

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Remote via GoToWebinar

Thursday, September 5, 2024
12:01 p.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair
AMOL S. NAVATHE, MD, PhD, Vice Chair
LYNN BARR, MPH
PAUL CASALE, MD, PhD
LAWRENCE P. CASALINO, MD, PhD
ROBERT CHERRY, MD, MS, FACS, FACHE
CHERYL DAMBERG, PhD, MPH
STACIE B. DUSETZINA, PhD
KENNY KAN, FSA, CPA, CFA, MAAA
R. TAMARA KONETZKA, PhD
JOSHUA LIAO, MD, MSc
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
BETTY RAMBUR, PhD, RN, FAAN
WAYNE J. RILEY, MD, MPH, MBA
SCOTT SARRAN, MD, MBA
GINA UPCHURCH, RPh, MPH

B&B Reporters
29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541

AGENDA	PAGE
Context for Medicare payment policy	
- MedPAC staff.....	3
Lunch.....	69
Cost sharing for outpatient services at critical access hospitals	
- Jeff Stensland.....	70
Recess.....	141
Medicare's measurement of rural provider quality	
- Ledia Tabor.....	142
Adjourn.....	182

P R O C E E D I N G S

[12:01 p.m.]

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

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.

MedPAC Staff: Welcome. In this I'll provide ~~presentation~~ 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

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

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

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

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

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

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

12 Medicare spending is expected to nearly double in
13 the next 10 years, increasing from about \$1 trillion in
14 2023 to \$1.9 trillion in 2032. Medicare's projected
15 spending growth is driven by three factors: economy-wide
16 price increases, which increase Medicare spending by about
17 3 percent per year; growth in the number of Medicare
18 beneficiaries as the baby boom generation ages into the
19 program, which increases Medicare spending by about 2
20 percent per year; and growth in the volume and intensity of
21 services delivered per beneficiary, which increases
22 Medicare spending by another 3 percent per year.

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

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

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

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

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

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

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

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

1 decade longer than was projected before the pandemic.

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

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

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

22 Medicare's other trust fund is called the

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

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

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

1 array of clinical settings.

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

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

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

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

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

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

18 The typical Medicare beneficiary has relatively
19 modest resources to draw on when paying their Medicare
20 premiums and cost sharing. Researchers estimate that in
21 2023, the median Medicare beneficiary had an annual income
22 of \$36,000 and savings of \$104,000. Medicare beneficiaries

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

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

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

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

22 We also see differences in health outcomes for

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

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

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

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

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

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

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

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

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

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

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

1 payment rates.

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

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

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

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

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

3 I'll now turn things back over to Mike.

4 DR. CHERNEW: Thank you. That was
5 terrific.

6 Without further ado, we're going to start Round
7 1, and just to remind people, we're looking for just
8 clarifying questions at this stage.

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

11 Is that right, Dana?

12 MS. KELLEY: Yes, it is.

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

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

22 STAFF: I'm going to ask my colleague,

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

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

6 DR. RAMBUR: Great, thank you.

7 MS. KELLEY: Okay. I have Tamara next.

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

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

14 STAFF: I think Paul actually had a thought
15 on what that was. Paul, could you remind me what you said
16 that is?

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

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

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

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

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

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

22 STAFF: We don't really definitively know

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

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

3 And then final question, a slightly meatier one.

4 So I'm really interested in those 6 percent of people

5 without supplemental coverage, and I know it's hard. We

6 don't really have great data sources on who has Medigap.

7 So, one, it would be nice to know if we're ever going to

8 get that, I wonder if there are ways to start collecting

9 that in some way.

10 But the other -- the question is, what else do we

11 know about those 6 percent of people who don't have

12 supplemental? Are these people who -- I mean, I know that

13 we'll talk about it later today in the rural section. They

14 are sort of disproportionately rural. Sixteen percent was

15 the number I'm remembering. But other than that, are these

16 mostly people who just never bought Medigap because they're

17 not very risk averse? Are they people who are, like,

18 switching back from MA? What are their demographics? Do

19 we know anything about that 6 percent of people who don't

20 have the supplemental coverage?

