MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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12:01 p.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[12:01 p.m.]

DR. CHERNEW: Welcome everybody to our first meeting of the 2024-2025 MedPAC cycle. We're thrilled to have you. We're excited to welcome our new Commissioners, Josh and Paul. So welcome to your first public session.

As you may see from our varied backgrounds, we are actually all really virtual, but as we've had experience, I think we can make this work. We are going to jump in with the Medicare context chapter, which appears every year in our March report, and Rachel is going to lead us through that.

So, Rachel, I am turning over to you.

MS. BURTON: Welcome. In this presentation, I'll provide some contextual information to serve as a backdrop for Commissioner discussions over the coming cycle. This information will be included in our March report to the Congress, along with our recommended updates to 2026 payment rates. A PDF of these slides is available from the webinar's control panel on the right side of your screen.

In this presentation, I'll touch on recent

spending trends, factors that are expected to influence projected Medicare spending in the coming decade, and the financial status of Medicare's two trust funds. I'll also talk about beneficiaries' enrollment options, financial obligations, and health care disparities. And I'll talk about the health care workforce and Medicare's role in shaping it.

First, some recent spending trends. In 2022, the U.S. spent $4.5 trillion on health care, equivalent to 17 percent of the country's GDP. Since national health care spending usually grows faster than GDP, it has made up an increasing share of GDP over time.

Spending temporarily diverged from this historical trend during the recent pandemic, sharply increasing as a share of GDP in 2020, before falling just as sharply in 2021 and 2022, due to a mix of temporary spending increases by the federal government early in the pandemic, patients and clinicians delaying and then resuming care, and the contraction and then expansion of the economy.

In 2023, spending trends are estimated to have returned to historical norms with national health care

spending growing faster than GDP. Meanwhile, Medicare spending as a share of GDP, shown by the lower line, has grown at a slower-than-usual pace during the pandemic. This is partly because in the first year of the pandemic, although spending increased on COVID-19 testing and treatment and on services that were temporarily made more widely available, this increase was more than offset by decreased spending on non-COVID care.

Looking ahead, CMS expects Medicare spending to grow by 7 to 8 percent per year over the next decade, faster than spending by all other types of payers.

Medicare spending is expected to nearly double in the next 10 years, increasing from about $1 trillion in 2023 to $1.9 trillion in 2032. Medicare's projected spending growth is driven by three factors: economy-wide price increases, which increase Medicare spending by about 3 percent per year; growth in the number of Medicare beneficiaries as the baby boom generation ages into the program, which increases Medicare spending by about 2 percent per year; and growth in the volume and intensity of services delivered per beneficiary, which increases Medicare spending by another 3 percent per year.

An increasing volume of services refers to providers delivering more services per beneficiary over time. An increasing intensity of services can occur when providers use more expensive options instead of less expensive ones.

For example, as shown in this graph, clinicians treating fee-for-service beneficiaries have been furnishing more office visits using the 99214 billing code, which involves a moderate level of medical decision-making, and fewer office visits using the lower-priced 99213 code, which involves a low level of medical decision-making.

Another factor that is expected to increase spending is Medicare coverage of a class of drugs called GLP-1's. Although these drugs have recently become popular for weight loss, Medicare Part D's statute prohibits covering drugs for this indication, so Medicare does not cover GLP-1's for weight loss alone. Medicare does allow coverage of GLP-1's for other FDA-approved indications, however.

Since 2005, GLP-1's have been approved for patients with type 2 diabetes, and in 2024, FDA approved a GLP-1 for patients with cardiovascular disease and obesity

or overweight. This latest indication is expected to increase Medicare spending by $36 billion over a 10-year period. If the FDA approves GLP-1's for additional indications, projected spending could increase further.

Recent clinical trials have found that GLP-1's may be effective in reducing the risk of major kidney disease events in patients with type 2 diabetes and kidney disease and may reduce the risk of developing obesity-related cancers in obese patients.

Medicare spending on GLP-1's will also depend on patient appearance rates, the degree to which Part D plans employ utilization management tools, and how the price of GLP-1's changes in the future due to competition within this drug class, individual plan negotiations with drug makers, and/or Medicare negotiations if this drug is selected for the new drug negotiation program.

I'll now talk about Medicare's two trust funds. The first of these and the one that people normally talk about is the Hospital Insurance Trust Fund, which finances Part A services, such as inpatient hospital stays and post-acute care afterwards. This trust fund is currently projected to remain solvent until 2035 or 2036, which is a

decade longer than was projected before the pandemic.

Medicare's trustees attribute this improved financial situation to a higher than expected amount of Medicare payroll taxes being collected in recent years and to Part A spending that is projected to be lower than previously expected. The lower Part A spending is partly due to lower projected spending on inpatient hospital and home health services based on recent utilization trends and a correction CMS made to how it calculates Medicare Advantage benchmarks.

Despite this reprieve, the Hospital Insurance Trust Fund still faces a fundamental financing problem, since the ratio of workers to Medicare beneficiaries has been declining since the program began and is expected to continue to do so.

Around the time of Medicare's inception, there were four and a half workers for each Medicare beneficiary, but by 2023, there were only 2.8 workers per beneficiary, and by 2029, when the entire baby boom generation will have aged into Medicare, there are expected to be only 2.5 workers.

Medicare's other trust fund is called the

Supplementary Medical Insurance Trust Fund. It helps pay for Part B clinician and outpatient services and Part D prescription drug coverage. This trust fund works differently than the Hospital Insurance Trust Fund, since it automatically remains solvent through transfers from the federal government's general revenues and beneficiary premiums that are repriced each year.

Over time, a growing share of federal revenues, which mainly consist of personal and corporate income taxes, are expected to be needed to finance this trust fund. For example, in 2023, 17 percent of all personal and corporate income taxes were transferred to this trust fund to pay for Part B and Part D, and by 2030, 22 percent of all income tax revenues are expected to be needed for this purpose.

Part of the reason for this increase is that over time, care has been shifting from the inpatient setting, paid for by Part A, to the outpatient setting, paid for by Part B. This shift is partly due to CMS removing certain services from its inpatient-only list due to technological advances that have allowed procedures to be conducted using smaller incisions and less invasive approaches in a wider

array of clinical settings.

I'm now going to zoom down from Medicare's big-picture financial situation to individual beneficiaries' experiences in Medicare.

I'll start by mentioning some commonly misunderstood or unknown facts about Medicare beneficiaries' enrollment options. For example, Part B premiums are deducted from both fee-for-service and Medicare Advantage enrollees' Social Security checks. MA plans can reduce the amount deducted by buying down some or all of the standard premium amount, but most enrollees don't receive this buy-down. There are late enrollment penalties for beneficiaries who don't enroll at age 65. For example, late Part B enrollees have a lifelong surcharge added to their Part B premiums that adds 10 percent for each year that they could have signed up but did not.

Enrolling in Medigap is typically a one-time decision, made at age 65. During this one-time window, beneficiaries are guaranteed the right to purchase any Medigap plan an insurer offers. The insurer cannot factor in the beneficiary's health status when signing the

premium, and beneficiaries can renew the plan they choose indefinitely.

Medigap is not subsidized by the government, and employers can subsidize retirees' Medigap, Part D, or MA plans.

There are differences in the types of coverage that beneficiaries of different races and ethnicities enroll in. According to our analysis of CMS's 2021 Medicare Current Beneficiary Survey, white beneficiaries were much more likely to have traditional fee-for-service Medicare coupled with some type of private health insurance, such as a Medigap plan. Meanwhile, Hispanic and Black beneficiaries were much more likely to enroll in an MA plan. They were also much more likely to be dually enrolled in Medicaid and/or to receive the Part D low-income subsidy. Specific percentages are mentioned in your chapter.

The typical Medicare beneficiary has relatively modest resources to draw on when paying their Medicare premiums and cost sharing. Researchers estimate that in 2023, the median Medicare beneficiary had an annual income of $36,000 and savings of $104,000. Medicare beneficiaries

typically do not pay premiums for Part A, but the annual cost of Part B premiums was about $2,100 in 2024, and the cost of Part D premiums was about $500.

Cost-sharing obligations for beneficiaries in traditional fee-for-service Medicare averaged about $400 for Part A services and $1,600 for Part B services in 2021.

Average cost sharing for beneficiaries with Part D coverage was about $500 in 2022.

About 7 percent of Medicare beneficiaries report problems paying a medical bill, but some subgroups shown at right report this at higher rates. Among beneficiaries with fee-for-service and no supplemental coverage, 14 percent report problems paying a medical bill. Among beneficiaries under the age of 65 who are either disabled or have end-stage renal disease, 20 percent report this problem. And among partial benefit dual-eligible beneficiaries, 23 percent report it. All of this is to say when Medicare increases payment rates for providers, it also increases premiums and cost-sharing for Medicare beneficiaries, some of whom already have a hard time affording health care.

We also see differences in health outcomes for

beneficiaries of different races and ethnicities. Black individuals have much higher age-adjusted mortality rates than white and Hispanic individuals. Black and Hispanic people age 65 and over are more likely to report being in poor health and more likely to have hypertension and diabetes. Black and Hispanic beneficiaries are more likely to receive care from a hospital or a skilled nursing facility with a one-star quality rating. And Black beneficiaries have worse rates of ambulatory care-sensitive hospitalizations and emergency department visits.

Interestingly, we find very few differences by race and ethnicity with beneficiaries' experiences accessing care when we examine surveys of Medicare beneficiaries fielded by CMS and us.

At least some of the race and ethnicity disparities we see are likely related to disparities in beneficiaries' income and assets. The median income of Hispanic and Black beneficiaries is substantially lower than that of white beneficiaries, and differences in beneficiaries' savings are even more stark.

In surveys, beneficiaries with very low incomes and assets are more likely to report foregoing care that

they thought they needed and to report delaying care due to cost. They are also more likely to experience an ambulatory care-sensitive hospitalization or emergency visit compared with higher-income beneficiaries.

Since Commissioners have expressed interest in thinking more about the health care workforce, we've added material to the context chapter this year that touches on this topic.

When it comes to the supply of health care workers, studies generally find that more is more. Hospitals with more registered nurses have better rates of hospital-acquired infections, readmissions, and mortality. And populations in areas with more primary care physicians per capita have longer life expectancy and better health status.

But assessing whether we have enough of various types of health care workers is complicated by the fact that the responsibilities of certain types of workers overlap. For example, advanced practice registered nurses and physician assistants can provide many services that physicians provide, and among nurses, licensed practical nurses can provide many services that RNs can provide.

Another issue is that national counts of different types of workers can mask shortages or excesses in particular geographic areas and medical specialties. For example, there are 4.3 million RNs and 600,000 LPNs in the U.S., which is enough to essentially fully meet the demand for nurses nationally. That said, some states have excesses of nurses while others have shortages.

An interesting fact about the U.S. is we do not produce enough medical school graduates to fill all of the post-med school training positions in this country, which are called residency and fellowship positions, and are usually offered by teaching hospitals. About one in four of these positions is filled by a graduate of a medical school located outside of the U.S. or Canada. Medicare helps subsidize residency and fellowship positions through its graduate medical education payment, which totaled an estimated $19 billion in 2022. Medicare generally does not specify where or in which specialties physicians are to be trained.

Medicare also influences the composition of the health care workforce through its payments to APRNs and PAs, which are set at 85 or 100 percent of physicians'

payment rates.

Since provider organizations pay APRNs and PAs much less than physicians, this creates a strong incentive for organizations to hire APRNs and PAs. This in turn may help explain why from 2017 to 2022, the number of APRNs and PAs who billed Medicare increased by 40 percent.

Since increasing payment rates for all clinicians is not likely to increase the supply of particular in-demand types of professionals, more targeted policies are typically used, such as the 10 percent bonus Medicare pays to physicians who work in shortage areas, higher payments for hospitals in underserved areas, and special incentives for providers in underserved areas in some alternative payment models.

With that, we'll turn to your discussion. I'll be looking for your feedback on whether anything in the chapter needs to be clarified. I would also welcome any other comments, questions, or guidance you have, including any passages you think could be shortened or cut.

As usual, the draft chapter Commissioners received for today's meeting will be updated in the winter when some newer data become available. Commissioners will

have an opportunity to review a revised version of the chapter in January.

I'll now turn things back over to Mike.

DR. CHERNEW: Thank you, Rachel. That was terrific.

Without further ado, we're going to start Round 1, and just to remind people, we're looking for just clarifying questions at this stage.

So I think the queue changed. Stacie got out of it. So I think now Betty's going to start the queue.

Is that right, Dana?

MS. KELLEY: Yes, it is.

DR. RAMBUR: Thank you so much. That was great, and I'll have more comments in Round 2.

I think this is a Round 1. On page 44, you clarify the $19 billion spent on graduate medical education, and that 77 percent of residencies are filled by graduates of U.S. and Canadian medical schools. Do we have or can we easily get or did you do an analysis of what specialties are being filled by international? I'm just curious about the primary care piece in this.

MS. BURTON: I'm going to ask my colleague,

Laurie, if she can pop in, because she actually wrote that text box.

DR. FEINBERG: We picked this up from the literature, so we do not know. It was not based on our own analysis.

DR. RAMBUR: Great, thank you.

MS. KELLEY: Okay. I have Tamara next.

DR. KONETZKA: I have three questions, two really short ones.

One, on the Medicare projection slide, which was Figure 1.1-2 in the chapter, there's this downward blip in the projected spending in, like, 2028. Is that due to Part D changes, or what did that come from?

MS. BURTON: I think Paul actually had a thought on what that was. Paul, could you remind me what you said that is?

MR. MASI: Yeah. Thanks so much for the question, and we can clarify that in the text.

My sense is that's due to something called a "timing shift," where if -- because Medicare Advantage plans are paid on the first day of a month, if that first day of a month falls on a weekend, then that payment is

accelerated to the preceding business day, so that Friday. And where this creates a little dip in the projection is when October 1st falls on a weekend, and then this timing shift mechanism actually moves one of the 12 annual capitated payments from one fiscal year to the preceding fiscal year.

And I think in this case, there might be something we think of as a timing shift triplet, where there are multiple October 1st's that fall on a weekend, and then that kind of creates this little shimmy that you see in the projection. But we will try to clarify that in the text so that you don't, just to be mindful.

DR. KONETZKA: Yeah, thanks. It just looked like, wow, what are we doing there? It's working. So if it's just an artifact, that's probably worth clarifying.

Second question, about the billing codes and intensity and the sort of 99214 being used more and more and the 99213 less, how subjective is that? And are there ways to sort of -- is there research that kind of compares the use of those billing codes to anything that would substantiate the fact that complexity is going up?

MS. BURTON: We don't really definitively know

what's going on there, so that's the short version.

DR. KONETZKA: Okay. So it might be subjective.

And then final question, a slightly meatier one. So I'm really interested in those 6 percent of people without supplemental coverage, and I know it's hard. We don't really have great data sources on who has Medigap. So, one, it would be nice to know if we're ever going to get that, I wonder if there are ways to start collecting that in some way.

But the other -- the question is, what else do we know about those 6 percent of people who don't have supplemental? Are these people who -- I mean, I know that we'll talk about it later today in the rural section. They are sort of disproportionately rural. Sixteen percent was the number I'm remembering. But other than that, are these mostly people who just never bought Medigap because they're not very risk averse? Are they people who are, like, switching back from MA? What are their demographics? Do we know anything about that 6 percent of people who don't have the supplemental coverage?

MS. BURTON: I'm wondering if Eric is available to pop on, because he's kind of our in-house Medigap

expert, and if he's not, then I can offer some words.

MR. ROLLINS: Sure, I'm happy to jump in.

The only thought that I had, Tamara, was that, to some extent, some of the 6 percent, aside from the rural points you raised, probably more likely to be under 65. The eligibility and enrollment processes for Medigap are really structured around sort of making that choice when you turn 65. And for beneficiaries who are under 65, the availability of policies may be much more limited. Some states may be not as limited as others, but it's generally much harder to get a Medigap policy, particularly an affordable Medigap policy, if you're under 65.

Now, when those beneficiaries later reach age 65, they can take advantage of sort of the normal Medigap selection process at that point. But off the top of my head, I would say that's probably one factor at play.

DR. KONETZKA: Okay, great. Yeah, I think just as we consider a lot of policies that will disproportionately affect people without supplemental coverage, it would be good, as time allows, to just have a breakdown of who those are.

All right, thanks.

MS. KELLEY: Okay. I have Cheryl next.

DR. DAMBERG: Great. Thank you for such a wonderful overview chapter.

I want to plus-one on a couple of Tamara's questions and comments about having better information on supplemental coverage and who the people are who are not signing up for it.

But I had a question on page 30, where it says when they first reach age 65, they're guaranteed the right to purchase any Medigap plan an insurer offers, and that it's not experience rated, related to their health status.

And I'm kind of curious, given that a significant number of people are working past age 65 and continue on their employer insurance, what happens to those folks when, say, they retire at age 70? Are they still allowed to purchase without health status being considered?

MR. ROLLINS: I believe -- so there's a six-month window where you can buy Medigap at 65, and I believe that if you delay the point at which you take Part B, the six-month window moves with you. But we can double check that.

DR. DAMBERG: Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Okay, thank you. When you start B triggers the six months. So if you delayed B because you're actively working, just FYI, that will move the six-month period of guaranteed issue rights.

I have several comments in Round 2, but my question for Round 1 -- and first, Rachel, great job. I mean, this is so much, and good luck trying to shorten it. I'm not going to be very helpful with that. I'll just be on record as saying that.

MS. BURTON: Okay.

MS. UPCHURCH: But great job.

My question is about graduate medical education. So the question I have is, do Medicare Advantage -- two questions. Does Medicare Advantage contribute to that, or is it just fee-for-service Medicare? And then, secondly, what does it come out of? HI or SMI? Part A or Part B? Where does the money come from?

Thanks.

MS. BURTON: I think that's an area we can clarify in the chapter. I'm not sure I have the perfect answer for you right now.

It looks like Allison might have the answer,

though. So let's see what she says.

MS. BINKOWSKI: Hi. Yes. So the Medicare program makes direct graduate medical education payments for both hospital share of fee-for-service patients and MA patients, and that is split between Part A and Part B, so some HI, some SMI.

The Medicare program also makes indirect medical education payments to hospitals and certain other facilities and makes those on behalf of both fee-for-service and MA beneficiaries, and it's carved out of MA benchmarks. And that would come purely from HI

MS. UPCHURCH: Okay. So most is coming from A, yeah. Thank you.

MS. BINKOWSKI: In response to Betty's question, we can get more details, but yes, about 14 percent of family medicine matched from international graduates, which was the highest specialty. And there were hires among certain other primary cares as well.

MS. BURTON: Is that it, Gina?

MS. UPCHURCH: That's it, thanks.

MS. KELLEY: Okay. Amol?

DR. NAVATHE: Thanks for this great work.

Obviously, it's always quite sobering to read this chapter.

