to
4 better understand the services they are purchasing.
5 CMS is currently working on improvements to the
6 IPF prospective payment system and quality reporting
7 program. These include greater enforcement in the
8 reporting of ancillary services, which we have previously
9 found to be poorly reported by certain IPFs.
10 This information is needed to calculate the cost
11 of providing IPF care and understand the types of services
12 beneficiaries receive.
13 IPFs would also need to collect patient
14 experience survey data from IPF patients upon discharge.
15 Items from the survey will be used to construct quality
16 measures.
17 IPFs will also begin to collect standardized
18 patient assessment data upon admission to the IPF. This
19 would include information on resources and interventions
20 needed and patient characteristics, which can be used to
21 improve the payment system and to better measure the
22 quality of care.

1 We will continue to monitor the use, spending,
2 and quality of care in IPFs.
3 We'll answer any questions you have and take your
4 feedback, and I hand it back to Mike now.
5 DR. CHERNEW: Thank you, Pamina and Betty. That
6 was terrific. I think we're going to just jump into the
7 Round 1 queue, and I think Robert is first.
8 DR. CHERRY: Yeah, thank you for this report.
9 Very nicely done. My question centers around Table 4 in
10 the larger report, which is a more detailed version of the
11 slide that was presented. And it basically demonstrates
12 how you came up with the $40 million of additional
13 spending. It seems relatively small, because the number of
14 covered days that would incrementally increase across the
15 board is 2.2 days.
16 And so I guess my question is, I'm wondering if
17 it's underestimating the total number of days. So for
18 example, if there was a beneficiary that was at 170 days
19 and they maxed out, did you just count only 20 days, even
20 though they may have needed a full stay of 30 or 40 days?
21 I wonder if perhaps a better way of calculating what the
22 true data is among these beneficiaries to see how many are

1 actually converted to Medi-Cal, and then follow them and
2 see how many extra days they actually utilized. I'm sorry,
3 I said Medi-Cal. I'm from California -- Medicaid, and were
4 converted to Medicaid, and then extrapolate from there
5 where the true cost would be.
6 Because I think that doing this to a comparison
7 group between 16 to 90 days may be just grossly
8 underestimating that the total number of covered days is
9 2.2.
10 DR. FOUT: I think that's a great point, and I
11 think we acknowledge that 16 to 90 day beneficiaries could
12 still be affected by the limit. We have conducted other
13 simulations of days, like further away from the limit. I
14 think it's harder for us to go and find out when they
15 enrolled onto Medicaid. And partially it's also a
16 limitation of the 190-day limit enrollment data that we
17 have insight into exactly when they reached that limit. We
18 just know it's sort of who has reached it for a particular
19 year. So it could've happened decades ago.
20 So for sure this is an approximation of what the
21 impacts could be, and there could be others that we're not
22 considering.

1 DR. CHERRY: Yeah, but it's very possible that,
2 who knows, maybe of these 1,300 beneficiaries they go on to
3 utilize 250, 300 days over the course of their lifetime,
4 not necessarily 2.2 per year.
5 DR. FOUT: Right.
6 DR. CHERRY: It's something to think about,
7 because I think the spend is actually larger. That's my
8 gut check on this, than actually what's being calculated.
9 MS. KELLEY: Tamara.
10 DR. KONETZKA: Yeah. Two quick questions and one
11 very related to Robert's question just now. And I'm
12 wondering, I agree completely with that suggestion, and I'm
13 wondering if you could even get -- I mean, you're not going
14 to like dig into the Medicaid claims probably to try to
15 find out who is getting that service or who is
16 transitioning to Medicaid. But maybe you could get some
17 gross data on utilization, just to sort of give some bounds
18 on that estimate, if there are people who then reach the
19 limit and transition to the different payer.
20 But anyway, that was not my question. The
21 related question was, two of them. I want to make sure I
22 understand the timing of your analysis. So people who

1 reach the limit that was like prior to the beginning of
2 2023. You said any time prior to the beginning of 2023.
3 And then the utilization you measured during 2023, any
4 time, and not after whenever. That's when your data ended,
5 right? So it's like the annual utilization having met the
6 limit --
7 DR. FOUT: That's right. It's just the annual
8 number.
9 DR. KONETZKA: Right. The other question, I want
10 to make sure I understand the Medicaid coverage. So I
11 think the 21 to 65 is sort of clear in that it's so limited
12 by the IMD restriction. For people who are duals or people
13 who are over 65, once they reach the Medicare limit, they
14 can transition to Medicaid. But are the requirements sort
15 of analogous to what happens with you get on Medicaid for
16 long-term care in that you have to meet the incoming asset
17 requirements of the state plus sort of demonstrate need for
18 this kind of care?
19 DR. FOUT: You would have to qualify for
20 Medicaid, and in most states if you've qualified for
21 Medicaid and you're over age 65, will cover your inpatient
22 psychiatric days.