21 STAFF: I'm wondering if Eric is available

22 to pop on, because he's kind of our in-house Medigap

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

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

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

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

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

22 All right, thanks.

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

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

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

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

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

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

21 DR. DAMBERG: Thank you.

22 MS. KELLEY: Gina.

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

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

10 STAFF: Okay.

11 MS. UPCHURCH: But great job.

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

18 Thanks.

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

22 It looks like Allison might have the answer,

1 though. So let's see what she says.

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

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

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

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

19 STAFF: Is that it, Gina?

20 MS. UPCHURCH: That's it, thanks.

21 MS. KELLEY: Okay. Amol?

22 DR. NAVATHE: Thanks for this great work.

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

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

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

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

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

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

12 DR. NAVATHE: Great. Thanks.

13 MS. KELLEY: Okay, Lynn.

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

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

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

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

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

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

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

17 MS. KELLEY: That sounds right.

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

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

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

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

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

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

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

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

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

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

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

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

21 MS. KELLEY: Cheryl.

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

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

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

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

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

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

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

15 MS. KELLEY: Kenny.

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

22 And then, similarly, in the same pre-meeting

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

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

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

15 MS. KELLEY: Okay. Larry.

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

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

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

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

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

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

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

22 And that's it. Thanks.

1 MS. KELLEY: Betty.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 MS. KELLEY: Gina

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

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

5 But there is a wide range of Medigap policies.
6 People can look for a Medigap policy at any time, any time
7 of the year. You don't have to do it even during open
8 enrollment. It doesn't mean you have rights to it. In
9 only, you know, about 30 states -- we know that about 4
10 states have continuous or annual enrollment to Medigap, but
11 otherwise only 30 states really allow even people less than
12 65 to have a Medigap policy. So there are many states that
13 don't even allow them to.

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

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

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

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

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

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

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

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

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

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

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

13 MS. KELLEY: Brian.

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

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

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

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

22 I noticed that there was mention of a Medicare

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

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

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

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

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

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

1 us we have some managed care people but not a lot. So I
2 think we'd do well to restore the public comment period
3 that we had, I believe, before the pandemic, for about 15,
4 20 years, after each session, so that way stakeholders can
5 engage us live. I think that would be a good move for
6 transparency. Because we don't have to agree with what the
7 stakeholders say or what they tell us, but I think it's
8 really important that we give them an opportunity to speak
9 to us and be heard in person and online. Thank you.

10 MS. KELLEY: Scott.

11 DR. SARRAN: Yes. First, thanks.

12 I know how difficult it is to put together such a
13 cogent summary, and I think you did an excellent job.

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

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

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

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

22 On the other hand, as other Commissioners have

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

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

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

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

7 MS. KELLEY: Robert?

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

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

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

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

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

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

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

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

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

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

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

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

1 chapter that could inform our discussions as well.

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

5 MS. KELLEY: Tamara?

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

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

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

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

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

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

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

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

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

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

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

22 Other examples are like if we pay physicians

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

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

14 Thanks.

15 MS. KELLEY: Amol?

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

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

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

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

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

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

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

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

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

22 Third point, I agree kind of broadly with some of

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

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

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

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

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

4 So thank you. I'll stop there.

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

7 MS. KELLEY: Yes. Paul, go ahead.

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

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

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

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

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

5 Thank you.

6 MS. KELLEY: I have Lynn next, Mike.

7 MS. BARR: Thank you.

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

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

21 STAFF: The Medicare Current Beneficiary
22 Survey does identify if respondents have Medigap. So we're

1 not completely blind there.

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

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

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

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

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

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

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

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

18 MS. KELLEY: Okay. We have Josh last.

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

22 A general plus-one on the work behind the content

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

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

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

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

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

6 With that, I'll close my comments.

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

8 Everybody, thank you.

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

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

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

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

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

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

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

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

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

18 Paul, do you want to add anything?

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

21 DR. CHERNEW: All right. All good.

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

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

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

AFTERNOON SESSION

22

[2:17 p.m.]

B&B Reporters
29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541

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

7 So, Jeff, take it away.

8 DR. STENSLAND: All right. Good afternoon.

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

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

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

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

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

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

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

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

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

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

22 The third type of rural payments are fixed

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

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

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

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

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

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

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

6 Next, we look at the second row. It shows that
7 Medicare fee-for-service outpatient revenue is 13 percent
8 of the total revenue at critical access hospitals and only
9 6 percent at PPS hospitals. The net implication is that
10 fee-for-service Medicare is a more important source of
11 revenue for critical access hospitals than a typical
12 hospital, and in particular, Medicare outpatient revenue is
13 an important source of revenue for the critical access
14 hospitals.