I have what I hope is a relatively quick question. So in the workforce portion of this, you all made note that HRSA, the Health Resources and Services Administration, had estimated the supply of NPs and PAs now exceeds the demand. And I was curious in the kind of preceding section or the preceding part of that text box, there was a discussion of the nurses' piece of this, and that varied heavily geographically as well as by specialty. And so I was curious about a couple of things.

One is, do we have a sense for, as HRSA did these estimates -- is there any variation by specialty since NPs and PAs participate both in primary and specialty care?

And then the second piece is, given that there is this primary care shortfall -- and the way it's kind of framed is that there's been a lot of increased entry from NPs and PAs from the perspective of supplying care and Medicare. But another way of thinking about it is that there's an unmet need and there's demand, and that demand is accelerating over time. So if we took a snapshot right now, it looks like maybe we're okay, but in the future, we may not necessarily be.

So I was just kind of curious. Are these HRSA estimates taking into account longitudinal trends and what's happening in terms of care delivery and demand to the program, as well as is there a variation by specialty and geography in the same way that the kind of nurse piece of this was described?

MS. BURTON: I will look at the HRSA data again. They did do projections. I'm pretty sure they did not subdivide the PAs and NPs by their specialty, and I don't recall the geography, but I can check. It's all on the HRSA website. This was all public information.

DR. NAVATHE: Great. Thanks.

MS. KELLEY: Okay, Lynn.

MS. BARR: Thank you. I love this chapter. I hate this chapter, love this chapter. It's like a sad story, but it's great work.

So my number one question is you mentioned the 10 percent bonus for HPSA, for the shortages, right. And I'm curious, because it seems to me like there were an awful lot of people that were qualifying for that. So how targeted is that? What percentage of physicians are eligible for that bonus?

MS. BURTON: I don't know that off the top of my head. I don't know if Laurie does either, but we could look into that.

DR. FEINBERG: I do not know. I looked at it only from the position of how it was funded, not who was affected.

MS. BARR: Since we're saying it's a targeted payment, I just want to make sure it's actually targeted. I think it's kind of broad at this point. Thank you.

MS. KELLEY: Okay, Mike. That's all I have for Round 1. Shall we move to Round 2?

DR. CHERNEW: Yeah. We should go to Round 2, and I will just say that was a very well done and disciplined Round 1. So I don't know what the secret is, but that was really exceptional. So we're going to go to Round 2, and if I have this right, Stacie is going to kick off Round 2.

MS. KELLEY: That sounds right.

DR. DUSETZINA: Great. Thank you. Rachel, this chapter is fantastic and such a service to the field. So like Lynn I'm also like, this is such an exciting, great chapter, but it's also very depressing.

I also, like Gina, I'm not going to probably

shorten the chapter in my comments, but I wanted to emphasize a few things that stood out to me as areas where we might want to make a couple of minor changes.

One is in the chapter you do such a nice job of talking about the share of Social Security that is made up of Part B and D premiums now, something like 26 percent of the average Social Security benefit, what it takes to cover those. I think it would really benefit us to have that estimate separated for the MA premiums and the stand-alone premiums, given where we're seeing them diverge, at least in the Part D side of the benefit, or maybe something more like a range, depending on what type of plan you're in. But I think that would be helpful moving forward.

I also really appreciate the section on drug spending, and I think the GLP-1 box, in particular, is going to be one that has a lot of updates as we get closer to this chapter going live, because it's so rapidly evolving. But it did seem like it would be worthwhile emphasizing that CMS has already indicated that plans can start to cover, or should consider covering these for the already approved indications, that are already covered under the Part D program, and also that the spending that

is referenced is during--if you're in--where those drugs are in pretty extreme shortage at times. So it's probably low relative to what we would've expected if people could get their hands on the meds.

I also absolutely love Medigap details and find them to be so helpful. And, you know, there was this one part that mentioned the range of premiums, I think, for a G plan, were like $110 to $412. And I was just sitting there thinking, what's the difference? Like what are you getting? Is there anything kind of obvious, like how much cost sharing you have, if any, that could be added there to explain? Maybe there is not really any obvious difference, but that would be incredibly helpful.

And in addition to that, I also found myself wondering two things. Like can your premiums just go up, like once you're in it? So you get community-rated premium to get into the program at 65, but can your premiums go up, and what does that typically look like for people. And what are employers doing? You know, I think that my gut reaction is like pensions, that retiree benefits are eroding in some ways, and I would love to know a little bit more about the composition of, you know, are employers

pulling back on offering these benefits and more people are responsible for covering that over time.

Okay. Two more things. The piece on quality and people going to one-star locations was incredibly bad and disappointing and concerning. And I wondered about -- and this is way outside of my wheelhouse, but I wondered what should we do about that? Is that because they don't have other locations near them that are better than that? And if that's the case, should there be something related to one-star locations can't count towards network adequacy requirements, something that really kind of forces people to raise the bar and improve the quality of care.

And then the last note, the section on basically improving fee-for-service, adding a cap on the benefits, making cost-sharing more reasonable, and then the piece on safety net index, incredibly hearty endorsement for all.

So again, thank you so much. I'll send a few kinds of minor detail things and reinforce this, because I know I spoke fast, but thank you for the wonderful, wonderful work.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thank you. I, similar to Stacie,

found myself wanting to unpack more in the Medigap section, particularly what that variation in pricing buys you. So a plus-one on that.

And then, again, a better understanding of the Medigap population, I suspect that population is more likely to be duals and unable to afford paying the premiums. So I think there's a thread throughout this chapter that is really all about income differentials and sort of the legacy of income inequality in this country. And I think some of the differences that we're observing in utilization relate to sort of structural barriers and systematic racism over the years.

We definitely know that not just in hospital but in the skilled nursing home setting that racial minority beneficiaries, as well as in a commercial population, are tending to use providers who are of lower quality care. And I do think that Stacie raises an interesting point about thinking about modifying the types of networks or providers that could potentially participate in a program. It also speaks to the need for investments in quality improvement.

But there is, you know, in work that I've been

involved with, as well as others, there's a lot of mistrust. So even if there's awareness in the population of better quality providers being available in the same geographic area, a lot of patients tend to sort of go to providers where sort of their community goes, and they have a better sense of trust in terms of how they will be cared for.

But again, I guess I'll just say this threat of income differences runs throughout this, and it really begs the question from me about how do we better support financially people accessing care in the system, because it doesn't seem to be as much about providers being available in some of these communities but the ability of people being able to afford to pay.

MS. KELLEY: Kenny.

DR. KAN: Thanks for a great chapter. On page 25 of the pre-meeting chapter notes, federal spending on entitlement programs and interest payments are projected to exceed federal revenues by 2044. At that point, all the federal spending will need to be financed through federal borrowing.

And then, similarly, in the same pre-meeting

chapter, Figure 1-4 suggests that people born in 1980 have about three years long life expectancy at age 65 than 40 years ago.

Given the following three-pronged construct, $35 trillion current national debt in a very depressing 2044 fiscal situation, longer life expectancy of at least three years right now, as Figure 1-4 suggests. Social Security now has full retirement benefits at age 67. Can we analyze the feasibility of raising the eligibility age of non-disabled Medicare benes to age 67? This will also improve the active worker-to-beneficiary ratio on page 12.

DR. CHERNEW: Kenny, to the extent that's a question to me, or a comment to me, there's a longer answer we'll talk about.

MS. KELLEY: Okay. Larry.

DR. CASALINO: Thanks, Dana. I thought this was generally a terrific chapter and honestly, even after five years on the Commission I find I still learn a lot from these context chapters. The writing, as usual, is really excellent. It's very clear and readable.

I just have a few quick comments. One is the emphasis of the chapter is very much focused on spending,

and Kenny just pointed out that spending is pretty important. But there's almost nothing about quality. And I think that is quite a gap. Any person looking at this chapter might just say, well gosh, I do care about Medicare spending, but is the quality any good? Is the quality good for Medicare beneficiaries? Is it getting better or is it getting worse? What are we getting better for what we spend? I realize that's getting into how is quality is not exactly going to shorten the chapter, but it still does seem like a gap there, not that I'd attempt to deal with it in any way.

Second comment. I really want to emphasize the difficulty of switching from MA back into traditional Medicare. That is so important. I mean, once you're in MA, in all but I think four states, it's prohibitively expensive to try to switch back to traditional Medicare, because of the penalties you have to pay or because of the underwriting for Medigap and Part D.

I don't think very many people know that. I didn't know that. I think the growth in MA would be a lot slower if people did understand that. Gina can speak to this better than I can, but I think it's worth it for us--

not criticizing that it's costly to switch from MA to traditional Medicare, not necessarily criticizing that, but just try to make, in every setting in which we can do it, try to make people aware that it is very difficult, that once you choose MA there is a good chance you're going to be in it for life. And I think people just need to be made more aware of that.

And then the last point. Thanks for the text box on consolidation. I'm happy it was in there, and it was well done, I think. You might add something -- and again, very briefly -- on possible effects of consolidation of quality and patient experience and clinician and worker experience, just very briefly. Because again, we have a fair amount about consolidation, what it does to spending, or prices, especially in the commercial market, but it could affect quality. And I think very briefly, conceptually, positively and negatively, what are the ways that consolidation might improve quality and patient and provider experience or might decrease these things, and then just a few words on what the data shows, so far as we have a few words on what they show about prices.

And that's it. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. Thank you so much for this important work. I can't imagine what a lift it is.

A few comments. The financial challenges feel very disconcerting to me, and hearing them every year, it's a concern. And it really underscores the importance to me of all of us getting on board in this country -- I don't mean the Commission -- on getting rid of waste and unnecessary care. It's just an ethical imperative, as you've heard me say before.

I'm particularly grateful that this year we're adding a broader lens on the workforce landscape. It's as if the nation's policy assumptions have been that physicians are okay and hospitals are sort of okay, we'll have the health system we need, and we really know it's a team effort. Increasingly it's a team effort, especially as we have more people living with chronic conditions.

I wanted to just underscore something that Larry said on quality. You did on this slide and in the document, some of the evidence about more nurses means better quality. And I think that's so important because our reimbursement system, for example, hospitals really put

those as odds because nurses are a labor cost, right. So there is this inherent tension that's part of our system.

I wanted to plus-one on Amol's comment, at least what I'm taking from it, as a Round 2. There is actually a lot of empirical evidence that nurse practitioners, perhaps PAs -- I don't know that as well -- are more likely to work in rural and underserved areas, often in the areas that they are from. So I think that's really an important consideration. And that data about the oversupply doesn't sort of line up with my own experience, for example, in the unmet need in behavioral and mental health, psych mental health nurse practitioners are a growing area. So I understand you have a reference, but it doesn't sort of line up.

I do want to particularly give a shout-out, too, for dissecting out the different levels of nursing. So many policy people, including at very high levels -- not saying that bad -- are really not clear on the difference between the generalist nurses prepared as an AD or a BS, and their license to work in any setting, and the advance practice nurse who really is a specialist as a family nurse practitioner, adult general nurse practitioner, and then

the other levels of nursing, like LPN and nursing assistant. And I think that you did a great job of underscoring how little the nation really knows about our largest workforce.

And my concern about this is who will care for us? Who will care for beneficiaries? Who will care for all of us? We can make all the policies in the world, but if there's nobody delivering the care it's not very good policy.

I can't help but briefly comment on the $19 billion staggering GME money. When GME started it was supposed to be temporary until a better system was grown, and it's out to $19 billion. I don't understand why we don't shift some of this to the graduate nurse education model, which was tested and found to be very successful. But at the very least, if we could just have a little footnote about what we spend on educating the other professions I think that would be very helpful.

I know that fiscal year 2023 nursing education had roughly $350 million -- with an M, not a B. So those are just fact that I think are helpful to the readers, not suggesting any policy changes at this point.

And finally, I was a little puzzled on page 45, it discussed the practice hours of advanced practice nurses and physician assistants. And it listed them as one year, something like that. And I know there's been recently things in public press about nurse practitioners having 100 hours of practice training beyond their RN. That is not consistent with the accreditation guidelines, which require at least 750 at the master's level and then another 250 at the doctorate of nursing practice. I don't know that PA requirements as well, but I can tell you when I got my preparation as an NP/PA, back in the day when you could do both, and it wasn't in the 21st century, so it wasn't very recent, we had to have 1,200 practice hours after a long time of being a registered nurse.

So there's a lot of misinformation out there, and just having the facts out there I think is very helpful.

But you did a great job opening the landscape of this discussion to at least help the nation understand better in what we're facing in the workforce. So thank you for that and all of the other work in this chapter.

MS. KELLEY: Gina

MS. UPCHURCH: Okay. Thank you. Thanks. I just

want to point out some things with Medigap policies, and I'm going to talk about the language we use when we maybe get to Eric's -- not Eric's presentation, but Jeff's presentation later.

But there is a wide range of Medigap policies. People can look for a Medigap policy at any time, any time of the year. You don't have to do it even during open enrollment. It doesn't mean you have rights to it. In only, you know, about 30 states -- we know that about 4 states have continuous or annual enrollment to Medigap, but otherwise only 30 states really allow even people less than 65 to have a Medigap policy. So there are many states that don't even allow them to.

In North Carolina, just as an example because that's what I know, the least expensive Medigap policy, with rights, so published rates are about $400 a month. It's really untenable for people who are younger and disabled in the Medigap market. Just FYI. I just wanted to point that out. And I'm glad we're paying attention to Medigap policies.

I have to keep coming back to this. We will often sort of throw out there, oh well, people have less

cost sharing when they're in a Medicare Advantage plan. I just don't agree with that. It depends on how sick they are and how many services they use. If you've got a Medigap policy and you have fee-for-service you may pay a lot less than if you got really sick and you were in a Medicare Advantage plan. So I just want to throw that out there as something.

Part D late enrollment penalties, I do think we're going to have a barrier to people participating with Part D if these folks have been sitting in safety net clinics and not understanding that they needed a Part D plan. I know you mentioned late enrollment penalties, but they are particularly worrisome for people who rely on safety nets. Speaking of equity, and the nice work that you did around disparities, I think that's really something we should be paying attention to over time.

Three more quick things here. I do hope that we can, if you call out some of the disparities we see, I would really love to know about these professions, by race. Now race is a special construct, but race and racism matter. And we know from literature that's coming out recently, when you have race concordance, we sometimes have

better outcomes. So building off of Larry's sort of quality thing, you know, quality comment, do we know about race concordance, and what type of diversity do we have in terms of providers, whether they be the nurses, the physicians, nurse practitioners, PAs, pharmacists. What kind of diversity are we building in our workforce. If we've got anything to add to that, that would be great.

I know Scott and I are very interested in geriatrics and geriatricians. I think we're supposed to be working with people who are older, and we are not paying attention to team-based care or supporting geriatricians in our country. It's a huge problem. So I'd like to call that out a little bit more and see what the data we have around geriatricians.

And then my last comment -- and this is probably not surprising to many of you -- yes, we have enough pharmacists, but they're not happy right now, many of them. As you all know from being squeezed by pharmacy benefits managers, I mean just in my hometown alone, in the last three months, two independent pharmacies are closed. So pharmacists, some of them have jobs, but they are endangered, and they are not happy with -- quite frankly,

they're being hired to do things that are really not their training. They are being hired by insurance companies to do health screening. They are being hired to do nutrition education, which is not what they went to pharmacy school for.

So we're not using pharmacists in the ways that they have their expertise and could contribute to team-based care. We're using them in other ways, just so they can stay afloat. So I really hope we'll pay attention to some of that over time.

I love the chapter. It's a lot, and I'm sorry I'm not helping you be more concise. Thanks.

MS. KELLEY: Brian.

DR. MILLER: Thank you for this chapter. I appreciated, like many of my colleagues, the additional workforce, and agree with Betty that we should note that there really isn't much in the way of graduate nursing education funding. Yeah, we're spending billions on graduate medical funding. I think the thing that is missing from the labor discussion is it's not necessarily a labor shortage. It is a lack of labor productivity growth. The Bureau of Labor Statistics has some phenomenal data on

this, going back decades, showing that there is no labor productivity growth. It's not that there is, and it's small, but that there isn't.

So as we have higher demands for health care there is a higher demand for labor that is functionally a technology and innovation problem. We should probably add something about how we need technology and automation to improve administrative process, automate the efficiency and effectiveness of the existing workforce, and to automate the components of simple parts of the care delivery system, whether you're in a hospital, a doctor's office, or pharmacy, a home health business. We need more productivity, not necessarily just more labor. We still need more labor, but we need both.

I think one thing that we also might want to mention is that veterans don't really intersect well with Medicare program benefits. We talked about dual eligibles, supplemental coverage options, retiree health options. I think it's worth mentioning that the VA does not intersect well with us. And I also appreciated the additional consolidation discussion.

I noticed that there was mention of a Medicare

Advantage discussion on page 18. The concern, of course, that our 22 percent number that we came up last year and adopted a new methodology without a vote doesn't pass analytical muster in terms of its external generalizability. It's also not internally valid, as mentioned in previous meetings, to end-stage renal disease population with the expansion of the 21st Century Cures Act actually shows that there's limited favorable selection, a lot less than our model estimates. The worry that we are being biased, and I'm confused as to why we're using that model, since we haven't validated that model.

I think that Stacie's points about -- which I believe referenced page 34 -- about the need to modernize the fee-for-service benefits package are an excellent one. That recommendation is about 12 years out of date. I think we should also consider is MA a more affordable option for beneficiaries to get Medigap coverage. So we noted that 62 percent of Hispanic beneficiaries and 59 percent of African American beneficiaries are in MA, and 75 percent have a zero-premium plan. That means they're paying nothing beyond their Part B premium to get Medigap coverage. So functionally, if you're poor or you're a minority, and

you're old, Medicare Advantage is your safety net program. So for managing Medicare Advantage, we're functionally hitting a safety net program for poor minority beneficiaries and damaging health equity.

So I look at Medicare Advantage functionally sort of, at least in the Medicare programs, similar to how Medicaid is for the broader population, which is why I get concerned how we seem to be relatively biased against it, because it's often the only affordable option to construct holistic health benefits, with A plus B benefits, Medigap coverage, and a Part D plan.

So I think that the Commission needs to move, in talking about both of these programs, and look at more of a staged comparison model, what is the cost to beneficiaries and the taxpayer for A plus B benefits, A plus B plus Medigap, and A plus B plus Medigap plus Part D. That's how I think we could be a better advisor to Congress in looking to fully update the fee-for-service benefit package, paid appropriately for Medicare Advantage plans, and I think do a good service for the broader population.

And I think one other thing, I know we all got a series of letters from George Halvorson. I think amongst

us we have some managed care people but not a lot. So I think we'd do well to restore the public comment period that we had, I believe, before the pandemic, for about 15, 20 years, after each session, so that way stakeholders can engage us live. I think that would be a good move for transparency. Because we don't have to agree with what the stakeholders say or what they tell us, but I think it's really important that we give them an opportunity to speak to us and be heard in person and online. Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Yes. First, thanks, Rachel and staff. I know how difficult it is to put together such a cogent summary, and I think you did an excellent job.