1 DR. KONETZKA: And they'll cover that in full
2 then.
3 DR. FOUT: Yes. But I think there is some
4 variation by states. Not every single state. It's not
5 considered like a mandatory federal requirement of Medicaid
6 to provide that for their beneficiaries, but most states
7 do.
8 DR. KONETZKA: Okay. Thanks.
9 MS. KELLEY: Gina.
10 MS. UPCHURCH: Yeah, thank you both for this
11 information. Very useful line of work here.
12 Is there any circumstance that we can think of,
13 and I never knew that, you know, welcome to 65 or welcome
14 to being disabled, you know, and you're going to have a
15 wait period to get your Medicare, and it's retroactively
16 going to take 150 days' benefit and look at it and say
17 we're going to pay for that and you have less days moving
18 forward. Is there any other circumstance where Medicare
19 does that?
20 DR. FOUT: Not that I know of.
21 MS. UPCHURCH: Yeah, 1965, behavioral health,
22 mental health discrimination. Yeah, it's alive and well.

1 So my second question is really built off
2 Tamara's question a little bit and Robert's. I mean, I
3 think everybody knows this, but dual eligible does not mean
4 you have full benefit duals, that you have Medicaid. You
5 can have a Medicare savings program that just pays your
6 Medicare Part B premium for you. So that's the MQB. I'm
7 going to make Larry's head blow up, but the MQB-E.
8 So I'm assuming a lot of states obviously don't
9 allow this extension of behavioral health. But just to
10 make clear with people, just because you're dually eligible
11 doesn't mean you would have this potential extension. Am I
12 right about that?
13 DR. FOUT: That's right. The way we described it
14 here was if you had any --
15 MS. UPCHURCH: Or full benefits.
16 DR. FOUT: -- partial, or yeah. But we did not
17 look at QMB, MQB-E part of it.
18 MS. UPCHURCH: Okay. And I don't know this, but
19 I'm imagining, just like the southern states which are more
20 heavily more diverse, more people of color, we were really
21 slow to expand Medicaid. Some states still have not. And
22 I'm assuming that the Medicaid -- and I don't know this to

1 be true, but I would like to know, do we know if the
2 Medicaid benefits that might extend behavioral health,
3 mental health services in the inpatient setting are less or
4 more likely in those southern states?
5 DR. FOUT: I don't know that off the top of my
6 head. We could look into that.
7 MS. UPCHURCH: That would explain some of the
8 racial disparities.
9 DR. FOUT: Yep.
10 MS. UPCHURCH: Thanks.
11 MS. KELLEY: Scott.
12 DR. SARRAN: Yeah, great work. I think it tells
13 a very cogent story. One thing I didn't see, unless I
14 missed it, and I'm looking in the background reading at
15 Table 2, in terms of the characteristics of the population
16 who is near or at the limit, or weren't at the limit but
17 had a history of freestanding IPF is with more description
18 of their diagnoses. I'm assuming these are either people
19 with schizophrenia, schizoaffective, or bipolar disease.
20 But I think it's worth teeing that.
21 And I'm also interested in terms of the diagnoses
22 how many of these had what's called dual diagnoses, meaning

1 a substance use disorder as well. Because I think that
2 helps illuminate the challenges of the population we're
3 dealing with.
4 MS. KELLEY: Paul.
5 DR. CASALE: Yeah, thank you for terrific,
6 terrific work. Just a quick clarifying question. I just
7 want to make sure. I thought it said that for 2023, there
8 were about 1,300 beneficiaries who reached the limit. Do I
9 have that right? And then in 2024, it's 39,000?
10 DR. FOUT: So that 1,300 is the number of
11 beneficiaries that newly reached the limit, as of 2023. So
12 in 2022 they still had some days remaining. But
13 cumulatively, about 40,000 had reached the limit as of
14 2023. They might have just reached the limit before 2023.
15 DR. CASALE: Okay. So there wasn't this sort of
16 tremendous increase --
17 DR. FOUT: No, no.
18 DR. CASALE: No. Okay. I misinterpreted that.
19 All right. Thank you.
20 MS. KELLEY: That's all I had for Round 1, unless
21 I've missed anyone. I think Paul Masi wanted to get in
22 here for a sec.