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

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

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

13 We estimate that critical access hospitals would
14 have received close to \$6 million per hospital for those
15 services if they were paid PPS rates. The implication is
16 that higher fee-for-service payment rates at critical
17 access hospitals increase payments by about \$4 million per
18 year per critical access hospital on average. This is far
19 larger than the critical access hospital's profits of 1- to
20 \$2 million.

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

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

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

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

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

19 Prior to accounting for the sequester, Medicare
20 program payments to critical access hospitals are equal to
21 100 percent of their allowable costs minus coinsurance.
22 What is important to note is that coinsurance is set equal

1 to 20 percent of charges.

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

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

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

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

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

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

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

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

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

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

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

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

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

17 So let's walk through a comparison of OPPS and
18 critical access coinsurance, emphasizing the cap. Let's
19 start with the PPS hospital example in the first column.
20 Assume the joint replacement surgery costs the hospital
21 \$13,000 to perform, and it charges \$26,000. The OPPS
22 payment rate is prospectively set for a high-level joint

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

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

8 In contrast, look at the second column. Here, we
9 assume the cost of the service is the same as the PPS
10 hospital at \$13,000, and the charges are also the same at
11 \$26,000. What is different is the coinsurance rules.

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

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

1 1997 because charges have grown faster than costs.

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

5 The second issue to summarize is the lack of a
6 cap on coinsurance, and this issue is also more problematic
7 now than it was when the program was started in 1997. This
8 is because there are a lot more high-cost services provided
9 in an outpatient setting in small hospitals. For example,
10 there are more high-cost Part B drugs now than there was in
11 1997. There are also more procedures done on an outpatient
12 basis. For example, joint placements used to only be an
13 inpatient service in 1997 at the start of the program.

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

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

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

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

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

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

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

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

13 The net increase in program spending between
14 covering the reduction in coinsurance and the cost of
15 Medicare Advantage would have been about \$3.2 billion in
16 2022.

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

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

6 But given that caveat, let's look back at 2022,
7 and we estimated that the cost in that year would have been
8 \$3.2 billion. That would have been split between the
9 taxpayers who would have paid 75 percent of the cost, or
10 \$2.5 billion, and the beneficiaries who are paying Part B
11 premiums who would have paid about \$0.8 billion in higher
12 Part B premiums during that year. And that is because CMS
13 sets Part B premiums so that the Part B premiums are
14 expected to pay 20 percent toward 25 percent of all Part B
15 costs.

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

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

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

9 And now I'll turn it back to Mike.

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

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

20 MS. KELLEY: I actually have Lynn first.

21 DR. CHERNEW: Go ahead, Lynn.

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

1 aren't you?

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

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

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

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

11 MS. BARR: And the beneficiary. Thank you.

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

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

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

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

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

1 worry about.

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

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

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

10 DR. STENSLAND: What we would do is we would --
11 it would be -- I don't want to call it a proposal either.
12 I want to say it an illustrative example, but to try to
13 give you guys an idea of how much is things changing. And
14 it would be based on the estimated costs. So the estimated
15 costs are going to be the charges times the cost to charge
16 ratio is going to get the estimated costs. That's
17 approximately your payment, and then they would be paying
18 20 percent of that. So essentially, they would be shifting
19 from -- the way the policy is right now with paying 20
20 percent of charges as your co-insurance, the beneficiary is
21 essentially paying all the extra costs, all the extra
22 payment that a CAH gets. It's basically all on the

1 beneficiary's shoulders.

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

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

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

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

22 So I would say the level of precision in

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

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

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

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

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

20 DR. STENSLAND: Right.

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

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

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

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

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

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

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

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

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

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

22 MS. BARR: Okay. Sorry.

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

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

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

7 DR. STENSLAND: Okay.

8 MS. KELLEY: Okay. I have Stacie next.

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

13 But I got a little bit hung up on the 16 percent
14 of people without a supplement, and I think in your
15 presentation you emphasized that's 16 percent of fee-for-
16 service, which then explains why it was different than that
17 6 percent we saw in the overview chapter.