So three very brief or high-level comments. The first -- and this is somewhat a plus-one on Larry -- since this is a high-level context chapter overall, highlighting the issue of value I think is helpful, and comparing, on one hand, per-beneficiary spend and the trend in that over time versus, on the other hand, measures of health status, including but not limited to life expectancy and key health outcomes, with some stratification by key demographics, such as persons of color, levels of education, financial

status, et cetera, I think that helps frame a lot of what we could and should and have to do better in this country.

Second, and this is somewhat a plus-one on Tamara and others, on the issue of traditional beneficiaries living with traditional Medicare, but not having that access to a supplement. It seems to me that we can, and perhaps should, paint a picture of how Medicare, as a program, really worked quite well for many types, or some key types of beneficiaries but not well at all for others, and maybe see what we can do, perhaps in the wording of things, to highlight that dichotomy.

So for example, on one hand Medicare generally works pretty well for people with financial resources and traditional Medicare with Medigap. I think there's a high level of satisfaction generally. And to some extent, at least on affordability, in an almost paradoxical fashion, Medicare may work well for a fair amount of full dual eligibles, not partial but full dual eligibles, of they have -- and I don't really like the term -- if they have a lot of health literacy, or a family member with a lot of health literacy.

On the other hand, as other Commissioners have

highlighted, if you have traditional Medicare but don't have a supplement, it doesn't work well in terms of affordability, et cetera. And as others have highlighted -- Larry and Gina, in particular -- and I think we need to continue to push on this point, people that have been in Medicare Advantage and for whatever reason believe it's in their best interest to opt out of that, and their lack of realistic access in many states to an affordable Medigap, or even an unaffordable Medigap.

Lastly, I would just remind all of us, and our listeners, what we have in this chapter, somewhat the picture that we've got, is a flat or highly variable improvement in health status and health outcomes. We've got widespread affordability issues. We've got a severely demoralized workforce. And we also have very profitable sectors across insurers, providers, device, pharma, et cetera. Framing it that way should give us all pause and highlight the importance of our work.

And I'll end with a plus-one to Brian. I think, Brian, one of the things I heard you say very well is to the extent that we can, in terms of solving these issues, try to give a fairer scorecard to who is doing it better,

who is enabling the solutions better, is it traditional Medicare or is it MA, that's not an easy sound first step. But to the extent that we can frame the issues on one hand, and then on the other hand try to highlight and paint a picture of who is solutioning better for our business and taxpayers. Thanks.

MS. KELLEY: Robert?

DR. CHERRY: Yeah. Thank you for a great chapter. I think it summarizes very nicely and succinctly a lot of the major trends that are happening.

I just have a few comments. So I wanted to dovetail on Betty's remarks. I agree that the experience and training hours for nurse practitioners varies quite a bit, and it's a lot more than 100 hours.

In the state of California, for example, there's a relatively new law that categorizes different sort of independent tracks for nurse practitioners. One of those is called a 103 Nurse Practitioner, and that requires 4,600 hours of clinical practice and mentorship or three years of full-time experience before getting into that category. So there's a wide range out there. So I just wanted to kind of underscore that.

One of the things that the chapter mentioned is that the cost and the spending around Medicare is driven by both volume and intensity, and that is correct. I think in terms of intensity, it does kind of simplify the problem a little bit. We've had a lot of conversations in the last cycle about intensity and what does that mean, particularly in the context of coding intensity. And so the 99214 versus 99213 came up in the chapter.

I think it's important to note that those differences in the codes really has to do with the complexity of the visit, and increasingly complexity of care is being introduced into all different types of inpatient and outpatient environments. The GLP-1's is a good example where -- you know, of complex decision-making, whether those drugs should be used and are appropriately indicated.

There's also -- you know, the next great thing is artificial intelligence being introduced in radiology reads and all kinds of places, and it would seem intuitively that that would make things easier, but paradoxically, it may actually increase the complexity of care and intensity of services associated with it.

And of course, there's the public health challenges that continue to evolve, whether it's people living longer with comorbidities, mental health challenges, a fentanyl crisis, all those things added on, increases intensity, and ultimately drives spending.

So I think we'll still continue. I probably would imagine that we can talk about intensity and provide some context in terms of what we actually mean around it.

In terms of the Medicare outlook, it's definitely encouraging to learn that the trust fund will probably be solvent to at least 2036. I think there's some questionary notes around that too, which is it's a snapshot in time around certain assumptions, and our economy still remains very dynamic. We really don't know what economic growth is going to look like over the next several months. There's a lot of economists debating that. We don't know about inflation, interest rates, monetary policy. And so I think we need to be just sort of open-minded over the course of this cycle that the Medicare outlook that's in the chapter may, in fact, abruptly change, and we should adapt accordingly.

And the other thing -- I'll just put this on my

data analytics wish list for consideration. I found it rather interesting that there are several groups that are having problems paying medical bills and that they were identified around several categories, the fee-for-service population that doesn't have supplemental coverage, those that have partial benefits and are dual eligible, and the other group is the non-elderly. And so that can range anywhere from 14 percent to 23 percent that are saying that they have problems paying medical bills.

It will be interesting to see, based on those projections around the Medicare Trust Fund, how that changes over the next 12 years, if there's some sort of trend line, and also looking historically what those trends have been, because I have a feeling that it's probably not going to get any better and if we're focused just on how much money Medicare program has, but don't pay attention to the real impacts of out-of-pocket costs and what that is doing to people's sort of personal abilities to be able to spend on basic living costs, and we're kind of missing the boat. So if we're able to trend that out over time, that would be great. I don't know what the level of difficulty is, but it could create an interesting narrative around the

chapter that could inform our discussions as well.

But anyway, this has really been a very well-written chapter and really been quite insightful. So thank you very much.

MS. KELLEY: Tamara?

DR. KONETZKA: Great. Just a couple of things. First, yeah, this was a really wonderful, concise summary. Very much appreciate the work behind this.

First of all, I wanted to add on to what a few people said about quality. After years of studying public reporting in health care, public reporting of quality, the one thing I think we know for sure is that it might move the needle a little bit for people to know the quality of the providers they have to choose from. But in many cases, distance, proximity to home is still going to be the biggest driver of where people go.

And so despite the promise of information, I think I keep concluding over and over again that we really need to focus on raising the quality of providers where people live rather than expecting them to go elsewhere.

And so I'm really intrigued by the idea that somebody brought up -- I can't remember if it was Cheryl or

somebody -- of perhaps folding quality into some of the network adequacy or other policies that might influence the choice sets that people have.

But a more general comment about the workforce part of the chapter. So first of all, I'm a big believer in the importance of workforce and really happy to see that section in this chapter. That said, I think when I read this section, I found it almost too optimistic in terms of what we know, what we don't know and what levers we have as the Medicare program. And so I think I would really love to see a little bit more nuanced setup of the context of these workforce issues.

So a couple of examples. I think there's certainly a lot of stickiness in this market, right? As my labor economist teacher once told me many years ago, like "What shortage? Just pay people more," right? And it's not that simple, obviously, in all of health care, because there's a lot of stickiness. There's a stickiness in supply, right? We know we have medical schools, nursing schools with certain numbers of slots. There is certainly stickiness in price depending so much on public payers and on negotiated prices with insurers, other insurers. But

providers can't always just pay workforce more to attract more nurses or physicians.

There's the long-run versus short-run problem, right? Like, even if you start paying nurses more right now, there might be not enough in the pipeline.

And then clearly, Medicare is only one payer, and providers may have more or less of an incentive to respond to that one payer.

And so this really complicates a lot of the research that was mentioned in the chapter, even things like the benefit of having more nurses. Even though, for example, in SNFs, I'm a firm believer that staffing is everything, and we need more staffing in order to improve quality. The research actually is not that good in providing exactly what that relationship is, right? We don't have a lot of causal research about many of these workforce issues and looking at sort of geographic areas and workforce shortages and the relationship to outcomes. So in that sense, I think some of our conclusions about the workforce were perhaps too optimistic in terms of what we know.

Other examples are like if we pay physicians

more, we don't see more applications to medical schools. Well, I think it sort of defies logic that paying people more isn't going to attract more people into the field, right? I think that would certainly happen, but it's all these other sort of sticky issues that maybe makes that not happen.

So I guess my overall comment is workforce is super important. I think we need to keep monitoring it, thinking about it, and certainly using the levers we have that might work to improve the workforce in ways that benefit Medicare beneficiaries. But I think we need to be cognizant of how hard this overall issue is and sort of the limitations on what we know and what we can do.

Thanks.

MS. KELLEY: Amol?

DR. NAVATHE: Thanks. I will try to be brief since I know we're running out of time here.

So kind of overarching reflection -- I think Larry gave one as well, as now we're the oldest folks on the Commission -- is it's pretty striking how the context hasn't changed overall. I mean, in some sense, it has because obviously the pandemic happened and the trust fund

solvency has moved out, but big picture-wise, 30,000-foot view, it really hasn't changed. And that's very sobering, I think, as we think about what are the tools, kind of picking up a little bit on what Tamara was saying about the workforce pieces.

It is striking, and it kind of highlights the limitations on tools that policymakers have to actually address these pieces or ways we can address it.

So five points I wanted to make. So one is, you know, it's very striking. I think we feel this tension oftentimes around access, and on the other hand, as has been very well highlighted in this chapter, in this presentation, the discussion, there's also this flip side around affordability, right, and how much out-of-pocket expenditures and those pieces.

And I think actually the chapter does a nice job. I almost would say, can we make it a little bit more obvious? Can we highlight the tension between these two points? Because as Tamara was saying from the labor market perspective, it might feel like, you know, let's pay more to get more access. But what we have to recognize alongside that is if we pay more to providers, then that

also comes with a greater cost-sharing burden, and that can impact affordability.

And this presentation, I think very, very much highlighted the affordability challenges, in some sense, even more so than the access challenges. So that, I think is a really important point. To me, it feels like a very important governing context point for the challenge for policymakers and thinking about the Medicare program going forward.

Second point I wanted to make is we talk about the workforce labor supply pieces. We discuss the physician shortages, et cetera. I think one of the pieces that's particularly important -- MedPAC obviously has done work on this recently -- is in the behavioral health, mental health, psychiatry area, where there's just a particularly -- almost particularly unique challenge there because a lot of psychiatrists don't even participate in Medicare, for example, which is different than other specialties. So if it were possible to add a small footnote or something to highlight that, I think that would be helpful.

Third point, I agree kind of broadly with some of

the comments that folks have made about quality. I will note that there is this section in health disparities, and many of the disparities that are highlighted are quality-oriented metrics.

I think the one piece that would be interesting -- again, I think there's obviously space limitations -- is looking at how those trends have or haven't improved, I think largely haven't improved, and that would be kind of some of the quality context that could be added or not, depending on space.

Fourth point is plus-one to workforce. I think there's been a fuller treatment here than in past times. I agree with a lot of the discussion with the kind of limitations that we have.

And the last point, fifth point, is there is this other kind of interesting tension between if we think about the context for the Medicare program writ large, MA, fee-for-service, the way that the Medicare fee-for-service program at least evolves is essentially through legislation, at least granting statutory authority to CMS to be able to do something. MA program has more tools to innovate. And I think that's becoming an increasingly

important context in a very general way for the Medicare program kind of writ large, spending other pieces, Brian and others have also brought up.

So thank you. I'll stop there.

DR. CHERNEW: I think we have Paul. Dana, I think we have Paul next.

MS. KELLEY: Yes. Paul, go ahead.

DR. CHERNEW: And then Josh. And then I think that's going to take us to our break, if I have that right.

DR. CASALE: Yes, thank you, and I'll be very brief. And again, adding my thanks for a really great report.

My comments briefly around workforce, I wanted to underscore Amol's comments and others as it relates to APPs, who continue to be a rapid area of workforce growth. And really, if there's a way to get additional information on specialty and geography, I think that would be really important.

And then my other comment is, as it relates to team-based care, you know, I'm seeing a growing use of collaborative care codes, particularly in the area of behavioral health with primary care, pharmacy with primary

care, others. And if there's any way to get any data that provides us some insights in that area, I think -- particularly in mental health, I think that would enhance the information in this chapter.

Thank you.

MS. KELLEY: I have Lynn next, Mike.

MS. BARR: Thank you.

Great chapter. Agree with a lot of the comments of the Commissioners. I want to very quickly give a plus-one on Brian that we should have the same benefits in fee-for-service as we should have in Medicare Advantage. So, you know, looking at the benefit package, you know, why don't we level the playing field? If we think we're paying more for one than the other, we should have similar benefits and let people compete on other issues.

In terms of the Medigap discussion here, I think there's a lot of interest in Medigap. I've been working hard on Medigap trying to understand the rural issues, and I am completely confused. Is it correct that we do not have Medigap data in MedPAC?

MS. BURTON: The Medicare Current Beneficiary Survey does identify if respondents have Medigap. So we're

not completely blind there.

I'm going to see if Eric Rollins has anything he wants to add here.

MR. ROLLINS: The only thing I'd add -- Rachel is correct -- there's information on who has Medigap in the MCBS, but it's very limited. It basically doesn't say much more than do you have Medigap. It doesn't say what type of plan you might have or what your premium is.

MS. BARR: Yeah, because it's very concerning to me that people are paying $400 a month for a Medigap policy. I mean, that presumes that -- I mean, that's almost $5,000 a year, right? And, you know, so in total average expenditures, you know, it just doesn't make sense. And so I'm really very curious.

And I think rather than trying to add Medigap to the context chapter, there's a lot of things we are really curious about on Medigap, and maybe this is an area of future concern for the Commissioners is to have -- because there seems to be a lot of interest and a lot of confusion and a lack of information that I've experienced myself.

I would like to -- when you talk about affordability, I think affordability is an incredibly

important issue. There are numerous studies showing that rural patients have worse affordability than urban patients. And so I haven't found any that say the opposite. So we're talking, you know -- and I know I say this every year in the context chapter is we talk about racial, but we don't talk about geography. And we do recognize geography as a disparity, and it's important to understand the underlying elements.

So when you are talking about some of these affordability issues for Blacks and Hispanics, if you would consider adding that analysis for rural patients as well, and I see some plus-ones, everybody thumbs up. I think we really need to get our arms around this as we're looking at the rural issues, because it really does drive the decision-making.

And I think that would be it for my comments. Thank you very much.

MS. KELLEY: Okay. We have Josh last.

DR. LIAO: Great. Thanks, everyone. And I'll be brief to take us to the break here. I just want to end with a few plus-ones and maybe one additional comment.

A general plus-one on the work behind the content

in this chapter. I agree with many of the Commissioners, lots of important, sobering, but consequential information. So thank you and very well done.

The second plus-one is on Medigap. People have talked about the issues. I won't repeat there, but I would love to see more work there.

The next plus-one is really around the comment around affordability and attention between that and accessing quality and spending the last outcome being maybe more confounded by the first few. I think the affordability piece to me, reading this chapter, really jumped out. And so I would just echo the need to kind of think about that and maybe make that explicit.

My kind of additional comment is really around the content of the chapter on consolidation. I thought that was a very important component, and I thought that maybe one addition that we could make in a concise and text-efficient way might be to think about geographically distant consolidation. Much of the work that I know about consolidation thinks about markets and geographies, and you can argue about how far, but they're kind of contiguous in some ways, as I kind of see the trend or at least an

evolution towards really distant across state, across disparate market consolidation. I think it would be nice to point to that, recognizing that we don't have maybe enough data for research in that space, at least acknowledging that as a trend to look for.

With that, I'll close my comments.

DR. CHERNEW: Great. Josh, thank you. Everybody, thank you.

Despite the fact that, in fact, I thought you guys were all really well disciplined and so I'm very happy with the general set of comments, we are in fact 10 minutes over. So I will try and be brief to summarize.

The first point is the most important one for me to say broadly is if you look at the affordability issue, Medicare spending is now driven by a combination of growing numbers of beneficiaries, which is a baby boomer issue, and assumed growth in volume and intensity. Prices are actually forecasted to grow at a sub-inflation rate. And since we spend a lot of time thinking about prices, we should understand that the core problem that Medicare spending growth faces is not a price problem per se. It is really how we efficiently manage the use of services.

Second point, I heard a lot of discussion on Medigap. I think some of you may know I'm doing a lot of work on Medigap personally, and if it helps to soothe you, we have a whole separate set of ongoing Commission work this cycle that we'll try and look at Medigap. And we agree it is a particularly important issue for a whole range of reasons.

The last point I will make is I very much and I think the staff very much hears the points about quality. It's a reasonably high bar to put a lot of things into the context chapter, but you should feel assured that quality is one of our indicators in every one of our update chapters, and we're going to continue to do a lot of quality work on that. And that work will not only be measuring it but also discuss the very complicated measurement issues related to quality.

I think the challenge we face is there are problems, but it's not clear how the levers move the problems, and you all said that. So I won't belabor it.

So there were a lot of other comments, and I will not try and summarize more of them, given time. But I will say to the public, thank you for joining us, and please, we

really do want to hear from you. We know many people do reach out to us, and the staff talks to a lot of people over the course of between meetings. But you can reach us at MeetingComments@MedPAC.gov. You can send emails. You can go on our website and leave comments. But please do send us any reactions that you have to this excellent work.

With that, I think we're going to take a break till 2:15, and then we are going to come back, and we're going to have a discussion about both cost sharing for critical access hospitals and, in the spirit of some of this, how we measure quality in rural areas. And there will be interesting issues, I think, in both. So we hope those of you at home can join us.

And to the Commissioners, we will see you again. Please log in before the actual 2:15 time so we can get started promptly. But thanks a lot, and we'll see you all in a bit.

Paul, do you want to add anything?

MR. MASI: Nope. Thanks for this discussion, and we're looking forward to the next one.

DR. CHERNEW: All right. All good.

[Whereupon, at 1:27 p.m., the meeting was

recessed for lunch, to reconvene at 2:15 p.m. this same day.]

AFTERNOON SESSION

[2:17 p.m.]

DR. CHERNEW: Hello, everybody, and welcome back for our afternoon session. We have two sessions, both related to health care in rural areas. This first one, which is going to be presented by Jeff, is going to focus on cost sharing for outpatient services at critical access hospitals.

So, Jeff, take it away.

DR. STENSLAND: All right. Good afternoon.

In our March 2024 meeting, we presented a rural work plan for this cycle, and you all had a general consensus that the Commission should look into cost sharing at critical access hospitals. In response to that request, we provided you some detailed information on cost sharing in your mailing materials, and I'll provide a high-level overview during the presentation.

In future meetings, we'll follow up on other rural issues such as cost sharing at rural health clinics and the effect of expanding MA enrollment in rural areas.