1 MR. MASI: Yeah, just real quick. Thank you for
2 this conversation. This is very helpful for us. I wanted
3 to add a note on the discussion around spending, that of
4 course CBO will ultimately be the arbiter of what the
5 estimated budgetary effect is. And I wanted to clarify
6 that this was very much just intended to give Commissioners
7 a rough sense of the ballpark. And, of course, whenever
8 we're talking about an increase in Medicare spending,
9 that's something we take seriously.
10 But just thinking about the relative magnitudes,
11 you know, we've talked about other types of recommendation
12 in the session that were denominated in maybe billions or
13 larger numbers, and this was just intended to give
14 Commissioners a rough sense of what the spending
15 implication might be for this. But we're happy to continue
16 thinking about that as you contemplate this recommendation.
17 DR. CHERNEW: And in that spirit, we're about to
18 start Round 2. I think Stacie is going to be first. But
19 beforehand, just to be clear, because we're going into a
20 discussion of a recommendation, I am going to make sure
21 that everybody at least gives a simple, one-phrase sentence
22 of what their view is, so we have a sense and the public

1 has a sense of what people are thinking. So Stacie.

2 DR. DUSETZINA: So I'll with a sentence. I am

3 incredibly supportive of the draft recommendations. To

4 Paul's point, even if we're off by quite a bit, the

5 magnitude of spending we're talking about for improving

6 care for some of the most vulnerable people in the Medicare

7 program, this feels like the most no-brainer of many

8 discussions that we've had.

9 And especially when you look at the

10 characteristics of people who are butting up against that

11 limit. It's the truly vulnerable population that I think

12 we need to support better. And certainly things have

13 changed since 1965. We would hope we can do better.

14 I just wanted to also put in a plug for the

15 workstream that you described and the information on

16 additional work on the quality of care. It's great to see

17 what we're going to have some measures and some better

18 patient surveys and things like that. So I'm very excited

19 about that.

20 I think in other comments that have come up

21 through other sessions it's clear that, in addition to

22 inpatient psychiatric care there is certainly a need to

1 think about behavioral health care access for Medicare
2 beneficiaries much more broadly. So I hope that we'll be
3 heading in that direction as well.
4 But this feels like a truly no-brainer of a
5 policy recommendation. Thank you so much for this great
6 work.
7 MS. KELLEY: Scott.
8 DR. SARRAN: Yeah. I just want to go on record
9 saying I support the Chair's draft recommendation, and I
10 think we're dealing with something that's archaic in its
11 genesis and is irrelevant, essentially, in terms of its
12 dollars. And as noted in Slide 11 and in our discussion a
13 moment ago, this is an extremely vulnerable population, and
14 we should remove any barrier, however small or infrequent
15 that barrier is, to the ability for them to access care
16 that they need, in whatever setting.
17 Lastly, although this is just completely out of
18 bounds for our body of work and I'm not suggesting teeing
19 it up, I am struck by every time I think about this
20 population how vulnerable they are and how poorly served
21 they are by the gaps between Medicare and Medicaid. In
22 some ways, if we could do the wave-a-magic-wand thing, it

1 might be to enable Medicare access at a certain point in
2 time, similar to how ESRD enables Medicare access, and then
3 have those beneficiaries auto-enrolled in sort of a FIDE C-
4 SNP, if you will.
5 Because having worked in this space, managing
6 between the two benefit plans and the community resources
7 that Medicaid is often much closer to and better at working
8 with, it's just horrible. And clearly the beneficiaries
9 who are in that position have no reasonable ability to
10 navigate that. And maybe that's a point in time years from
11 now, when maybe we're going to finish the work around
12 institutionalized beneficiaries, we take on a more broad
13 body of work around this. Again, this is a very challenged
14 and vulnerable population. Thanks.
15 MS. KELLEY: Cheryl.
16 DR. DAMBERG: I also want to go on record as
17 supporting the Chair's draft recommendations. As others
18 have noted, this is a particularly vulnerable population
19 who they have really critical care needs, and making this
20 policy change will help them get access to the care that
21 they need.
22 I also want to sort of plus-one on all of the