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

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

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

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

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

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

7 DR. STENSLAND: Mm-hmm. Okay.

8 DR. DUSETZINA: Thanks, Jeff.

9 MS. KELLEY: Larry.

10 DR. CASALINO: Can we take a quick look at Slide
11 6, please?

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

14 DR. CASALINO: There you go. Thank you.

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

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

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

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

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

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

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

22 And then each plan will have a different

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

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

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

10 DR. CASALINO: Thanks, Jeff.

11 MS. KELLEY: Amol.

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

18 DR. STENSLAND: Yeah.

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

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

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

6 DR. STENSLAND: 200,000, yeah.

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

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

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

17 MS. KELLEY: Gina.

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

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

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

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

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

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

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

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

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

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

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

4 DR. STENSLAND: They are related. Right now, if
5 you just did the third bullet, if you say we're just going
6 to put a cap on there but we're not going to change how it
7 is, I think then there would be -- I think it was about
8 \$400 million reduction in coinsurance. Because you have
9 places that are over the cap, because the coinsurance was
10 so big when it's 20 percent of charges.

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

16 MS. UPCHURCH: -- the cap.

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

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

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

8 MS. KELLEY: Brian.

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

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

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

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

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

4 DR. CHERNEW: Yes.

5 MR. MASI: And real quick --

6 MS. KELLEY: Oh, sorry.

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

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

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

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

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

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

6 MS. KELLEY: Lynn, go ahead.

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

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

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

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

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

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

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

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

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

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

15 MS. BARR: Got it. And they've also got like a
16 70 -- it's any provider within 70 miles, I believe, right.
17 So their closest provider can be very far away and could be
18 in an urban center, in most cases. So anyway, I'm worried
19 about that.

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

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

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

11 MS. KELLEY: Stacie.

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

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

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

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

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

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

4 MS. KELLEY: Tamara.

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

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

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

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

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

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

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

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

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

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

1 beneficiaries. Thanks.

2 MS. KELLEY: Brian.

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

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

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

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

13 Two additional thoughts I had on this. One is
14 looking at the estimates on page 28, we said that fee-for-
15 service, I think, was \$2.5 billion, and MA would then be
16 \$1.3 billion to solve this problem, which suggests that MA
17 is a cheaper solution. I don't think it's necessarily just
18 that it's MA. I think that there's dynamic opportunities
19 in managed care which have benefit flexibility, so can
20 adapt and change things without incurring as much expense
21 as the taxpayers.

22 And then the third thing, a couple of people

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

16 MS. KELLEY: Cheryl.

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

22 So I definitely support, in the very near term,

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

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

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

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

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

3 MS. KELLEY: Gina.

4 MS. UPCHURCH: Thanks.

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

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

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

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

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

14 So thanks, Jeff.

15 MS. KELLEY: Kenny.

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

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

22 However, point number two, there are many

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

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

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

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

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

3 Thank you again for an outstanding chapter, Jeff.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 MS. KELLEY: Scott.

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

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

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

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

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

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

13 MS. KELLEY: Robert?

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

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

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

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

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

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

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

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

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

10 MS. KELLEY: Greg?

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

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

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

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

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

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

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

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

13 MS. KELLEY: Betty?

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

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

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

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

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

19 MS. KELLEY: Amol?

20 DR. NAVATHE: Thanks.

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

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

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

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

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

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

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

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

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

13 MS. KELLEY: Larry?

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

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

1 charges.

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

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

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

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

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

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

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

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

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

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

9 MS. KELLEY: Josh?

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

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

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

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

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

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

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

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

3 Thank you.

4 MS. KELLEY: Paul C.?

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

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

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

17 So thank you.

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

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

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

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

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

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

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

1 health care.

2 [No response.]

3 DR. CHERNEW: You're muted.

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

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

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

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

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

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

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

12 We're going to take a three- or four-minute break
13 and not a five-minute break. Let's try and come --
14 actually, let's try and come back a little bit after, like,
15 3:52, to make the trains run on time, because we have one
16 more session left. It's also interesting that you left
17 with quality there, Lynn, because we have this whole other
18 agenda about rural hospital quality that has a whole bunch
19 of other stuff that we could do beyond what you're about to
20 see, and I think it will be reasonable. We'll see, when we
21 look at the material that's going to come up, what are the
22 next steps to do or not on this other body of work. So I

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

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

10 [Recess.]