We'll start the presentation by reviewing the Commission's principles for rural payment policies. We'll then provide an overview of rural special payments to hospitals, with an emphasis on how Medicare supports

critical access hospitals. Third, we'll walk through the current state of critical access coinsurance. And finally, we'll present some data on an illustrative example of an alternative way to set critical access coinsurance.

Commissioners can use this information to decide if they want the staff to continue to explore alternatives to the current way coinsurance is computed at critical access hospitals.

In 2012, the Commission published a chapter on rural payment policy and established four principles to target special payments to rural providers. The first principle is that payment adjusters should be targeted to providers that are necessary to preserve beneficiaries' access to care. Second, the magnitude of the adjustment should be empirically justified. Third, payments should be structured in a way to maintain incentives for cost control; and finally, if there are low-volume adjusters, they should be focused on isolated providers. We want to preserve access but not necessarily preserve all providers. For example, we would not want to subsidize two critical access hospitals that are located in the same town when both struggle with low patient volumes.

Next, we'll show how existing programs have had mixed success adhering to these principles.

Fee-for-Service Medicare makes three types of special payments to rural hospitals. One type is higher prospective payment rates. Inpatient rates for sole community hospitals and Medicare-dependent hospitals are partially based on their historical costs. Low-volume hospitals receive an add-on to their inpatient rates.

One type of PPS hospital also receives an add-on to its outpatient rates. Sole community hospitals receive a 7.1 percent add-on to their outpatient rates. This increases program payments and cost sharing by 7.1 percent.

Fee-for-service Medicare also makes cost-based payments to critical access hospitals. In a given year, hospitals receive preliminary payments based on their estimated costs, and then after the year is over, cost report data is used to make payment adjustments so that the hospital ends up receiving approximately 100 percent of their fee-for-service Medicare costs. Outpatient cost sharing at critical access hospitals is the focus of today's discussion.

The third type of rural payments are fixed

payments under the new rural emergency hospital designation. Fee-for-service Medicare makes fixed monthly payments to help cover providers' fixed costs, plus gives the hospital prospective rates for service.

We discussed this new model in our March 2024 report to Congress. In total, over 90 percent of rural hospitals get at least one of these special rural-focused payments for their fee-for-service patients.

For the rest of the presentation, we focus on critical access hospitals. To set the stage, this slide presents a comparison of critical access and traditional hospital finances.

Critical access hospitals all have 25 or fewer beds, but they can vary widely in the services they offer. For example, some may not offer surgical services, and others may have a large orthopedic surgery business.

Nevertheless, it can be instructive to compare the average critical access hospital to the average PPS hospital to provide you with some idea of how the typical critical access hospital differs from a typical PPS hospital.

Now we'll walk through this slide row by row.

The first row shows that overall Medicare fee-for-service revenue represents about 25 percent of total revenue at critical access hospitals. This is the first column. In contrast, it represents 16 percent at the typical PPS hospital. This is the second column.

Next, we look at the second row. It shows that Medicare fee-for-service outpatient revenue is 13 percent of the total revenue at critical access hospitals and only 6 percent at PPS hospitals. The net implication is that fee-for-service Medicare is a more important source of revenue for critical access hospitals than a typical hospital, and in particular, Medicare outpatient revenue is an important source of revenue for the critical access hospitals.

I should note that Medicare Advantage is slightly less prevalent in rural areas with about 48 percent of beneficiaries in the critical access hospital market being in MA. That's slightly lower than in urban areas, but that's not the main driver of the difference we see in this table. The main driver is that Medicare and Medicare-focused outpatient business, in particular, tend to be more important in rural areas.

Now, to understand the economics of critical access hospitals, it's important to know how dependent the CAHs are on being paid more than standard PPS rates. As we said on the prior slide, CAHs receive an average of $10 million in cost-based fee-for-service payments for a critical access hospital.

To estimate how much more these hospitals receive in cost-based payments than they would have received under the traditional OPPS system, we repriced critical access claims using prices in the OPPS fee schedule for outpatient services and using rates received by small hospitals for inpatient and post-acute care and swing beds.

We estimate that critical access hospitals would have received close to $6 million per hospital for those services if they were paid PPS rates. The implication is that higher fee-for-service payment rates at critical access hospitals increase payments by about $4 million per year per critical access hospital on average. This is far larger than the critical access hospital's profits of 1- to $2 million.

So we should also note that MA also generally follows fee-for-service rates. Despite some claim denials

and other issues, the critical access hospital executives we spoke to indicate that MA payments were still higher than standard outpatient PPS rates.

Therefore, the critical access status has a benefit of far greater than $4 million on average, and the implication is that critical access hospitals would often struggle without supplemental payments well above fee-for-service rates.

While critical access hospital status helps rural providers, much of the additional payments are funded by higher outpatient coinsurance. We focus on outpatient coinsurance because that is where coinsurance differs substantially between critical access hospitals and PPS hospitals.

We provided details on outpatient coinsurance of traditional and critical access hospitals in your mailing materials, and today I'll provide a high-level explanation of the differences in this presentation.

Prior to accounting for the sequester, Medicare program payments to critical access hospitals are equal to 100 percent of their allowable costs minus coinsurance. What is important to note is that coinsurance is set equal

to 20 percent of charges.

Now, charges, as you know, are list prices that are often far higher than hospitals' costs, meaning 20 percent of charges can be a large portion of the total payment to the hospital.

In addition, charges vary substantially from hospital to hospital, meaning the share of the payment paid by the patient can vary substantially from hospital to hospital.

For comparison, PPS hospital cost sharing is 20 percent of the administratively set payment amount. This tends to be far lower than charge-based coinsurance and is more consistent across providers.

In aggregate, there was about $3.3 billion in coinsurance billed to beneficiaries and their supplemental insurers in 2022 for outpatient services at CAHs. Program payments were about $3.2 billion, and total payments for services that require coinsurance were about $6.5 billion. This means that about half of fee-for-service outpatient payments to critical access hospitals were coinsurance.

There were about 1.9 million beneficiaries using these services, and they or their supplemental insurers

paid an average of $1,750 in coinsurance aggregated throughout 2022. Note that for about 84 percent of rural beneficiaries, rural fee-for-service beneficiaries, that is, they usually do not pay the coinsurance directly. However, those buying Medigap policies in their states will pay higher premiums because the higher coinsurance paid by their supplemental insurers.

There is about 16 percent of rural fee-for-service beneficiaries that do not have coinsurance. They would be billed 20 percent of their charges directly as coinsurance.

How much coinsurance is billed to the beneficiary all depends on charges. Even for hospitals with identical costs, as in this example, the coinsurance can vary substantially if the hospitals have different markups.

In the first column, we show that if a hospital's service cost $600 to provide and it charged $1,000 for the service, then its coinsurance would be $200.

In contrast, look at the last column. This is for a relatively high-markup hospital at the 90th percentile. At that hospital, if the critical access hospital charged 400 percent of costs, or $2,400 for the

same service, the coinsurance would have been 20 percent of charges, or $480.

The takeaway point is that coinsurance share of the total payment will depend on how much the hospital marks up charges over costs.

Another important difference between critical access and traditional hospitals is the existence of a cap on coinsurance at traditional hospitals. In 2024, this cap is $1,632 per outpatient procedure, which is the amount of the inpatient deductible. The idea is that a beneficiary should not pay more in cost sharing for a single outpatient procedure than they would for an inpatient stay. Without a cap on OPPS coinsurance, a beneficiary without supplemental insurance would have an incentive to have a joint replacement done on the inpatient setting to avoid the high level of outpatient coinsurance.

So let's walk through a comparison of OPPS and critical access coinsurance, emphasizing the cap. Let's start with the PPS hospital example in the first column. Assume the joint replacement surgery costs the hospital $13,000 to perform, and it charges $26,000. The OPPS payment rate is prospectively set for a high-level joint

replacement at $12,540 for a hospital with a wage index of 1. You see this in the third row.

The coinsurance is the smaller of either the cap or 20 percent of the payment rate for a PPS hospital. In this case, the cap is lower than 20 percent of the OPPS payment rate. Therefore, the coinsurance would be $1,632, the cap.

In contrast, look at the second column. Here, we assume the cost of the service is the same as the PPS hospital at $13,000, and the charges are also the same at $26,000. What is different is the coinsurance rules.

The coinsurance has no cap and is set at 20 percent of charges for a critical access hospital. Twenty percent of the $26,000 of charges is $5,200 as we see in the second column. The point of this example is to show that the coinsurance difference between a PPS hospital with a cap on coinsurance and the critical access hospital without a cap can be substantial.

In summary, there are two issues that cause coinsurance at critical access hospitals to be about half the total payment. The first is charges are marked up well above costs, and this is more problematic than it was in

1997 because charges have grown faster than costs.

Basing coinsurance on charges also results in a wide variation in coinsurance due to a wide variation in charges for identical services.

The second issue to summarize is the lack of a cap on coinsurance, and this issue is also more problematic now than it was when the program was started in 1997. This is because there are a lot more high-cost services provided in an outpatient setting in small hospitals. For example, there are more high-cost Part B drugs now than there was in 1997. There are also more procedures done on an outpatient basis. For example, joint placements used to only be an inpatient service in 1997 at the start of the program.

So now we shift to providing an illustrative example of how critical access hospital coinsurance changes could affect beneficiaries and taxpayers. To provide you with some idea of the magnitude of changes, I've modeled the cost of shifting coinsurance from 20 percent of charges to 20 percent of the outpatient payment amount.

The key feature of the illustrative model is that it reduced cost-sharing to 20 percent of the payment amount. The foundational assumption I'm using in this

modeling is that program payments will increase to offset any reduction in beneficiary coinsurance. The implication is that payments to the critical access hospital will not change, even though beneficiary cost-sharing declines.

Because coinsurance is set equal to 20 percent of the payment, this means that any increase in payments due to cost-based payments at the critical access hospital would be paid 80 percent by the Medicare program and those purchasing Part B insurance and 20 percent by those using the critical access hospital or their supplemental insurers.

Now I'll walk through what the implications of the policies would have been in 2022 if coinsurance had been based on the payment rate rather than on charges, and this model just looks at the coinsurance change. Adding a cap may involve slightly higher costs.

We examined 2022 critical access hospital claims and computed what coinsurance would have been in that year if it was set at 20 percent of the estimated cost of the service as reported on the claim. We found that beneficiary coinsurance would have been about $2.1 billion lower. That's about a 60 percent reduction in coinsurance

for the beneficiary. This primarily would have resulted in lower coinsurance being paid by Medigap plans but would also have reduced coinsurance bill to Medicaid and to those without supplemental insurance, as we discussed in your mailing materials.

The secondary effect, as fee-for-service program payments increase and, as I said, when beneficiary coinsurance goes down, program payments would go up, increased Medicare program payments would result in higher Medicare advantage benchmarks. And we estimated this would increase federal spending by an estimated additional $1.3 billion.

The net increase in program spending between covering the reduction in coinsurance and the cost of Medicare Advantage would have been about $3.2 billion in 2022.

And now I want to just take a pause and stress that I'm looking backward at 2022 data. If this policy was changed going forward, the cost of the policy in the future would differ because Part B coinsurance at critical access hospitals have been growing at a range of 7 to 8 percent per year. So I don't want somebody to think, oh, we could

change this policy for a cost of $3.2 billion because we would expect actually a higher cost because it would occur in the future when the coinsurance would be higher and the amount of additional costs for the program for adopting the policy would be higher.

But given that caveat, let's look back at 2022, and we estimated that the cost in that year would have been $3.2 billion. That would have been split between the taxpayers who would have paid 75 percent of the cost, or $2.5 billion, and the beneficiaries who are paying Part B premiums who would have paid about $0.8 billion in higher Part B premiums during that year. And that is because CMS sets Part B premiums so that the Part B premiums are expected to pay 20 percent toward 25 percent of all Part B costs.

Given that there were about 60 million beneficiaries with Part B in 2022, the increase in the Part B premium would have been about $13 per person per year if the policy had been in effect in that year.

Now, to help the staff know how to proceed from here, we would like to get your thoughts on three questions on this slide. First, are there any questions about the

material? I provided a lot of detailed data in the presentation and in your mailing materials. And more importantly, should outpatient coinsurance continue to be set based on charges, and if not, is setting coinsurance based on 20 percent of the payment rate a reasonable alternative? And third, should there be a cap on coinsurance at critical access hospitals like there is in the OPPS system for traditional hospitals?

And now I'll turn it back to Mike.

DR. CHERNEW: Yeah, thank you. I have to say this was not something I knew a lot about until I began discussing it with the staff, and I knew it actually, personally, is shocking. So we're going to go through, I think, hopefully what will be a reasonably quick Round 1, and then we'll get some answers to these questions in particular ways, hopefully from everybody in Round 2, to help guide the direction and pace that we move forward.

But let's start with Round 1, and I think that's Stacie first, if I have that right.

MS. KELLEY: I actually have Lynn first.

DR. CHERNEW: Go ahead, Lynn.

MS. BARR: You're just trying to ignore me today,

aren't you?

DR. CHERNEW: I don't think you're sending the messages to everybody, Lynn. You have to send it so I see it. If you send it just to Dana, I miss.

MS. BARR: I'm sorry. I'm sorry. My bad.

So I have some questions. On your Medicare revenue slide in the presentation, does that include coinsurance, or is that just Medicare payments?

DR. STENSLAND: That is the total amount paid by the program and the beneficiary.

MS. BARR: And the beneficiary. Thank you.

You gave an average number per beneficiary of coinsurance. How does that -- a rural beneficiary -- how does that compare to a non-rural, for a CAH beneficiary? How does that compare to, say, a rural PPS beneficiary or other beneficiaries?

DR. STENSLAND: I do not know. We're aggregating all of the coinsurance for people who are using the critical access hospital throughout the year. So these people would have used the critical access hospital for some of their care, and they probably would have used a PPS hospital for other care. So it's going to be a blend.

That would be a different project. We would have to look at the blend of coinsurance for all outpatient services at PPS and critical access hospitals for those using the critical access hospitals versus those not. We haven't done that.

MS. BARR: Okay. It just really -- I'm struggling in the paper to get my head around scale here. You know, it's just like really being able to -- the numbers are not clear. There's some good numbers in here, but I'm not really sure what that means. And so if somebody -- if I think the number was like $1,700 per patient, is that high, low, medium? I don't really have context for it. So it would be nice to have a little more context on that.

In the paper, you mentioned this NORC article on bypass, but that article -- and the author, Alana Knudson, will be the first to tell you -- is not a qualitative article. So it doesn't tell you anything about the qualitative reasons for bypass, and it's a quantitative article that says people drive by CAHs if they have a stroke. Well, if you don't drive by a CAH if you have a stroke, you're not going to have a lot of other things to

worry about.

So I just really -- I question including that paper. I think it is not -- I would ask you to review that paper again and think about whether or not we want to present that.

And it does -- we have no qualitative data -- oh, that's a Round 2 comment. I apologize.

The policy that you propose, is that still based on the chargemaster?

DR. STENSLAND: What we would do is we would -- it would be -- I don't want to call it a proposal either. I want to say it an illustrative example, but to try to give you guys an idea of how much is things changing. And it would be based on the estimated costs. So the estimated costs are going to be the charges times the cost to charge ratio is going to get the estimated costs. That's approximately your payment, and then they would be paying 20 percent of that. So essentially, they would be shifting from -- the way the policy is right now with paying 20 percent of charges as your co-insurance, the beneficiary is essentially paying all the extra costs, all the extra payment that a CAH gets. It's basically all on the

beneficiary's shoulders.

This would shift it so 20 percent would be on the beneficiary and 80 percent would be on the taxpayer and those buying Part B premiums.

MS. BARR: I understand that. My question is it's still based on the chargemaster. So if the charge master says that a CT scan is $1,000 and the cost-to-charge ratio is 200 percent, they're still going to be paying more than Medicare would have paid for that CT scan under this proposal.

And we know chargemasters are all over the place, right? And that happens to be a highly -- you know, for a low-volume hospital. So one of my biggest concerns about the proposal is we're still tying it to something that's based on fiction.

DR. STENSLAND: It's going to be -- like, there is a cost-to-charge ratio for many of these places for their CT scanner. Often it's, like, 20 percent of the charges. So if somebody billed $1,000 and their cost-to-charge ratio was 0.2, it would show up as a $200 estimated cost.

So I would say the level of precision in

estimating what the cost of the service is, is dramatically better when you're multiplying the charges times the cost-to-charge ratio, rather than just assuming the charges are reflective of it. So it's a --

MS. BARR: Oh, if I'm mistaken then, Jeff, isn't there one cost-to-charge ratio? Are you saying that every charge has its own cost-to-charge ratio?

DR. STENSLAND: There is -- every department has its own cost-to-charge ratio.

MS. BARR: Got it. Okay. Thank you for that clarification.

One of the justifications for the proposal alternative, et cetera, is that this is like sole community hospitals, right? And so we're having more parity, and I'm thinking disparity, and you're thinking parity. So I just want to ask you a question. That 7 percent increase in sole community hospital payment, now they pay 20 percent of that. So that would be 1.4 percent increase in co-insurance in a sole community hospital.

DR. STENSLAND: Right.

MS. BARR: But you're talking about, in this proposal, a 10 percent increase. I mean, there's still a

huge disparity. I mean, I'm glad it's going from 50 to 30, but it's still a huge disparity versus other Medicare beneficiaries. And I want to make sure that we don't -- it's misleading in the paper to say like sole community hospitals, I think, because the magnitude is nowhere near the same. Do you agree?

I don't know. Is that Round 2? I'm sorry.

DR. STENSLAND: It's going to depend on the individual hospital and what their costs are.

The general principle that's going on here is -- you'll see in a lot of the outpatient situations, if somebody goes to a higher-cost site of care, usually what happens is the program will pay 80 percent of that extra cost and the beneficiary will pay 20 percent.

So if somebody lives in Manchester, New Hampshire, and they think, "Oh, the care is better in Boston, I'm going to drive down to Boston," it's going to cost about 15 percent more to have your care delivered in Boston. And they'll pay 20 percent of that 15 percent, and the program will pay 80 percent. Or if a small rural hospital says, "We're going to reclassify ourselves out of this rural region into the urban area for wage index

purposes," and that reclassification increases their payments by 30 percent, well, then the program will pay 80 percent of that extra cost for that hospital, and the beneficiary will pay 20 percent.

And it's similar with the sole community hospital, that that's how we're splitting it. It's certainly a normative decision of how much of the cost of going to a higher-cost provider should be borne by the patient and their Medigap policy and how much should be borne by the program. And essentially, that normative decision where most of the time, it's the program pays 80 percent of the payment amount and the beneficiary pays 20 percent.

The biggest outlier right now is critical access hospitals, because right now the beneficiary is essentially paying all of that extra cost, and so it's dramatically higher co-insurance, and they're paying half. The cost is higher than PPS rates, and they're paying half of that higher rate. So that's the real outlier right now.