1 future looking work around better understanding of the
2 quality of care that's delivered to this population. You
3 know, it's concerning that we don't really have a good
4 handle on what types of services are being provided and
5 whether quality differs between, say, hospital-based versus
6 freestanding inpatient facilities.
7 And just trying to get some sense of whether the
8 care needs of this population are being met in a way
9 related to the appropriateness of care and whether it's
10 improving their outcomes. I think that's essential.
11 MS. KELLEY: Tamara.
12 DR. KONETZKA: Thanks. This is mostly going to
13 be very repetitive, but I'll go on record saying I also
14 think this is a no-brainer. I'm very supportive of these
15 recommendations. I think that the sort of original reasons
16 for providing these limits or including these limits just
17 don't really apply anymore, this avoiding the cost-shifting
18 from state budgets, now that the providers of this care are
19 pretty different, or concerns about moral hazard. I think
20 it's just not something we should worry about here.
21 And so, yeah, it should definitely be changed.
22 It's a small number of beneficiaries, not actually that

1 much money, but a very vulnerable population, and I think
2 this change would help.
3 And then I'll also double down on people's
4 support for looking at the quality of care. You know, I
5 think the institutionalization, for all its problems, sort
6 of happened for a reason, and there were a lot of concerns
7 about people staying in state-run psych facilities for a
8 long time, with poor quality of care, you know, decades and
9 decades ago. And we want to make sure we don't sort of
10 come full circle and go back to that with Medicare paying
11 for it now.
12 So it's very exciting that it seems like there
13 are a lot of new quality measures that will be possible
14 over the next few years, and I'd encourage us to keep
15 following that and study the quality. Thank you.
16 MS. KELLEY: Gina.
17 MS. UPCHURCH: Thanks again so much for this
18 work. I also want to go on record as supporting the
19 Chair's draft recommendations.
20 One thing, in looking at the future work, I'm
21 very excited about that. I hope we'll look at chemical
22 restraints also. I don't think I saw that necessarily

1 mentioned. But we know traditionally that's been a much
2 bigger problem. It's been getting better, but just making
3 sure we're paying attention to that.
4 And then the other thing I would just say is I
5 hope this doesn't interject more challenge to some people
6 in Medicare Advantage plans as opposed to traditional
7 Medicare. I think most of you all know if you're obviously
8 in traditional Medicare you potentially have this
9 deductible when you go to the hospital, inpatient stay,
10 behavioral health, mental health, or, you know, regular
11 inpatient facility. But many people have secondary
12 coverage. But if you're in a Medicare Advantage plan,
13 there is a daily rate. So there's a daily rate anywhere
14 from one to five days, usually sometimes six, seven, of
15 $300, $400 a day.
16 So I do worry that people in Medicare Advantage
17 plans have even more of a hesitation potentially to be an
18 inpatient anywhere, and particularly if they're vulnerable
19 for inpatient stays. Of course, if you're dual that's
20 different, but if you're not a dual, if your income is just
21 above that, there may be some slight differences there.
22 Thanks again for the work.

1 MS. KELLEY: Greg.
2 MR. POULSEN: Yeah. We're sort of going down the
3 line here, and I would reinforce the very positive comments
4 in terms of the recommendation and the commendation for
5 great work. Thanks so much.
6 I did talk to staff a little before the meeting
7 just to mention that I thought that there was something
8 that we could think about that would be hugely important.
9 We know of the inability to place people after inpatient
10 care. That was brought out in the presentation. And I
11 think that that whole idea is something that when we talk
12 about, Scott and others have mentioned, follow-on work that
13 makes sense, that whole limitation I think is enormous and
14 is something that could be dealt with in a positive way.
15 And basically in other key areas of health care -
16 - cardiac care, neurological care, orthopedic care -- we
17 have in intermediate capabilities, rehabilitation and SNFs,
18 that do an enormous amount of good. They take people out
19 of a very high-cost setting, put them into a lower-cost
20 setting, but help them to make progression.
21 And we really lack that in behavioral health.
22 People can go from the highly intense, very expensive

1 inpatient setting to, good luck, and get some care. It
2 should be no surprise that we have people often fail that
3 and end up back in the hospital, or worse, and end up in
4 dramatic life or death situations, death situation often.
5 So something that I think we could contemplate,
6 and when I talked to our mental health colleagues,
7 something that they think would be an enormous benefit
8 would be the equivalent of rehabilitation, post-acute care
9 for people with behavioral health issues.
10 Something that would be substantially less
11 expensive than the hospital setting, but would provide the
12 support and capability to help people to basically
13 rehabilitate themselves, and to be rehabilitated in much
14 the same way that we do for people in other medical
15 situations. That would be enormously cost effective, I
16 think, as well as enormously humane for the treatment of
17 some of the, as all people have said, this most vulnerable
18 of populations. We do that, interestingly enough, very
19 effectively for adolescents, but we haven't figured out how
20 to do that for adults, and seniors in particular.
21 So thanks again for great work.
22 MS. KELLEY: Brian.