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

15 MS. KELLEY: We are live.

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

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

4 MS. TABOR: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 In today's presentation we will focus on quality reporting

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

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

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

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

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

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

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

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

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

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

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

1 "left before being seen in ED" measure.

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

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

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

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

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

14 First, Medicare does not collect clinical
15 information -- for example, blood pressure readings and
16 many lab results -- or patient experience and patient-
17 reported outcomes at the beneficiary level. Second, CMS
18 measures the performance of clinicians using the Merit-
19 based Incentive Payment System, or MIPS, which, in March
20 2018, the Commission recommended eliminating because it is
21 fundamentally flawed.

22 Third, for claims-based measures, Medicare's

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

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

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

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

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

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

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

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

1 determining ACO shared savings or losses.

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

8 Many ACOs participate in rural areas and take
9 accountability of the quality of care provided to the
10 beneficiaries attributed to their organization.
11 Beneficiaries residing in rural areas that are attributed
12 to ACOs are included in the ACO's quality reporting.
13 Although RHCs are not required to participate in a Medicare
14 quality reporting program, CMS reports that as of January
15 2023, about 45 percent of RHCs were participating in MSSP
16 ACOs and therefore are likely reporting quality.
17 Increasing provider participation in value-based programs,
18 such as ACOs, is consistent with the Commission's
19 principles.

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

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

5 For example, the largest MA contract has 2.6
6 million enrollees. Those enrollees are in almost every
7 state, with over 1,000 enrollees in each of 46 states, and
8 also a large number of enrollees in many states with over
9 20,000 enrollees in each of 30 states.

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

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

21 Prescription drug plan star ratings are based on
22 12 measures, which are a subset of the MA star rating

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

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

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

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

16 The group listed 37 key rural measures including
17 21 hospital-setting measures and 16 ambulatory care-setting
18 measures. Most of the measures the Advisory Group selected
19 are included in the various Medicare quality reporting
20 programs we described on the previous slides. Also, many
21 of the measures identified as key measures are tied to
22 clinical outcomes, patient experience, and value, and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 MS. TABOR: That's a --

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

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

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

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

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

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

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

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

1 Why don't our REHs have outpatient measures?

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

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

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

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

1 REHs?

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

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

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

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

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

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

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

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

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

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

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

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

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

19 MS. KELLEY: Okay. I have Cheryl next for Round
20 1.

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

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

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

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

1 the cost-based environment.

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

10 Anyway, that's my question. Thanks.

11 MS. KELLEY: Amol.

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

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

22 DR. NAVATHE: Great. Thanks.

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

4 DR. CHERNEW: I am ready.

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

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

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

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

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

9 MS. KELLEY: Tamara.

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

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

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

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

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

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

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

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

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

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

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

7 MS. KELLEY: Brian.

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

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

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

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

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

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

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

11 MS. KELLEY: Okay. I have Cheryl next.

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

16 In terms of Table 1 where you show the number of
17 measures for MIPS, I'm a bit worried about that number 100
18 being sort of construed as a really burdensome. So there's
19 100 measures spread across many different specialties, so
20 any given physician is not measured on 100 measures. So I
21 don't know if there's some way to finesse that so it's a
22 little bit clearer.

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

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

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

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

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

3 MS. KELLEY: Robert.

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

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

1 perhaps those are the most important measures.

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

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

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

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

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

20 MS. KELLEY: Betty.

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

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

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

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

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

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

5 MS. KELLEY: Scott.

6 DR. SARRAN: Yeah. First, thanks, Ledia, for the
7 excellent work summarizing the area. I have very little to
8 add to the already excellent comments. Just one thought.
9 Given that in many rural areas the local hospital as, I
10 think, a uniquely strong relationship with the population
11 in terms of their ability to impact on the health status of
12 that population. I mean, in an urban area you may have 5,
13 6, 8, or 10 hospitals that divvy up market share. Rural
14 areas, much less likely that that's the case.

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

1 looking at a local hospital.

2 MS. KELLEY: Paul.

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

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

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

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

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

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

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

1 for Medicare beneficiaries in sort of an efficient way.

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

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

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

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

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

17

18

19

20