DR. CHERNEW: Jeff and Lynn, we're at about eight minutes on Round 1.

MS. BARR: Okay. Sorry.

DR. CHERNEW: There's a lot of people.

DR. STENSLAND: All right. I'll make my answers quicker.

MS. BARR: Okay. All right. All right. All right. I will wait and save the rest for Round 2. Thank you.

DR. STENSLAND: Okay.

MS. KELLEY: Okay. I have Stacie next.

DR. DUSETZINA: Thanks for this excellent work, Jeff. I think infuriating is kind of my thought when I was reading about these co-insurance billing trends based on charges. More in Round 2.

But I got a little bit hung up on the 16 percent of people without a supplement, and I think in your presentation you emphasized that's 16 percent of fee-for-service, which then explains why it was different than that 6 percent we saw in the overview chapter.

But I keep wondering, like do we know what happens to people in the MA plans going here? Like I noticed in the chapter there is some discussion about the MA payments to the hospital but not necessarily like are these treated like out-of-network visits for the patients,

and is the patient on the hook also for those charges, even if they would've hit like an out-of-pocket maximum? I'm curious if you know anything about what's going on with MA people going to these sites.

DR. STENSLAND: So I did look up some of the MA plans and how they pay these places, and it depends on the region and it depends on your MA policy. But in a lot of cases they will have, if you're in network, some sort of fixed coinsurance amount per visit or procedure. Sometimes it's a percentage of the payment, but more often it's a fixed dollar amount. That's for the in-network.

For out-of-network, at least one of the major players has a coinsurance set at 40 percent of whatever they have to pay. So they're kind of insulating themselves, to a degree, if you go to some out-of-network provider that's a critical access hospital, and they pay the cost-based rates, which are going to be close to double PPS rates, they are basically insulating themselves by dumping a lot of that extra coinsurance cost on the beneficiary.

DR. DUSETZINA: Okay. And we don't know, at this point, how many of the contracts are set up with in- versus

out-of-network? Just trying to think through, part of this goes to who benefits from the policy change. You mentioned Medigap plans. But are MA plans also benefitting if people would've hit a cap and it was in-network. I feel like we need that piece of information probably to put together exactly who benefits with the policy change.

DR. STENSLAND: Mm-hmm. Okay.

DR. DUSETZINA: Thanks, Jeff.

MS. KELLEY: Larry.

DR. CASALINO: Can we take a quick look at Slide 6, please?

MS. KELLEY: We'll get there, Larry. It takes a minute.

DR. CASALINO: There you go. Thank you.

DR. CHERNEW: Go ahead and ask your question while we get there.

DR. CASALINO: No. It's a pretty simple question, one I maybe should know the answer to but don't. So just looking at the first row there, total fee-for-service Medicare revenue, is about 25 percent of the mean critical access hospital revenue. How about revenue from MA?

DR. STENSLAND: MA revenue would be a little bit less than that.

DR. CASALINO: So if you combined fee-for-service and MA, together they make up about half of critical access hospital revenue, outpatient care?

DR. STENSLAND: On average, but may be a little bit less than half, yeah.

DR. CASALINO: Okay. But it's close anyhow. And MA plans wind up, if it's in-network, at least -- I wasn't clear the answer you just gave to Stacie, Jeff, about how MA plans pay critical access hospitals compared to traditional Medicare, and what the relative rates are, essentially.

DR. STENSLAND: Well, we went and visited several of them and they all basically said the MA plans contract to pay the cost-based rates, the fee-for-service rates. There is question of whether they actually get paid. Like there is definitely some frustration about claims being denied or there's going to be a slow payment, or saying it's not medically necessary. But in terms of the rate, it's the fee-for-service rate.

And then each plan will have a different

splitting of that payment between the cost-sharing that the MA beneficiary is paying and the amount that the MA plan itself is paying.

DR. CASALINO: So what the MA plan pays is not really based on market power.

DR. STENSLAND: Not in any of these. There is an old survey that suggests in some cases the MA plan tries to negotiate lower rates, but in most cases, and we've talked to them, it's the fee-for-service rate.

DR. CASALINO: Thanks, Jeff.

MS. KELLEY: Amol.

DR. NAVATHE: Yeah, thanks for this work. Super helpful. I had a question related to OPPS cap piece in this. I think in the paper, in the mailing materials, you discussed the ortho procedures and some Part B drugs. That would be the ones in the CAH world for which the OPPS cap would kind of be binding.

DR. STENSLAND: Yeah.

DR. NAVATHE: I was curious, if you think about this kind of in the longitudinal trend world, how often is the OPPS cap on cost-sharing affecting OPPS benes, benes receiving care in the OPPS world?

DR. STENSLAND: You know, I don't have the OPPS number. I could get that the next time around for you. I think I said that the number in the critical access hospitals was about 4 percent.

DR. NAVATHE: Yeah, I think you said like 200 --

DR. STENSLAND: 200,000, yeah.

DR. NAVATHE: Yeah, so okay, that would be helpful. I think the main reason I'm asking is because --

DR. STENSLAND: It's less than 1 percent, but yeah, go ahead.

DR. NAVATHE: Yeah. Just because since we've been kind of thinking about a policy change but then obviously things evolve over time, payment rates, et cetera, evolve over time, it would be curious to get a sense of how binding that cap is, and therefore, how relevant it would be. But thanks. I appreciate it.

MS. KELLEY: Gina.

MS. UPCHURCH: Did you say me? I don't think I'm next. I'm not sure. Yeah. So a couple of questions. First of all, I'm glad I like math because this chapter was full of it, so thank you for trying to make it as simple as possible.

There was a line a couple of times that talks about Medicaid pays -- I'm assuming, and I'm going to second round, about using language -- but you talk about Medicaid being secondary coverage to Medicare, but only paying 65 percent of bad debt. Is that through DSH payments? What is that?

DR. STENSLAND: So what it is, a dual eligible person [inaudible] the critical access hospital then sends the bill to the Medicaid Department, saying here is the coinsurance. But Medicaid Department will often say, "We're not going to pay any of that because our rate is lower than the Medicare rate." So they send back something saying, "We're paying nothing." So then that becomes bad debt for the critical access hospital. And then the Medicare program pays that critical access hospital 65 percent of that as a bad debt payment.

MS. UPCHURCH: Okay. So it's the lesser-of states, primarily, or is that something totally different?

DR. STENSLAND: It's going to be the lesser-of states. Any state where they're not paying the full product, and it varies a lot by state.

MS. UPCHURCH: Okay, great. Thank you. So there

were also some assumptions built in when the secondary coverage happens to be Medigap, that if we fix this problem and base it on, you know, cost versus charges that all of a sudden these Medigap policies will, and insurers, will drop their costs for their policies. Do you see that happen, because I don't really hear about that happening much. Is that something we know happens?

DR. STENSLAND: We don't know that it's happening. It's our theory that if their costs will go down, their premiums will go down. And there is a limit on how much. You know, they have their medical loss ratios. So if the actual costs go down below the medical loss ratio, they'll have to lower their premiums.

MS. UPCHURCH: Yeah, but their medical loss ratios is 65 percent, which you say in a footnote, just so people are aware. We just rarely see Medigap policies going down, but I mean, maybe this would cause that to happen in certain places.

But then my last question here is, if you look at the third bullet here, should there be a cap on critical access hospital coinsurance, if that were to happen, you wouldn't need that to happen if we did base it on cost

versus charges. Is that correct, or not really? Are they two separate issues, or would we take care of the third bullet if we took care of the second bullet?

DR. STENSLAND: They are related. Right now, if you just did the third bullet, if you say we're just going to put a cap on there but we're not going to change how it is, I think then there would be -- I think it was about $400 million reduction in coinsurance. Because you have places that are over the cap, because the coinsurance was so big when it's 20 percent of charges.

But if you shrunk it down, and you said, okay, now we're going to do both. So first we're going to take the coinsurance and shrink it down by about 60 percent, and now because it's so much smaller, a far fewer number of the cases are actually going to --

MS. UPCHURCH: -- the cap.

DR. STENSLAND: But it's still a material number of them, something like there would still be like $55 million or something in that neighborhood of lower coinsurance due to shrinking it down, because there are certain things that are just expensive, like a hip replacement or something these cancer drugs, that it's

still going to be binding for them, even when we move it down to 20 percent of the estimated cost.

MS. UPCHURCH: Right. Right. And that was shocking. I mean, I've done a lot of Medicare insurance counseling. I didn't even know that could exist. I mean, I didn't even know there was a cap. So thanks for all this great work.

MS. KELLEY: Brian.

DR. MILLER: I liked this chapter. It was fun. I learned a lot.

Quick question. Table 1, page 11, could we also add a column maybe out the -- or an adjacent table or separate table -- about the number of hospitals that have, say, the number of designations. So like 100 hospitals have 4 designations, 50 hospitals have 3 designations, 200 hospitals have 2 designations, 1,000 hospitals have 1 designation.

DR. STENSLAND: Yeah, I think we could put something like that in the footnote.

DR. MILLER: That would help us. Because the hospital designations was a great learning thing for me from MedPAC last cycle. Thank you.

MS. KELLEY: All right. That's all I have for Round 1, unless I've missed anyone. Mike, should we go to Round 2?

DR. CHERNEW: Yes.

MR. MASI: And real quick --

MS. KELLEY: Oh, sorry.

MR. MASI: -- I'm sorry to interrupt you. I just wanted to emphasize one thing that Jeff said earlier around this is not a proposal. This is really just our best attempt to provide some information to help inform your discussion around some of the moving pieces here, and we look forward to your feedback about how you wrestle these different normative judgments.

DR. CHERNEW: So that is all true, but as I wrote in my note, while this may not be a proposal, we are trying to figure out how you feel about how quickly we should move to a proposal and what that might look like. And it's really important to get a sense of that from Round 2.

So you can make broad comments, hopefully very concise, but I really would like to get some very specific sense of when we debrief on this we can know actually your views.

So with that, and because you did send this to everybody, Lynn, I do know that Lynn is first.

DR. RAMBUR: I think you're muted, Lynn.

DR. CHERNEW: If we can't hear Lynn it's just going to be unbelievably ironic.

MS. KELLEY: Lynn, go ahead.

MS. BARR: Okay. I got it now. Thank you. That would be unbelievably ironic.

All right. Thank you so much for taking this important issue up, and I think we're all very disturbed by what's happening with the beneficiaries. I appreciate you guys putting in a proposal that closes a lot of the gap. But I am not in support of the alternative scenario because it also closes doors for us. And I don't think it goes far enough because we still would have disparities in cost, so that's a problem for me.

But more important, all we want to do is create value for the beneficiary, and that is not just price, right, and reducing this -- overcharging is very important -- but it is also about quality. And we do not currently have a pathway for these facilities to get paid for quality. And so my proposal is that the critical access

hospitals would bill the PPS rate, and be able to participate in the PPS quality program, to the extent they can.

Now obviously they're going to get the balance of their payments in cost-based reimbursement, so it's almost like -- they get prepaid on PPS, and then they get the rest, in their regular cost-based reimbursement payments. But then they're in a framework where they're in the 21st century. They are billing. They are coding. You know, we can use their claims data in a meaningful way to assess their performance, and they can participate in the quality programs.

Now I know that just raising the rates doesn't matter because it's all cost-based reimbursed, but that calculation of what they would've gotten in bonuses on the OPPS could be a lump sum payment to them, and that could be outside of the MA benchmark.

I would also proposal that all cost-based reimbursement payments are not in the MA benchmark and that MA should just continue to pay the full charges are they, and they can bill Medicare for the CBR part of it. Because my concern is the more we pay critical access hospitals,

like you say, the more MA is going to sign up those patients and then send them somewhere else.

And Jeff, I think I've asked you before, I asked you this question, but isn't the reality is that for the majority of rural patients could sign up in an MA plan and not have any providers in their community? Isn't that correct?

DR. STENSLAND: That's something we're going to look into later about what the requirements are. There is an issue where the MA plan doesn't have to cover 100 percent of the people in the county. Like its network doesn't have to cover, and that's a serious issue we'll bring up later, and the whole network adequacy issue is interrelated with this payment issue.

MS. BARR: Got it. And they've also got like a 70 -- it's any provider within 70 miles, I believe, right. So their closest provider can be very far away and could be in an urban center, in most cases. So anyway, I'm worried about that.

I think that what you have is a good alternative, but I would really encourage you to look at a PPS alternative because of the other benefits of modernizing

the health system, giving them parity with everyone else, actually bringing their coinsurance to the same rate. I don't think that the complexity -- you mentioned the complexity in your paper, but you could set a statewide rate for the CAHs, right. And it would actually probably be less complex than for the hospitals to try to figure out how to refigure their charge masters and try to deal with still a broken system, and still have to pay 50 percent more coinsurance than everyone else.

That's all I'm going to say. Thank you.

MS. KELLEY: Stacie.

DR. DUSETZINA: Great. Thank you. So I don't know how hard this is to change, but I assume, like many things, it's difficult when we have a pretty complex set of recommendations. So I'll say first, I find charging coinsurance based on actual charges to be completely unreasonable, and I think that should be fixed as soon as possible. It's not fair for beneficiaries to pay up to nearly 80 percent of the actual paid amount. That's crazy. So I am very pro any solution of fixing that and then working around the details of how we get there.

A couple of principles I think are I don't think

that, you know, there are some ways that you should have the money, where the money would come from or how it would increase spending in other ways that maybe are not optimal, like increasing MA benchmarks, maybe a lot of the money going back to the Medigap plan. I think that's not necessarily -- you know, I wouldn't necessarily want to see it going that way because what we're trying to do is lower what the beneficiary pays, and not necessarily send all that money back to other parties.

I did appreciate your comment about Medigap and that eventually that would lower the premiums. So maybe that kind of self-corrects so that beneficiaries are getting even more benefits from the change.

I did want to say one overarching thing. There were some bounding exercises in the chapter that talked a little bit about people without supplements and their lower use of health care services. And it just struck me as we might want to be cautious about that type of framing, because I don't think it's because of a lack of need for services, but a lack of ability to afford to receive services. So I think just being cautious about that sort of framing would be really important.

Again, I'm incredibly supportive of changing that beneficiaries pay based on cost rather than charges. I'd like to see that happen sooner rather than later.

MS. KELLEY: Tamara.

DR. KONETZKA: Great, thanks. Jeff, thanks for a really thorough chapter. I think you upfront considered so many direct and indirect consequences of this. That was really well done.

A couple of reactions. One is that I am in favor of, in the longer run, looking at different ways to pay critical access hospitals. I agree with Lynn for sure on this that it seems perhaps antiquated what we're doing and that moving more toward a PPS kind of a system, but maybe with a lump sum subsidy if we need to, to keep them in business. I think that in the long run we should consider different models.

As a related issue to that, I'm really interested in this idea of bypass. Lynn, I don't know that Knudson article, so I don't know if that 30 percent of people in rural areas bypassing critical access hospitals is a good number or not. But I think it's a really interesting statistic to dig into a little bit more, again, in the

longer run when we think about how we need to pay these hospitals, to keep them alive.

But I think in the short run I agree totally with both Stacie and Lynn that we need to fix this coinsurance problem. I mean, to me, it's just absolutely insane, and it's clearly a historical blip, right. There was no motivation originally for making rural beneficiaries pay these astronomical prices, based on charges.

And so even as we think about all the costs and benefits of fixing this, to me it's not even an issue where we have to weigh the costs and benefits so much. We just have to look at the different ways of doing this, because it's something that is so blatantly unfair that we just have to fix it.

And I'm in favor of doing that in the shorter run, because I think these longer-term sort of issues around changing the way we pay critical access hospitals will take longer, and I don't think that switching now to changing based on 20 percent of payments, perhaps with a cap -- I think I like both of those ideas -- as a good place to start, as a way to fix this in the shorter run, like coming up with a recommendation this cycle.

I guess a couple of other issues related to that, and why I think it's also sort of important to do in the short run, even if we don't have everything figured out is that it seems like it's not that many people who are affected, but it's a huge issue for those people, and it's incredibly unfair.

And then I was really interested in some of the bad debt data and discussions, but I just want to start for the record that even when people don't have supplemental insurance are billed these rates and don't pay it because they can't afford it or whatever, having unpaid medical debt is also costly to people, in so many ways. So that's also not a good outcome, even if people just don't pay it and Medicare ends up covering some of that in bad debt payments.

So I guess I'm, like I said, in favor of trying to fix this in the short run and coming up with a recommendation to do it. I feel like in terms of additional analyses, I think what is resonating with me in this discussion is that we really need to dig into the MA part of this a little bit more, just to see what the consequences would be on MA payments and for MA

beneficiaries. Thanks.

MS. KELLEY: Brian.

DR. MILLER: This was a really interesting chapter because I read it, and I was very excited, and then as Stacie has noted, who wins and loses became more complicated, and I became much more worried. Because I was reading this and I was like, oh, that's the beneficiaries, and then I read, on page 21 we were talking about the change from charges to the Medicare rate, which on the surface seems like a good idea, ends up actually more benefitting the Medigap plans, so that 84 percent of benes, then you're enriching the Medigap plans, and that doesn't really make a lot of sense that we'd want to be subsidizing the insurance industry as opposed to the beneficiary.

And then the other point someone made about this increasing MA benchmarks, right, because then you're subsidizing the MA industry, or the Medigap industry, and again, you're not subsidizing the beneficiary. And this is sort of the broader problem with making general industrial policy-type decisions, where we're trying to micromanage benefit design. I agree that there's a big problem here, and I'm not sure if the options that we have are

necessarily good options, because we're all going to have to change them again in three to four years when something else on the market changes.

So I wonder if there's a broader question of how CAHs are paid and how that is shared with consumers and this large list of hospital designations, and maybe the deeper question here is how do we simplify this and make it more efficient, straightforward, and easier for hospitals appropriately target payments, and make sure that beneficiaries, who are patients at the end of the day, aren't harmed simply because they live in Rural America, which is the current status quo.

Two additional thoughts I had on this. One is looking at the estimates on page 28, we said that fee-for-service, I think, was $2.5 billion, and MA would then be $1.3 billion to solve this problem, which suggests that MA is a cheaper solution. I don't think it's necessarily just that it's MA. I think that there's dynamic opportunities in managed care which have benefit flexibility, so can adapt and change things without incurring as much expense as the taxpayers.

And then the third thing, a couple of people

mentioned that if we're going to juice fee-for-service that it doesn't go to MA, just like I have that same concern that the stars rating program only benefits MA and not fee-for-service, and the fee-for-service plan doesn't have a star quality rating, it doesn't get a bonus. That should be a bonus penalty, too, for both. I don't think that we should favor fee-for-service for rural hospital payment and not do something similar for MA rural hospital payments. So I think we need to be equitable across programs, make sure we're not subsidizing just one insurance market for another, implement some sort of dynamism in the policy because we're going to end up making it more rigid and then having to come back and try and solve the problem in a couple of years, when some of us are still here, and some of us have rotated off. Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks Jeff, for such a great chapter. Per usual, I always learn a lot. I was really struck by the burden on beneficiaries in these rural areas who are disproportionately of low income, not exclusively but a fair number of low-income folks live in rural areas.