1 DR. MILLER: Thank you for this work.
2 One small change I would make before I get to my
3 broader comments, on page 21, it suggests that IPFs should
4 be sending in staffing information and time spent on tasks
5 to CMS. I don't think -- you know, I don't support that.
6 I don't think that we should do that. I don't think CMS is
7 in the business of regulating the intricate details and
8 staffing roles of every clinical organization. I don't
9 think that that's a good idea for the marketplace, because
10 that would encase current care models, which I think we all
11 would agree across many settings, regardless of the, you
12 know, various administrators' best efforts that those care
13 models are frequently have a lot of room for improvement.
14 So I think we should remove that language on page 21,
15 because we want to focus on outcomes in the Medicare
16 program, not regulating the minutia of how we get there.
17 So I have cared for this population, obviously,
18 as a hospitalist, and I can say that there are lots of
19 challenges with getting these patients to inpatient
20 psychiatric care. And they often sit in acute care
21 hospitals on hospital medicine floors, not just for days
22 but for weeks. And it's very challenging, and many of

1 these patients, understandably, don't want to be in the
2 hospital waiting to go to the psychiatric hospital. Some
3 of them don't necessarily want to be in the hospital,
4 regardless, but need to be in the hospital.
5 And this population, to Scott's point, often has
6 dual diagnoses. They have medical issues, which often go
7 unmanaged, because we haven't fully addressed their mental
8 health issues. I'm generally supportive of the idea of
9 getting them access, more access to inpatient care.
10 I think there are a couple of things for us to
11 keep in mind. One is this is a population that might not
12 get better under current medical therapy. So this is a
13 population -- it's a small population, but they're going to
14 be in and out of the hospital a lot. And many of us, who
15 are clinically active out in the world, see these folks and
16 know them. Depending upon their health status, sometimes
17 they get to know us, and sometimes they don't. They might
18 not remember. So it's a very vulnerable and challenging
19 population.
20 So I think we should be conscious of the fact,
21 this population, to some degree, is like the ESRD
22 population in that we might not think it's a big issue

1 right now in terms of physical issues. Many years down the
2 line, it could turn into a big one. I'm not saying that
3 that's a problem. I'm just saying that's something we
4 should keep in the back of our head. This population needs
5 access to care, regardless, because it's the right thing to
6 do.
7 I think the other thing that we should think
8 about, given that 84 percent of these folks are dual
9 eligibles -- and for their other care, Medicaid serves as
10 their WRAP, which is a state-federal split. Have we looked
11 into -- and I'm somewhat familiar with the statutes around
12 IMD exclusion and Medicaid. Maybe that's something that
13 needs to be addressed.
14 And I'm not saying that it's not the Medicare
15 program's responsibility. It's not a, you know, brother-
16 sister fight between Medicare and Medicaid; you know, it's
17 my turn to, you know, mow the lawn or not. I'm generally
18 supportive of this recommendation.
19 I think in the broader picture is -- I think that
20 there are opportunities for our sibling to think about --
21 our program sibling to think about doing some things
22 differently.

1 Thank you.
2 DR. CHERNEW: I just wanted to make sure I got
3 your just overall view of the recommendation.
4 DR. MILLER: I'm generally supportive, but I
5 think that we should also add some language that, you know,
6 MACPAC should look at this issue, if they haven't already
7 recently.
8 Even if we fix this for the Medicare population,
9 there are other problems with this population in Medicaid.
10 MS. KELLEY: Betty?
11 DR. RAMBUR: Thank you.
12 I support this recommendation. I think it's an
13 example of the important work of modernizing Medicare.
14 I had a different perception of the piece of the
15 mix. I actually think it's very important to look at the
16 mix and types of staffing. So I read that piece
17 differently, because the bulk of these are for-profit. So
18 there is a tremendous incentive to keep the numbers of
19 staff as low as possible and the skill mix less.
20 So I think the statement that you had about
21 monitoring use, spending, and quality is extremely,
22 extremely important, because we have a very, very