So I definitely support, in the very near term,

changing the coinsurance to 20 percent of payments as well as also support the cap on coinsurance. Those seem to move in the direction of fairness.

But I would not want that step to preclude what I think needs to be larger payment reform in this space. And I think adding to what Lynn brought up, as I was reading this I kept thinking of some type of blended approach, of PPS or something else, to get us into a better space with these 1,500 hospitals, which is a fairly substantial share of all hospitals in the country, as in the fact that they're not in the PPS part of the payment system doesn't seem quite right.

And I think one of the things that I was wondering about, and thought it might be helpful to add to the chapter, would be trying to understand the distribution of these hospitals across the state. So I don't know whether that's in the form a map or a table, but I think it would be interesting to see how these are distributed across states.

And then I think that this chapter, once again, underscores the need for patient-level data on the supplemental insurance, that we can connect back to plans

to get a better understanding of what's going on in this space.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks.

This is complicated. So I just want to say plus-one to Tamara's comments and a lot of the comments that have been made. I do sort of favor -- I think it's highly unfair to people in rural areas to have to pay so much more, and we don't even necessarily know the quality of the care that they're receiving.

I do have concerns about administrative burden of making these changes and then deciding a few years later that something else needs to be done. I just don't know administratively like what that means for the people trying to implement all this. So that's my big concern with doing that, but I do feel like it's really unfair and needs to be regulated in some other way.

My main point -- and this is just -- in several parts of the paper, we talk about supplemental coverage, supplemental, supplemental, and what we mean by that can either mean a Medigap policy, or it could also mean employer coverage and Medicaid. So I'd rather us use

secondary coverage to mean all of those things. The term "secondary coverage" means all of those things, and when we're talking about supplements, it's called "supplement Medigap," so it's crystal clear, because there are different parts of the paper where we call things different things. I think it's very confusing. So if we can just try to stick with secondary coverage, if we're meaning all of those things, and just supplemental or Medigap when we're specifically talking about this policy.

So I do think we need to address it, but I am concerned about the administrative costs of making major shifts and then having to make them again. And I don't know enough about it to weigh in on that.

So thanks, Jeff.

MS. KELLEY: Kenny.

MR. KAN: Jeff, thank you for an outstanding chapter.

Four points to convey. One, I'm not a fan of basing outpatient co-insurance on charges. We really need to move away from this while ensuring that CAH remains financially sustainable.

However, point number two, there are many

complicated first-order and second-order effects that I believe merits more analysis. For me, most intriguing is the fact that a $2.1 billion decrease in outpatient cost sharing could actually result in a $3.2 billion increase to other stakeholders. It's a net $1.1 billion increase to the health care ecosystem, and it also artificially increases MA benchmarks and rebates, which I do not favor.

So, as a result, point number three, I recommend that we actually have deliverables over two cycles. The first cycle, from '24 to '25, we articulate observations and principles and alternatives. You know, there may be two or three alternatives. One alternative could be based -- you know, this perhaps you could have it based on 20 percent of the payment rate, but subject to a cap -- or subject to some cap, because it has to be transitioned, because remember we have to ensure the solvency of the CAH. Alternative one.

Alternative two could be Lynn's idea of having a quality add-on bonus and other alternatives.

So I think in the first cycle, we should seek to understand the pros and cons of each alternative, and then in the '25 to '26 cycle, that's when we as a Commission

explore the alternatives and come up with a policy recommendation. That would be my suggestion.

Thank you again for an outstanding chapter, Jeff.

DR. CHERNEW: Can I jump in for a minute? I think we're roughly in the middle of Round 2, and I just want to make a general statement as you go through this, because I hear different things. And the only thing I want to emphasize to folks is there are real tradeoffs on whether you think we're going to get to places like that, Kenny, because there's other things that later people are going to want the same staff to do. And so when we add a deliverable to do blah, blah, blah, blah, blah, there's a bunch of other things that then will not get done, some of which, by the way, have also been put as high priority, like things like how rural -- and they affect rural hospitals and a bunch of other stuff.

So the core question, in some sense, is -- and again, I'll let Paul jump in in a minute. That's a trigger warning, Paul -- is sort of the timing. There's what I'll call -- now I'm going to call it the Konetzka view, and it might not be yours tomorrow, but I think it makes sense. It might have been, I think, maybe where Stacie was. You

kind of fix this now, acknowledging that there's some deleterious potential other issues you're going to have to deal with, which we could write about, and we could do it in a vague or non-vague way. You kind of try and fix this right away in a particular way, and then you weave all these other things about payment and how you balance across MA and how you think about the Medigap plans and all that other stuff. You weave that in over time to other work as it plays out, which is one strategy.

The other view is don't do anything until you've done the whole bolus of work and then try and decide what you sort of want to do, and the problem is finding that sort of intermediate landing turns out to be much, much harder than some of you may necessarily think, because all these different pieces are connected.

So I'm going to leave it there to give a sense, but I don't think it's the case. We certainly could do something simple, which is if we just deal with cost sharing and not payment, we can explore different ways of managing the cost sharing. When we start to add on other pieces of things we want to do, it tends to push the work out to more analysis, and we either have to drop other

things that the same people are doing or delay when we get there, and that's the part that's hard. And it's hard for me because I think we would all rather do more quicker.

Anyway, Paul, you can now correct me since you know more about the staff, and as an aside, I'm not counting, Kenny, any of my speech on your time -- or maybe I will, actually. My speech will probably be on your time.

MR. MASI: I think that was well said, Mike, and as always, the staff are happy to kind of pursue whatever process and goals the Commissioners want, but I think you point to the important issue of tradeoffs here and whether as -- I think you're right, I think that's more pointed to in the beginning, whether you want to do some things now and other things later in a way that's somewhat synchronized or if you want to pursue a different kind of path. I look forward to your feedback.

MR. KAN: Mike and Paul, if I may, just briefly respond to that point. I hear the concern. The thing that I'm -- and I don't know how to think about this, is that what if in trying to evaluate these tradeoff questions, we come up with an intermediate solution and then somehow there are, like, bigger unintended policy consequences that

result. I think that's the part of me that's hesitating as a result.

DR. CHERNEW: Kenny, that is 100 percent reasonable. I agree completely, and let me just be super clear. I 100 percent agree. If we go down the path of doing this, we can say something about the unintended consequences or what we think the consequences were of this specific thing.

What tends to take a lot longer is if one says, well, the alternative to this specific thing is something else. Then you have to do this thing. It's unintended consequences. The other thing, it's unintended consequences. The third thing, it's unintended consequences. We don't get that much time to discuss all of the different policies.

So some of the unintended consequences have been raised, and to be clear, I am fine. The whole point of the session is to get people to say what they want, but understand that it never seems to get as smoothly to the end as quickly as you want because there's always some version of that. To some extent, again, my personal view is I view this as a really egregious problem, and I would

like to try and do something quicker than later. But I fully -- Brian said this; others said this. I fully, fully, fully understand there's a lot of potential unintended consequences, and we're either going to have to decide to quantify them best we can and take a stand or to wait and just see what we can do. That's the gist.

I'm sorry. Who's next, Dana?

MS. KELLEY: Scott.

DR. SARRAN: Yeah. Jeff, again, thanks for a really succinct chapter. It certainly highlights the issues very well.

One of the key issues I think that it highlights, again, is how poorly the Medicare program works for beneficiaries who are in traditional Medicare and lack, for whatever reason, a supplement or Medicaid, particularly in this case.

I certainly respect Lynn and others' comments about the desirability of pursuing a more integrated, comprehensive approach that better links rural hospital payments to at least their cost structure, if not ideally their quality and outcomes. But that said, I'm coming down on the side, as I think Mike has, that, gosh, we may have a

simple fix to a material beneficiary issue by changing away from the current approach where a beneficiary without a supplement is exposed to charges.

And I guardedly think we should grab that opportunity, fix it, obviously continue to be alert for unintended consequences. Obviously, we're going to continue to look at rural hospitals and rural providers broadly along a number of fronts in several domains.

But I feel that the ability to address right now in a relatively straightforward fashion an issue that is material for some segment of beneficiaries is an opportunity we should take.

MS. KELLEY: Robert?

DR. CHERRY: Yes, thank you. So, you know, I'll modulate my comments according to, you know, Mike and Paul's, you know, input as well.

You know, I think, first of all, in terms of the report, I think many of us, including myself, find it rather surprising and striking in terms of its content, and the inequities are kind of readily apparent here. It makes you wonder what else is lurking under the hood in this massive program that we call Medicare.

You know, the short answer is that -- you know, I agree with fast-tracking this because it seems as though it's such an egregious sort of issue, that having it held up by more and more data analysis may not necessarily be appropriate here once we find out that there's a real issue.

The model, the illustrative model is not perfect, but it is an illustrative model. So just simply making a recommendation and saying here's one example of how to fix it and let others sort of in a fast-track way kind of figure that out, I don't have a major issue with that.

But nevertheless, I can't resist proposing an add-on because I think that's where I think we have that temptation.

One thing I agree with Tamara is that it just has to be fixed, but I disagree at any cost, because there's this interesting loophole with CMS regarding urban acute care hospitals that have reclassified themselves as rural hospitals, because there's these loopholes that exist. And in some cases, it's fairly egregious.

I don't know what the incremental cost of that is, but if we could be able to obtain that relatively easy,

that could offset the cost for adjusting for these co-insurance inequities that exist. So that may be one way of finding the dollars because urban hospitals, that they're declaring themselves -- rural hospitals is also equally egregious, too. And it takes away from resources from critical access hospitals in rural areas, which we are talking about.

So that's my one add-on, and I don't have an issue with fast-tracking this.

MS. KELLEY: Greg?

MR. POULSEN: Okay. I hope you can hear me. My sound has been a little bit weird today, but I would, again, just say, Jeff, great job. I think this was really illustrative and helpful. I learned a lot from this chapter.

One of the things I learned is to interpret something I had heard and didn't understand, and that was when we've done focus groups with rural communities, we have heard people say, well, the cost difference in going to the urban hospital and staying in my rural community is enormous. And I knew the price differences and so forth and was surprised at that, and so I admit naivete of not

understanding this issue at all effectively. And it really illustrated for me how important this is.

And the bad debt that comes from both people who can't afford to pay and the other mechanisms that you mentioned in the chapter and that Tamara highlighted, I think are really important, and I'm grateful to do that.

While I absolutely get the "let's do the right thing" as opposed to "let's do something quickly," I wonder if that isn't just something that we might end up finding a really long pathway to get to and postponing appropriate and necessary reform longer than we should.

And I wonder if -- I guess what I don't think -- a couple of people have said if we do this, we'll be back at it in two or three years trying to get it right. That may be true, depending upon what adverse and unanticipated consequences there are that we haven't thought of yet. I hope we can get to those if we go to the next step of analysis and understand that. But my thought would be if we do this -- and I would suggest doing both setting the coinsurance based on payment rates and having the cap -- it would be my thought that if we did that, then we don't have to revisit this in two or three years. We could revisit it

in more of the five- or ten-year time frame, and that would be successful. And in that time frame, we would also see what happens to the MA penetration in rural areas, which may take this to be a much less important issue than it is otherwise.

So at least I would -- based on what we find through further analysis, my perspective would be let's go ahead. Let's look at what this would mean. Let's make sure that we understand to the best we can what this would be but with a predisposition that we should fix this sooner rather than later, probably using the mechanism identified here.

MS. KELLEY: Betty?

DR. RAMBUR: Thank you. Greg teed this up perfectly for me. Thank you so much for such an interesting chapter and conversation.

I'm very sensitive to ensuring that any changes that we make don't contribute to CAHs exiting the market. I think of the people who use these facilities, 20 percent of our population living in rural areas, farmers, ranchers, people who create our energy, and a disproportionate amount of elderly. So the nation depends on this infrastructure.

And my sense, for all the reasons many of you have said, is that a comprehensive approach is better.

However, as I sat down and tried to model that out for myself, I tried to make a graph of who benefits, as Stacie has said, who pays, and the tradeoffs were more than I could navigate. And I think it would take a lot of time and effort, and I know tradeoffs are always part of policy. But right in front of us, we have a situation which I think is egregious. I didn't understand this, and it does make sense that people would decide to bypass if it's going to be more expensive in their local community. It's just one more factor.

So I think these are very reasonable first steps, underscoring that they are first steps, because it's just untenable to set co-insurance on charges in my view, and I'm comfortable with the cap, recognizing that there may be consequences, but we could address the whole thing over time. Thanks.

MS. KELLEY: Amol?

DR. NAVATHE: Thanks.

I think at this point, I think I'm piling on with a lot of the Commissioners' comments. But just to make

sure I'm clear about it, I think I also find this quite egregious.

I think while I was kind of generally aware of the issue, the magnitude of the differences between the cost sharing that the rural venues pay and CAHs versus others was really striking to me. I mean, the percentages and the dollar values are -- they're very material. I mean, you can imagine for rural populations that these are really financially impactful. So I think that does create, for me at least, a really strong sense of urgency.

I don't think that undermines or undercuts the kind of totality of the issues that we have already started doing some work on, and I think Mike and Paul and others' leadership has tried to signal that we are sort of taking on and willing to do systematically over time. But I think, in some sense, holding hostage this one issue for either the need for systematic reform, which is going to take a long time, or other artifacts or other challenges that we have in the policy design of the Medicare program, I think that also doesn't seem fair to the rural venues. It's not their fault that M.A. benchmarks are set the way that they're set. And so saying, hey, we're going to not

do this because we're worried about the way that M.A. benchmarks are set, to me that feels, again, kind of in a boomerang way, again, not fair to them. That's not their issue. They're not the ones that set that policy.

And I think on one hand, just thinking about what Kenny said, there's certainly puts and takes here from a financial perspective in terms of which stakeholders the dollars are flowing to. At the end of the day, it does seem like the vast majority of the dollars are being rearranged in some way, whether the dollars are flowing to the supplemental plans or to higher Part B premiums. One way or another, these dollars are kind of being shifted around. The one exception, of course, is this Medicare Advantage benchmark, which is why I called it out. It's not really the fault, if you will, of the rural venues.

So that's my kind of core perspective. I think just to be really clear about it, I support both of the questions that are teed up here in terms of shifting toward payment rate as a reasonable alternative as well as having a cap because I think these are dynamic, and the dollars will only likely to grow over time. So I think the cap becomes important for symmetry. Brian has called it out in

the context of MA versus fee-for-service symmetry. I think there's also obviously the rural/non-rural symmetry piece here that we're interested in. So I think that piece is also worth flagging.

Simultaneously, I'd also say I support the idea of continuing our work around MA rural, around broader rural policy and policy that we've started to embark upon. I think, Jeff, if you're able to pull some of those kind of factoids around a little bit more granularity, just information on the MA cost-sharing side as well as on the OPPS cap pieces, I think that would be informative as we hopefully push this forward. So thank you so much.

MS. KELLEY: Larry?

DR. CASALINO: Yeah, it's an interesting discussion. I feel like I'm watching a tennis match. My head's swirling back and forth.

You know, just one thing, on charges nowadays, it's absolutely ridiculous, and any chance we have to articulate that as a principle, that payment should not be made on charges, we should take that chance, I think, because that problem is only going to get worse. It's unfair among hospitals. We see a big difference in their

charges.

But one thing we haven't really mentioned, or not very much, is that people that are uninsured or poorly insured, if they get killed by charges, they're billed for charges, and the cost program as it is now just is one additional incentive to increase charges. So that's one reason to want to get away from charges quickly.

The other is when charges get increased, uninsured people have to get bigger bills. They don't pay them. That increases bad debt, and the government winds up paying back some of that bad debt. So it's really bad all around. So I just would like to make that clear whenever we get a chance. It's just absurd to base things on charges.

In terms of what to do now, I have to say I'm very intrigued by what Lynn has proposed, and I think it probably is in the right direction and possibly writing the specifics as well. But I'm not really in favor of -- let me come back in a minute.

There's two questions about that. One is if we do this kind of quick fix, which I think would be pretty simple, does that then reduce the chances of getting a more

comprehensive solution? It's hard to judge that, but this is such a quick and simple fix, I think, that I'm not sure it would greatly reduce the chances of eventually getting to a more comprehensive example.

If instead we chose to let's try to get a more comprehensive fix and we'll divert a lot of staff time to doing that quickly, that I would, I think, oppose. And the reason is we've never -- in the time I've been on the Commission, I can't remember an explicit conversation about this, but when we choose the topics that staff and Commissioners devote time to, I think -- and for myself at least, I guess I would base it on how horrible is the problem, how egregious is it, how kind of dumb is it, and how much is it hurting some people. That's one thing, but it's not the only thing.

The other important thing is how many people are affected? So this is clearly a horrible, egregious thing that affects a relatively small number of people, right? So would I favor moving away from -- moving staff away from some of the MA work, which affects not only half the Medicare beneficiaries, but really affects the structure of the health care system, to work on something that affects a

million or two beneficiaries, not to -- I wouldn't favor that, right?

So that's why I think that the kind of quick fix and then staff working as time allows to move toward a more comprehensive fix is probably where I would be right now.

I will just say parenthetically that I guess -- this is, well, where I thought, so I'm not going to go into parenthesis. I'll stop there.

MS. KELLEY: Josh?

DR. LIAO: Great. I'll be brief as well.

I think my main comment is to kind of underscore a few things that other Commissioners have mentioned. I think on the one hand, we have a clear problem in front of us. Words I've heard used are "unfair," "egregious." I would say asymmetric with other parts of the fee-for-service program, and to that, I would agree.

I think on the other hand, we have what I consider a worthy aspirational goal for more comprehensive solutions, but I think their implementation concerns are notable.

And like Betty, I've been drawing lines and figures on my paper here, and the tradeoffs are a myriad,

at least in my own head, and so I think both from a perspective of MedPAC work as well as the more broader policy implementation question.

So I think in short, we have an issue that I think needs change, and we're likely looking at complexity and weights, on the other hand. So just to kind of land this on the questions for the screen, I think I don't know that current insurance should be a set of charges. I think the idea that's being proposed here, a 20 percent payment, is a reasonable alternative that we could flesh out and consider as near-term action.

I think in that pursuit, I would be in favor of exploring the effect of a cap, and I think about the kind of historical analog from OPPS where it went from a charge base to kind of an allowed amount payment base, but over time having a cap implemented to kind of mitigate that disincentive for in- versus outpatient that we heard about. And so as I understand it, maybe the shrinkage that we would have from charge to payment now would not make the cap binding, but that's obviously preliminary. It's based on one year of data from 2022. As a lot of amounts drifted up over time, you could imagine a cap being relevant. So

any kind of more evaluation of this alternative, I would love to see a cap be part of that.

Thank you.

MS. KELLEY: Paul C.?

DR. CASALE: Yeah, thank you. And I also learned a lot. Thank you, Jeff, and I'll be brief as well.

Really agreeing with what I'm hearing in general. First, there's no question that there's urgency in moving away from payments based on charges, and the short-term proposal, I think is reasonable, basing it on 20 percent of payment rate and exploring also the use of a cap.

And I also support what others have said around an iterative approach, and I think we can include that in the work -- in the short-term work, recognizing that this is not the end, but that this needs to be fixed in a timely manner.

So thank you.

DR. CHERNEW: I think that's the end. Is that right, Dana?

MS. KELLEY: Yes, it is, unless I've missed someone.

DR. CHERNEW: Okay. And we, I think, are five

minutes over, if I have the schedule correctly in my head, which is actually pretty good.

So, Lynn, I think you wanted to say something. I'm going to let you say something in a minute, but really just for a minute.

I will say that the trade-off here is if we're going to do something this April, we need to do something in January. If we do something in January, we're going to have to bandwidth for a lot more analysis. If we don't do something in January and then we don't get to place in April, that's fine. We can revisit next year, but there are real trade-offs to where we get to. And what we'll do is we'll take all of the sets of comments we hear, and we're going to make a decision about whether or not, to be frank, how this fits into the January agenda, because that's the next and, frankly, the only slot that I think we have to get us to where we might want to be in April if we want to get there.

But, Lynn, I know you want to say something broadly and in the public session. I know you will tell me separately as well, but go ahead. You have the floor, and then we're going to move on to another topic on rural

health care.

[No response.]

DR. CHERNEW: You're muted.

MS. BARR: It's the best place for me.

I do really appreciate the support of the Commission on this work, and the most important thing is we do fix this beneficiary co-pay issue. So I see where you all are standing.

It would be, I think, a great benefit to the Commission if we could model the PPS proposal at the same time. It's very straightforward. I've worked to simplify it to death with stakeholders. There's broad support for it, and it would give us a pathway to quality that we don't have.

I'm as concerned about quality as I am about price, but if the Commission wants to just go forward, I will go with the Commission. But I think we lose a great opportunity, and my experience in Medicare policy has been that you get one bite at the apple, and that's all you're going to get. And so we're not going to fix the quality -- we could fix them both at once, and I don't think the modeling is all that difficult.

And since this was an illustrative model, I would appreciate us illustrating both models so that Congress and others have a better opportunity to at least look at what the tradeoffs are, and then we can make our recommendation based on that.

I don't know, Jeff, if that's going to be too hard. Like I say, I think we simplified the heck out of this proposal. So that's my only comment. But I appreciate the support of the Commission, and it would be better to fix this than to not.

DR. CHERNEW: All right. Thank you, Lynn.

We're going to take a three- or four-minute break and not a five-minute break. Let's try and come -- actually, let's try and come back a little bit after, like, 3:52, to make the trains run on time, because we have one more session left. It's also interesting that you left with quality there, Lynn, because we have this whole other agenda about rural hospital quality that has a whole bunch of other stuff that we could do beyond what you're about to see, and I think it will be reasonable. We'll see, when we look at the material that's going to come up, what are the next steps to do or not on this other body of work. So I

hope at least by how these are juxtaposed, you'll see some of the more complicated tradeoffs.

But anyway, what I hear is a lot of sense of urgency. There's a real acknowledgment, and I could not agree more that this is an issue. And we will look at all the comments when we come back at the end to figure out exactly when we do this cycle on this topic, and let's jump back again. Let's come back at 3:54. I keep changing the time because I keep talking. Don't stray far.

[Recess.]

DR. CHERNEW: Okay. I think we should probably get started because I want to make sure we have enough time to go through this next session. Dana and Paul, I assume we're live and that the world can hear me?

MS. KELLEY: We are live.

DR. CHERNEW: All right. So in what is a testament to the incredible scheduling, Lynn was able to end the last session within appeal to the quality of care in rural markets, and it turns out we happen to have a session about measurements of rural provider quality. It is something that in many ways is largely FYI. It focuses on how we measure more than the actual specific measures.

All of the sectors will have the actual measures presented, but there was some Commissioner interest in understanding this. So Ledia, why don't you take it away.

MS. TABOR: Thank you.

Good afternoon. The audience can download a PDF version of these slides in the handout section of the control panel on the right side of your screen.

To conduct effective monitoring of the Medicare program, promote quality improvement, and inform beneficiaries' choices about where to receive their health care, Medicare has implemented a variety of quality reporting and measurement programs for many providers, including many in rural areas.

During recent meetings, Commissioners have asked for more information about how the Medicare program measures the quality of care furnished by rural providers. This presentation provides background information to facilitate your discussion.

This material is part of an ongoing body of work on rural Medicare beneficiaries and the providers that serve them, and will be included in our June 2025 report to the Congress.

Before moving on I would like to thank Jeff Stensland and Brian O'Donnell for their feedback on this work.

First, I will review the Commission's prior work on quality measurement. Then I will present background on Medicare's current quality reporting programs and rural providers, followed by initiatives to improve measurement of rural providers' quality of care. Then the Commissioners can discuss the material and provide guidance on potential future work.

The Commission has developed a general set of principles for measuring quality in the Medicare program. Quality measurement should be patient-oriented, encourage coordination across providers and time, and promote change in the delivery system; be not unduly burdensome to providers; and include measures such as outcomes, patient experience, and value.

Medicare quality programs should give rewards based on clear, absolute, and prospectively set performance targets, and
take into account, as necessary, differences in a provider's patient population, including social risk

factors. Finally, Medicare should target technical assistance resources to low-performing providers.

In 2012, the Commission established a set of principles designed to guide expectations for the quality of care in rural areas going forward. These principles were generally centered on hospitals but could be applied to other providers.

First, expectations for quality of care in rural and urban areas should be equal for the nonemergency services that rural providers choose to deliver. That is, if a provider has made a decision to provide a non-emergency service, that provider should be held to a common standard of quality for that service, whether the service is provided in an urban or a rural location.

Second, all providers should be evaluated on the services they provide -- emergency and nonemergency alike -- and the quality of the services should be collected and reported publicly.

I'll now present some background on Medicare's current quality reporting programs in the context of rural providers. There is a lot of information I am going to present, but I wanted to note that a takeaway of our

analysis is that Medicare does measure the quality of care of many rural providers, where feasible.

Quality payment programs can create incentives for providers to furnish efficient, high-quality care. There are broadly two types of quality payment programs. The first are pay-for-reporting programs, in which providers that successfully report designated quality measures are financially rewarded, or not penalized. The Congress has enacted quality reporting programs for fee-for-service provider types that account for a large majority of services furnished to Medicare beneficiaries. CMS reports data from those programs on the Care Compare website as summary star ratings and as detailed measure results.

The second are pay-for-performance programs, or value-based purchasing programs. Typically, these programs adjust payments to a provider, upward or downward, based on its performance on quality measures. CMS now has pay-for-performance for several entities including hospitals, clinicians, SNFs, home health agencies, dialysis facilities, ACOs, and MA plans.

In today's presentation we will focus on quality reporting

programs because they are the foundation for any quality programs, including pay-for-performance programs.

As previously stated, the Commission contends that it is important to measure the quality of care furnished by rural providers to monitor performance, publicly report information to patients and payers, and incentivize high-quality care. However, there are practical challenges in measuring some individual rural providers' quality of care and holding these providers accountable in quality reporting programs. Many of the challenges are broader limitations in measuring the quality of smaller providers and are not unique to rural providers.

What most rural areas have in common is low population density, resulting in low patient volumes. Some rural providers do not have enough patients to produce reliable and valid measurement results. Also, quality measurement may create a heavier burden, because many rural providers are small and may have limited time, staff, and finances available for quality improvement activities.

Some rural providers are currently not required to participate in the Medicare quality reporting programs. Rural providers may be excluded from quality programs in

legislation because they are paid outside of traditional payment systems, meaning providers that are paid on a cost basis, or because of program rules defined by CMS, in particular measure-specific minimum case counts needed to produce reliable and valid results.

` However, our analysis found that many rural providers report quality results to CMS and meet program rules for public reporting of at least some quality measures.

Also, during site visits this summer, leadership of rural providers cited the value of voluntarily reporting to gain experience with quality measurement and improvement. A director of nursing at one CAH recounted receiving only one completed patient experience survey in some months. The CAH did not meet the CMS minimum for public reporting for that time period, but they said the information was helpful for their own quality improvement activities.

Over the next set of slides, we'll review quality reporting program requirements and participation by some rural providers, including hospitals, post-acute care providers, clinicians, as well as for ACOs and MA plans.

Starting with hospitals, Medicare has two quality reporting programs for acute care hospitals: the Hospital Inpatient Quality Reporting Program and the Outpatient Quality Reporting Program, which are described in the first two rows of this table. There are 36 quality measures in the inpatient QRP including readmissions, mortality, and patient experience. There are 19 measures in the outpatient QRP, including imaging for low back pain, patient experience, and left before being seen in the ED.

For both programs, critical access hospitals are excluded because they are not paid under the PPSs, however they are encouraged to voluntarily submit measure data for public reporting on Care Compare.

Ninety-nine percent of CAHs voluntarily participate in the QRPs, meaning they report measure results to CMS and allow CMS to calculate their results on claims-based measures. CMS will publicly report results if the provider meets the measure-specific minimum case count for public reporting. Looking at some examples, 83 percent of CAHs met the CMS minimum case count for readmissions and had their results publicly reported. Seventy-one percent had sufficient volume for public reporting of at least the

"left before being seen in ED" measure.

Looking at the last row, the new Medicare provider type, rural emergency hospitals, are measured on four measures that are part of the outpatient QRP, including time spent in ED. Data collection began for that program in 2024.

Next let's review some of the post-acute care quality reporting programs. The SNF QRP has 16 measures, including, change in mobility and readmissions. All freestanding, hospital-based, and PPS hospitals with swing beds are required to participate in the QRP or have reduction in their payment update. Eighty percent of freestanding and hospital-based SNFs in rural areas met CMS minimum case count to have at least readmissions results publicly reported on Care Compare. However, PPS hospitals with swing beds often do not meet the minimum case count CMS requires for public reporting, so only 17 percent of PPS hospitals with swing beds have at least readmissions result publicly reported. CAH swing beds do not report data.

Looking at the second row, there are 21 measures in the home health QRP, including improvement in management

of medication and patient experience. All home health agencies paid under the PPS are required to participate in the program or have a reduction in their payment update. Looking at Care Compare data we found that 87 percent of home health agencies with the majority of their patients in rural areas met the CMS minimum case count requirement and have at least readmissions results publicly reported.

Before reviewing the quality program for clinicians, we wanted to provide some context, that in its annual assessment of the adequacy of payment for clinician services, the Commission discusses that the quality of clinician care is difficult to assess for several reasons. These reasons are true both in urban and rural areas.

First, Medicare does not collect clinical information -- for example, blood pressure readings and many lab results -- or patient experience and patient-reported outcomes at the beneficiary level. Second, CMS measures the performance of clinicians using the Merit-based Incentive Payment System, or MIPS, which, in March 2018, the Commission recommended eliminating because it is fundamentally flawed.

Third, for claims-based measures, Medicare's

"incident to" policies obscure the ability to determine who actually performed a service because a substantial portion of services performed by APRNs and PAs appear in claims data to have been performed by physicians.

Finally, there is an issue of small numbers of cases for measuring individual clinicians, a perennial issue in quality measurement for clinician services because it can make the results at the individual clinician level unreliable and inequitable.

Acknowledging all these challenges in measuring the quality of clinician care and our standing recommendation to eliminate MIPS, we present information on the program here since it is the basis for Medicare's current clinician quality reporting program.

MIPS is a system that calculates individual clinician-level or group-level payment adjustments based on hundreds of measures across four areas: quality, improvement activities, promoting interoperability, and cost. These measure results are used for reporting on the Care Compare.

Clinicians participating in advanced alternative payment models, like many accountable care organizations,

do not need to report data under MIPS because their quality of care is assessed by the ACO. To account for the small numbers issue tied to measuring clinician quality, MIPS excludes clinicians who do not meet low-volume thresholds of Part B-covered services. In 2022, clinicians who bill more than $90,000 for Part B-covered professional services, and see more than 200 Part B patients, and provide more than 200 covered professional services to Part B patients must participate in MIPS.

CMS reports that 94 percent of MIPS-eligible clinicians in rural areas actively submitted MIPS data. Clinicians who bill exclusively through FQHC and RHC payment models are not included in MIPS. However, if a clinician is a part of a RHC or FQHC and bills for Medicare Part B services under the fee schedule, then payment for those services could be eligible for MIPS payment adjustments.

Here we present the quality reporting requirements for two ACO models: the Medicare Shared Savings Program and the ACO Realizing Equity, Access, and Community Reach model. ACO quality results are used by CMS for monitoring performance, public reporting, and

determining ACO shared savings or losses.

In MSSP, ACOs are measured on up to 10 clinical quality measures, 2 claims-based measures including readmission, as well as patient experience survey measures. In the ACO REACH model, participants are measured on 4 claims-based outcome measures, including readmissions as well as patient experience survey measures.

Many ACOs participate in rural areas and take accountability of the quality of care provided to the beneficiaries attributed to their organization. Beneficiaries residing in rural areas that are attributed to ACOs are included in the ACO's quality reporting. Although RHCs are not required to participate in a Medicare quality reporting program, CMS reports that as of January 2023, about 45 percent of RHCs were participating in MSSP ACOs and therefore are likely reporting quality. Increasing provider participation in value-based programs, such as ACOs, is consistent with the Commission's principles.

Moving on to discussion of the final Medicare quality reporting program, those for MA and Part D plans. For context, the Commission has long discussed a flaw in

current MA plan quality reporting. CMS collects MA quality measure results on a contract-wide basis, which are used to determine a star rating for all plans under the contract which can reflect many diverse health care markets.

For example, the largest MA contract has 2.6 million enrollees. Those enrollees are in almost every state, with over 1,000 enrollees in each of 46 states, and also a large number of enrollees in many states with over 20,000 enrollees in each of 30 states.

Because of this issue, the Commission has recommended that MA quality should be evaluated at the local market-area level, as well as replacing the current quality bonus program that has been based on the MA star rating with a value incentive program that would address this and other flaws in the program.

MA star ratings, which are reported on Medicare's Plan Compare website, are based on 42 measures, including process, intermediate outcome, outcome, patient experience, and access measures. MA enrollees residing in rural areas are included in MA contract-level quality results.

Prescription drug plan star ratings are based on 12 measures, which are a subset of the MA star rating

measures. Enrollees in PDP plans, included those residing in rural areas, are included in contract-level quality results.

Now I'll present some initiatives to improve measurement of rural providers' quality of care.

Quality measurement among rural providers could also be improved by focusing on metrics tailored to rural providers and the concerns of patients treated by those providers.

The National Quality Forum, funded by CMS, convened a multi-stakeholder Rural Health Advisory Group that identified the best available measures to address the needs of rural populations, for example measures of topics important to rural patients and are resistant to low case-volume challenges.

The group listed 37 key rural measures including 21 hospital-setting measures and 16 ambulatory care-setting measures. Most of the measures the Advisory Group selected are included in the various Medicare quality reporting programs we described on the previous slides. Also, many of the measures identified as key measures are tied to clinical outcomes, patient experience, and value, and

therefore align with the Commission's principles for quality measurement. The Advisory Group also identified gaps within the updated measure set for further measure development, including intentional and unintentional injury, telehealth-relevant measures, and cancer screening measures.

The Commission has maintained that the goal of improved care should extend to all patients, regardless of health status, income, and race. These expectations are more likely to be met if they are combined with additional resources to build a provider's ability to address particularly challenging environments for care delivery.

There are examples of current resources and funding programs available to help rural health care providers develop quality improvement programs. These include quality improvement organizations, or contractors working directly with small rural and CAHs on quality improvement, as well as HRSA's MBQIP, which provides technical assistance to help CAHs report measures for CMS programs.

To summarize today's presentation, in principle, all providers should be evaluated on the quality of

services they provide, and quality results should be publicly reported. However, there are challenges in measuring the quality of small providers, many of which are rural providers.

There are several federal and multistakeholder initiatives are intended to drive improved quality measurement of rural providers.

Many rural providers report quality information either at the provider level, to the extent feasible, or as part of ACOs and MA quality measurement.

For Commissioner discussion, we welcome your questions and feedback about the materials, as well as ideas for future work on rural provider quality measurement. As a reminder, this is planned for a chapter in the June 2025 report.

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

DR. CHERNEW: Ledia, thank you. Quality measurement is always a challenge, and I think this emphasizes how many different programs we have. But we will now go into discussion of that. And Lynn, you are first.

MS. BARR: Hi, Ledia. Thank you so much for this

great work. So Round 1 questions. So you talked about 99 percent of CAHs participate in a quality improvement program, but they don't get paid anything for that. Is that correct?

MS. TABOR: That's correct. So the IPPS, or the Inpatient Quality Reporting Program, doesn't actually pay extra for reporting. Hospitals who do participate in the QRP do not have reduction in their market basket update. So it's not really a reward. It's more of like they don't get a penalty or a reward, whereas IPPS hospitals could potentially get a penalty if they don't participate.

MS. BARR: Okay. So there's no payment for CAHs. You mentioned in your analysis about most clinicians that are MIPS eligible in rural report. What percentage of fee-for-service clinicians are MIPS-eligible, given that they have got a pretty high threshold, and most of them are in RHCs? So if you --

MS. TABOR: That's a --

MS. BARR: -- of physicians in -- and you may not know this answer, but I think it's important, because you have an opening statement that says, you know, there's a lot of quality reporting going on out there, and I'm going

to question that. I don't want the numbers.

MS. TABOR: Yes, yes. I think that's a great question and something that we can look into more. I will say that we are limited in kind of knowing what the universe of physicians is. This is just based on what CMS makes publicly available. But we can continue to kind of dive into that.

MS. BARR: Just, you know, like how many providers have we got at RHCs and then how many are fee-for-service, and how many of them are reporting. I think the numbers are going to be vanishingly small.

When it comes to the ACO and MA PDPs and our kind of satisfaction that we are getting reporting from them, do you know, for example, for our ACOs we didn't actually give them meaningful feedback because the sampling requirements on those plans are so small. So when you're saying that, it's like you have to actually -- I mean, you measure to improve, right, but you have to have enough information to be able to assess where you are. And so does that do the ACOs and MAs and PDP reporting actually qualify as quality improvement-based reporting, given the really tiny numbers they're asked to participate in?