1 vulnerable population here.
2 I support all the comments about a broader look
3 down the line as how we think about this important
4 population, and that includes Greg's comment on post-acute.
5 So thank you very much for this really valuable
6 work.
7 MS. KELLEY: Paul?
8 DR. CASALE: Yeah. Thanks again for this work.
9 I also support the recommendation and really apologize for
10 being repetitive, but I just wanted to also emphasize this
11 placement issue. I think several of my Commissioners
12 brought it up. It's such a huge issue in my experience.
13 Brian said weeks or months. I've seen years.
14 You know, I mean, it's really profound, and I think
15 thinking about that going down in the future, I think it's
16 really important. So thank you.
17 MS. KELLEY: I was about to call on Larry before
18 I realized that that is me.
19 Okay. I will read Larry's comment. Larry
20 supports the recommendation. It would be useful to have
21 some estimate of the non-behavioral potential savings from
22 receiving adequate inpatient psych care. For example, take

1 beneficiaries at or near the limit and compare spending on
2 their care for non-psych conditions over the 30 days
3 following discharge to spending for patients not near the
4 limit.
5 He thinks it's quite plausible that the savings
6 from having had extra, quote/unquote, "inpatient care"
7 would exceed the spending on that care.
8 I have Kenny next.
9 MR. KAN: Thank you for an excellent chapter.
10 I support the recommendation due to the
11 insignificant cost for a vulnerable population.
12 Some suggestions for improvement for the chapter.
13 I am a plus-one on Greg's point about the lack of subacute,
14 you know, for this vulnerable cohort of patients.
15 And then one of the things that we can shed some
16 color on in the chapter is to ensure, provide more context
17 and color why, even though we support this, it doesn't
18 constitute a precedent for loosening any benefit
19 limitations in other types of other sites of care. You
20 know, some of the benefit limit, like either the 100-day
21 benefit periods or, you know -- that would be very helpful.
22 But thank you. Nice job.

1 MS. KELLEY: Robert?
2 DR. CHERRY: Yes. Thank you very much for all
3 the information.
4 You know, whether this is a $40 million spend or
5 a $20 million spend or a $100 million spend, it really
6 doesn't matter. This is an almost 60-year antiquated rule,
7 and we just don't think about mental health in this way in
8 terms of this particular cap.
9 So, you know, my mind's unchanged since the first
10 time I heard this, which is that it needs to go away. I
11 think the analysis is important because it's not a $1
12 billion problem, because then we will be having a different
13 kind of conversation, I'm sure. So, you know, very
14 supportive of this.
15 I think if it does get enacted, and I hope it
16 does, you know, some sort of retrospective look to
17 understand what the actual spend is would probably be
18 helpful over time.
19 All right. Thank you.
20 MS. KELLEY: Mike, that is all I have for Round
21 2, and Amol has not said anything.
22 DR. NAVATHE: I'm supportive of the

1 recommendation.

2 [Laughter.]

3 DR. CHERNEW: Amol has spoken.

4 Yeah. I -- sorry. This is -- I actually think -

5 - I do want to say I think it is actually a really

6 important issue, and I think the -- I just want to

7 emphasize something that I think is -- that seems to be

8 pretty universal amongst all of you, which is there's

9 general support for this recommendation, which obviously

10 I'm happy about. And there's widespread acknowledgment

11 that this recommendation is one thing to do in what is a

12 really challenging area, and there's a lot of other things

13 to do. And some of those other things might be MedPAC,

14 MedPAC Medicare things, and some of those other things

15 might be not MedPAC Medicare things. But I think it is

16 very clear that working to make sure that this population

17 has access to the care that they need, even if we can't,

18 you know, be sure, you know, how we're going to get them

19 better or what we're going to do, I think it is just

20 important. This clearly seems to be an unnecessary

21 impediment to care that we want to promote people's access

22 to.

1 So we will work through the chapter. This will
2 come back again, and if I'm right, we're thinking January
3 for a vote. But that is all good.
4 For those of you at home that want to weigh in
5 one way or another on this, please reach out to us at
6 MeetingComments@MedPAC.gov or any one of the other ways you
7 can send emails. We really do want to hear from you.
8 And to Pamina and Betty, thank you so much for
9 your work here. I think you hear a lot of support amongst
10 the Commissioners and appreciation for all that you've
11 done. So, again, thank you.
12 We are now going to adjourn our November meeting,
13 and we will be back in December.
14 So, again, thanks again. Everybody try to fly
15 safe. See you after Thanksgiving. Try to fly safe or
16 train safe. But, anyway, have a happy, healthy
17 Thanksgiving is probably a better thing.
18 [Whereupon, at 11:22 a.m., the meeting was
19 adjourned.]
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22