MS. TABOR: I think that's a fair point. I kind of think of it as two levels -- what the Medicare program collects and uses for distributing payments based on performance versus what the ACO does with the providers to help manage the quality and improve quality for their patient population. So what we presented today is really what the Medicare program uses for quality measurement. And I don't think there would be a lot of good public data points on how ACOs are working with the providers on quality improvement, but I think your point stands up. There are kind of these two different levels of the Medicare program versus quality measurement at the individual ACO or MA plan level.

MS. BARR: Yeah. I mean, like in our case we basically told people they might have to report 10 data points a year for a typical clinic because of the size of our ACOs. So I just don't want to overstate this quality. I just felt like we were kind of like, we've got a lot of quality reporting out there. And I'm like, I'm not sure I see that.

So those are really my -- oh, one more Round 1 question. I think this is Round 1. You can correct me.

Why don't our REHs have outpatient measures?

MS. TABOR: They do. So I guess the quality reporting program for REHs, there are four measures right now, and many of them are actually part of the -- it's a subset of the Outpatient Quality Reporting Program.

MS. BARR: Four measures? Yeah, I just didn't see, you know, preventive care. I mean, just sort of like, you know, kind of the things that you would see in clinics. So I'm not quite sure. The REHs, they do clinic services as well, right?

MS. TABOR: So the four measures that are part of the REH quality reporting program right now are median time from ED arrival to ED departure, abdomen CT use of contrast material, hospital visits within seven days after hospital outpatient surgery, and then a seven-day standardized risk hospital visit rates after outpatient colonoscopy. And CMS did explain, in the proposed and final rules, that they selected these measures because they are likely going to be done at all of, or many of the new REHs, so then could have the ability to compare across these programs.

MS. BARR: All right. But we don't really have clinic measures. And they do have clinic services in the

REHs?

MS. TABOR: They get to select what outpatient services they are going to provide.

MS. BARR: Got it, because I can't imagine -- I mean, they still have their doctors in the community, or are they like separated? I don't know. I don't want to take up too much time, but I'm just really kind of confused about what kind of quality reporting is happening in REHs that are inpatient, outpatient. I can't really make sense of that, and like, well, so who's reporting on, you know, preventive measures and blood pressure and things like that. Thank you.

MR. MASI: And just to add, Ledia, is it right that the REH quality reporting starts this year, 2024, and so it may take a couple of years before we get those data and can report out on it. But we are given an annual mandated report from Congress to report out on the status of the REH program, so in the future when we get those data we're more than happy to provide information on what's collected and what we know.

MS. BARR: Thank you. I just have a quick follow-up question. Are you going to show us any quality

data then, as the chapter matures? Are we going to be able to see rural versus urban? Because I was shocked when I went out and started reporting quality in rural communities, of the gap. And I don't know where that evidence lies. Is there anything -- are you able to do this?

DR. CHERNEW: So we had a conversation about that, Lynn. Those will appear in the chapters when we do our update stuff. Paul, am I right? In this chapter, the answer, we're not going to redo it. You'll see some of that data, I believe, but it's going to be put into the -- we have quality all the time in our update chapters.

MS. BARR: But it's not rural specific.

DR. CHERNEW: Well, I think you're going to see some that is rural specific. We've been working through how much of that could be done now. But that's sector specific. Paul, did I get that right?

MR. MASI: Aspirationally, that's what we're going to try to do. I do want to emphasize that as you all know there are some challenges with quality measurement, in general, and then about making really firm conclusions about the state of quality in one group relative to

another. And so I think I do want to highlight the challenges that we're wading through, but we're going to do our best to provide as much information as we can. And as Mike said, following best practice, the home for that will likely be in the update chapters.

MS. BARR: Would that be -- and again, I apologize, but would that be like using claims-based information, like colonoscopies and things like that, where you can take snapshots?

DR. CHERNEW: Since we're now like 10 minutes in, I won't charge you for all that time, Lynn. But we can have that continued discussion. But I'll echo what Paul said. Aspirationally, we would like to do that, and the update chapter seems to be the place where we're going to try and do it.

MS. BARR: Okay. It would be great information for people to know. I couldn't stress how shocked everyone was when we first did quality reporting, and nobody knew.

MS. KELLEY: Okay. I have Cheryl next for Round 1.

DR. DAMBERG: Lynn was channeling many of my thoughts. Thanks, Lynn. This is kind of not a question,

but I just want to follow up on it. While you were talking about it's going to appear in the update chapter. I would encourage you to use as many of the quality measures as possible, not just the ones based on outcomes.

Going back to the question, I'm curious, and I guess I don't know the history on this, why those providers who were paid on a cost basis would be excluded from the quality reporting. So if you could maybe clarify that for me, that would be helpful.

MS. TABOR: I don't know all the legislative history because there is a long history, but I can state that kind of operationally it would be challenging because -- so I'll take the Inpatient Quality Reporting Program as an example. There is a PPS that every year has a market basket update, and if hospitals do not report satisfactory for the QRP, CMS can decrease that market basket update, and therefore affect all payments going forward. For the cost-based reimbursement, there no market basket update, so there's kind of not as easy of a vehicle as there is, or the vehicle is not the same as in the traditional PPS system. So it would have to be like a new design of how to kind of reward or penalize based on quality reporting for

the cost-based environment.

DR. DAMBERG: Thanks, Ledia. I kind of struggle with that concept because I think there are multiple goals associated with performance measurement. And so while it may not be tied directly to payment, or modifying payments, I still it's important to measure and be accountable for that. And a lot of the improvement comes through understanding where you stand relative to your peers, and kind of these reputational effects.

Anyway, that's my question. Thanks.

MS. KELLEY: Amol.

DR. NAVATHE: Ledia, thanks so much for this. I have what I think is going to be a quick question, which is how do IRFs get treated here? They seem kind of like a missing category, but they're not paid on a high PPS. I think they're paid on a separate PPS. If you could help elucidate that, that would be really great.

MS. TABOR: Yeah. There is an IRF quality reporting program. There is no IRF VBP, and we can add in the details of that program in the next round of the chapter.

DR. NAVATHE: Great. Thanks.

MS. KELLEY: Okay. That's all I have for Round 1, unless I've missed anyone. So if you're ready, Mike, I'll go to Round 2.

DR. CHERNEW: I am ready.

MS. KELLEY: All right. So we have Lynn first.

MS. BARR: And you can just call me a broken record because, you know, I've been working with the NRHA and cost accountants and stakeholders and hospital leaders to try to come up with a system that fixed both the quality program and the cost-sharing program. And our proposal is to allow them to participate, voluntarily allow them to participate in the PPS program. And they would still get their cost-based reimbursement on top of that, but then if they earn the quality bonuses, instead of getting a rate update they would get a lump sum payment. And this would allow them to be part of the 21st century. It's not mandatory, but it would allow them to.

So I do think there's a pathway to get these hospitals into quality reporting, and to pay them for it, and to get the clinics into it, as well, and I just think that we need to sort of think about how we can move them into the 21st century. Because by saying you're too small,

you're too weak to report quality, we are hurting the beneficiaries, and that's just unacceptable. So we're penalizing them in costs and we're penalizing them in quality, and we can come up with solutions.

So I don't know if that's the right solution, maybe it's not, but it was one simple solution we came up with that, on a voluntary basis, could cover both problems. Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: Great. Thanks, Ledia. Really interesting work, and I have three short but somewhat disparate comments.

First, I just want to take the opportunity to say, once again, as we say every time we meet, that we need to keep emphasizing the need for patient experience measures to be added to the SNF public reporting program. It's just a sector where it's probably almost more important than any other sector, yet it's one of the only ones that doesn't have that data available.

Second, we talk about small numbers and there not being enough of a denominator for many measures that we might be interested in. But there's also a time element

there. And so one solution that I think we should keep in mind is just lengthening the time period over which we measure things. We lose some immediacy when we do that, but it's also testable. We can see how much these things change over time. But it could very well be that things that are measured somewhat arbitrarily on an annual basis, maybe we could use a two-year moving average and not lose as many providers by doing that.

And so whether that's part of -- I mean, I know that some of the CMS public reporting systems have done that. They have decided that they are going to lengthen the time over which they measure something, just to include more providers, because, you know, they're somewhat arbitrary to begin with. So even if we do that for some of our own analysis, I think it could be helpful.

And third point, I just kind of want to reemphasize some of those principles around quality measurement, that I was happy to see. But one of these principles is that I think we want to be able to measure all providers, sort of fairly, equally, on different measures. And yet I think there's also this tendency to want to sort of tailor metrics towards certain populations

or certain kinds of providers, which is inherently not a bad thing.

I just want to make sure we stay conceptually very clear, because there is a fine line, I think, between tailoring metrics to certain populations and discrimination. I think there should always be, we should always try to have a core set of measures and sort of absolutes in quality that we want to measure across all providers of a certain type, like hospitals. And there might be some measures that are sort of more important for providers in rural areas than in urban areas. But I think we want to try to keep that core so that we can compare across those kinds of areas and don't end up sort of setting different standards of quality for different areas.

And I think, you know, one example of that is in the chapter, the National Academies report was referenced, where they were coming up with measures that were very good for rural areas. The text says, "They selected measures with a heavy emphasis on behavioral and mental health, substance use, infectious disease, access to care equity, and social determinants of health," which to me doesn't seem very specific to rural, right? If these are important

things, I think we should be measuring them across those urban and rural areas.

I don't think we've actually gone in that direction too far. I would just like to reemphasize that's sort of an important point of the principles that I think we should try to adhere to. Thanks.

MS. KELLEY: Brian.

DR. MILLER: So quality reporting is a fun pet policy rock, sort of floating around in my shoe, irritating me. So I was happy to have this. This is a -- and it's even harder in a rural. So just two principle things and then sort of an operational thought for us.

The principles, we said that we had an absolutely contraindication to tournament models. I just want to say I think that's wrong. I think we also sometimes want tournament. Sometimes we want absolute. It sort of depends upon what you're trying to measure and what you're trying to titrate. So for a policy principle, obviously absolutely quality metrics are great and are very appropriate, but sometimes all you can get away with realistically is a tournament. So I think you might want to rethink that principle.

A principle we might want to add is the quality metric lifecycle. Our poor colleagues at CCSQ have a library of 2,000 or so, maybe it's 1,500, it's a lot -- it's a number of quality metrics. So perhaps the quality metric lifecycle of figuring out when metrics top out, when they need to be retired, et cetera, is something that we could, as a principle, integrate into our future work.

Operationally -- so this was interesting -- one, I completely agree that obviously MA star ratings are not the best thing, to say the least. But it's also interesting that was the only market that had 100 percent quality reporting, and then we didn't have a fee-for-service plan of quality rating. And where I am going with that? I think it's important for us to measure, at the individual provider or hospital or SNF or home health agency level, like many other people have said, but not to do so in a way that generates a crap ton of paperwork.

There was a nice JAMA paper last year talking about quality reporting. It's written by some colleagues. I think it was 100,000 hours or so that were spent for a single hospital to report on Medicare quality measures, and that was a big hospital with lots of staff. So you can

only imagine what it's like if you're a small, rural facility or a two-doctor practice.

The reason I mentioned a fee-for-service plan quality rating is that might allow us to also lighten up on some of the individual physician, physician practice, hospital, SNF, home health, whatever, reporting metrics, be more targeted in reporting metrics for specific service delivery orbs, and then have overall quality ratings that we can compare between fee-for-service and MA. Because we don't want to micromanage people, and currently we are.

MS. KELLEY: Okay. I have Cheryl next.

DR. DAMBERG: Thanks. So going back to the issue of providers who are paid on a cost basis, I do think that CMS should require reporting even if they are not in a traditional payment system. So that's commentary.

In terms of Table 1 where you show the number of measures for MIPS, I'm a bit worried about that number 100 being sort of construed as a really burdensome. So there's 100 measures spread across many different specialties, so any given physician is not measured on 100 measures. So I don't know if there's some way to finesse that so it's a little bit clearer.

I also would like to see the stratified results, and I know that's a coming attraction.

And then per the small numbers issue, just adding onto what Tamara said, not only sort of aggregating across time, but I do think that there are other strategies for improving what reliability is a signal that you're getting. And one could explore constructing a composite-level measure, sort of like an opportunities composite, and comparing providers to other providers who have similar mixes of patients. So it's kind of a massive regression model, but something that CMS could consider doing.

I also, like Tamara, was struggling a bit with the set of metrics. I recognize that the areas called out are significant areas of importance for rural areas, but they also struck me as they apply to urban areas. And overall I guess I would like to see both urban and rural measured and compared on that same group of measures.

And then I guess, more fundamentally, I think as we think about improving quality, even in the areas where it's sort of challenging to build them into financial incentive programs, I do think the whole focus on measurement, feedback, accountability is still vitally

important to give to all providers, to try to derive quality improvement in the system.

MS. KELLEY: Robert.

DR. CHERRY: Yes, thank you. And a very good report. And it does give me a headache when I think about this too much, because it's a really challenging problem. You know, rural areas are very different because of staffing needs and just the whole clinical workflows that impact how you report out quality measures. So it's not surprising that the volumes are low in certain aspects, that it's burdensome for certain clinic practices, that it can be costly, and then when you throw on the various EMRs or lack of EMRs that exist out there, it becomes quite a stew.

I think that the whole idea of what measurement set do we need for rural areas, how do you select those measurement sets, what's most effective, how many, I think a lot of us will have various opinions on that. It would be helpful if there was consensus or agreement around certain broad areas. In other words, is the quality of care or the problem that we're trying to solve around rural areas is mainly around access and timeliness to care, then

perhaps those are the most important measures.

And then we can always perhaps even agree to fine-tune measures that are specific to the rural areas based on timely access to care. So for example, if there are certain specialties, like OB/GYN or primary care or pediatrics or access to colonoscopies and mammography that is most important, you know, in terms of an 80/20 rule, then it's easier to kind of get a little more specific and customize around the rural areas.

Sometimes I do wonder whether, in terms of patient experience, there should be even a rural version of CG caps. Of course there has to be a core set of principles around access to care and timeliness of care. You know, should there be a different version of that survey?

The other thing is to a certain extent, you know, incentivizing providers to be part of these ACOs and make plans does create economies of scale and allows for greater ease for reporting. But we also know that on the flip side of that we have trouble getting high-quality data from our MA programs, as well. So I'm not quite sure if that entirely solves the problem.

One thing, and this may be a bit of heresy considering that MedPAC has a very narrow focus, but a lot of the data that's being pulled or being looked at is around the Medicare population. But if you really want to look at the totality of the care that's being provided, looking at the Medi-Cal population and pulling that into your quality measures, the commercial payers, and how many of those patients that they're seeing and pulling that into the quality measurement can compensate for lower volumes and perhaps create a much more realistic picture of the case mix and the payer mix that rural providers are actually seeing. And then the interventions and the type of public policies that are needed is much easier to wrap your mind around than if you're looking at sort of a slice of the population, which kind of distorts things quite a bit.

So I'm sure we'll be talking about this again throughout the cycle, but just some preliminary thoughts as we start this new year.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much for this great work and the interesting conversation. My comments will be

brief and somewhat built off of Tamara and Cheryl and Robert, actually.

As I think about this measurement set it does seem to me that there are some, many that are universal. But I wonder if actually what constitutes quality isn't in the metric but the level. And this is not because of any data that I have. You reported that 87 percent of home health institutions report their hospital readmissions, and I'm thinking maybe in a frontier area we should expect that their readmission rate would be higher, or maybe in a place, a very rural area, who is delivering babies -- not within our responsibility -- but maybe you might expect a higher rate of C-section, for a number of reasons in terms of what it takes to mobilize.

So I'm very sensitive to the issue of being, you know, there are some that are universal, but I do think that there are either some differences in measures, perhaps, or what constitutes quality within that same measure.

And I just have to pile on about Tamara's comment on patient and family experience. I think that's really important. And then once again I know that you commented

on the problem with incident to billing, but it's a good reminder why this is so important for Congress to get rid of incident to billing, so we can really see what's happening. Thanks

MS. KELLEY: Scott.

DR. SARRAN: Yeah. First, thanks, Ledia, for the excellent work summarizing the area. I have very little to add to the already excellent comments. Just one thought. Given that in many rural areas the local hospital as, I think, a uniquely strong relationship with the population in terms of their ability to impact on the health status of that population. I mean, in an urban area you may have 5, 6, 8, or 10 hospitals that divvy up market share. Rural areas, much less likely that that's the case.

And since health status is such a critical issue for many rural populations, I'd like to see us recommend including -- as a reporting-only, not a P4P -- but including already available data -- not asking anyone to create new data sets -- on the health status of the communities, so that at least patients, communities, other stakeholders can see how, over time, the health status of a particular community is or is not improving as they're

looking at a local hospital.

MS. KELLEY: Paul.

DR. CASALE: Thank you, and I appreciate all the comments. Just a brief comment as it relates to ACOs. I know in the slide they illustrated the requirements reporting on ten measures and a few claims. As many of you know, that's going away, and it's really moving to eCQM reporting of three measures, potentially Medicare, and then ultimately to all payers. So the 43 percent or so, that are in ACOs in rural areas, the burden around reporting will be different, and maybe there's an opportunity for the comparison, at least within that population.

MS. KELLEY: Okay, Mike, that is all I have for Round 2.

DR. CHERNEW: All right. I will try and summarize. First let me say broadly, I think it was a great meeting to kick off our September cycle. It makes me even more excited for October and seeing you all. With regards to this particular topic, you really realize how much there is to ponder, the issue about measuring the quality reporting on the providers or the quality received by the patients, because, of course, patients in rural

areas get care from other places. Understanding once you measure what would move the dial, one of the issues that arises throughout all the rural areas is that quality measurement is sometimes a statistical exercise, and so I think, Tamara, you mentioned trying to average over years and do a bunch of things.

I think we continue to struggle, and if you look at our other quality work with some of the specific quality programs, I won't recap all of what we think about some of them, but MedPAC has a number of them, about some specific quality programs. So trying to figure out how to put all of that together for everybody is hard enough in some of the areas. When you get to rural, it just extends that.

And I think several people pointed out, I think appropriately so, there is an administrative burden with all this. So if you're going to impose that administrative burden, you better really think through what you're trying to accomplish and hope that you will accomplish it.

But for where we are now, I think this has been a useful discussion as we continue across all of the sectors, both urban and rural, to think about quality measurement and trying to understand how we can get the best quality

for Medicare beneficiaries in sort of an efficient way.

So I'm going to leave this topic for now. Again, it will appear in a chapter later. But for those at home, thank you for joining us. Please reach out at meetingcomments@medpac.gov, or go to the website and let us know your thoughts. We are really anxious to hear what you have to say. People are usually not shy. The staff is wonderful. They don't bite.

So I will then close. Paul, if you want to add anything. Otherwise I'm going to close with a thanks.

MR. MASI: A great meeting. Thank you so much, and we'll see you in October.

DR. CHERNEW: All right. So thanks, everybody, and we will see you in October. Be safe. Bye.

[Whereupon, at 4:50 p.m., the meeting was adjourned.]