MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
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Thursday, January 16, 2025
10:19 a.m.

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P R O C E E D I N G S

[10:19 a.m.]

DR. CHERNEW: Hello and welcome, everybody, to our January MedPAC meeting. Happy New Year. It is a packed full meeting with some presentations and important votes, and we are going to start with the physician and other health professionals' fee service, and so am I turning it over to Rachel?

Rachel.

MS. BURTON: Good morning.

In this session, we'll recap our December presentation assessing the adequacy of payment rates for clinician services and present a draft recommendation for how to update payments in 2026.

For those watching online, you can find a copy of these slides in the handout section of the webinar's control panel on the right side of your screen.

I'll start by going over some key facts and figures about Medicare's physician fee schedule and then run through our assessment of various indicators we use to determine if payments are currently adequate.

Geoff will then walk you through the proposed

update for 2026.

In 2023, 1.4 million clinicians billed Medicare's physician fee schedule for 666 million clinician encounters with 28.2 million beneficiaries in fee-for-service Medicare. The Medicare program and fee-for-service beneficiaries paid $92.4 billion for these fee schedule services.

An important development to keep in mind when considering payment rates for clinician services is the recent increase to payment rates for evaluation and management visits. As shown in the left graph, CMS substantially increased the payment rates for office and outpatient E&M visits in 2021. This required an offsetting budget neutrality adjustment to the fee schedule's conversion factor, shown at right, which will be fully phased in in 2025.

So while it is true that the conversion factor has decreased in recent years, it's important to remember that payment rates for office visits, which are billed frequently by many types of clinicians, have increased by a large amount in recent years.

I'll now turn to our assessment of the adequacy

of payment rates for physicians and other health professionals. In this sector, our assessment is informed by indicators in three categories: beneficiaries' access to care, the quality of their care, and clinicians' revenues and costs. I'll walk through our various findings on the next few slides.

In terms of access, this year we continue to find that beneficiaries have relatively good access to clinician care. Our 2024 survey found that Medicare beneficiaries ages 65 and over reported access to care that was comparable with or in most cases better than that of privately insured people ages 50 to 64.

Comparable shares of clinicians report accepting patients with Medicare and private insurance.

The total number of clinicians billing Medicare is increasing, although the mix of clinicians is changing, and the number of clinician encounters per fee-for-service beneficiary increased by 4.3 percent in 2023.

It's difficult to assess the quality of clinician care, but we note wide geographic variation in rates of ambulatory care-sensitive hospitalizations and emergency department visits and stable patient experience scores.

In terms of clinicians' revenues and costs, spending per Medicare fee-for-service beneficiary increased by 4.2 percent in 2023. Private insurance payment rates increased faster than Medicare's payment rates in 2023 and are now 140 percent of fee-for-service Medicare payment rates.

Median all-payer compensation grew by 3 percent for physicians and 6 percent for advanced practice providers in 2023. And clinicians' input costs, as measured by the Medicare Economic Index, grew by 4.4 percent in 2022 but are projected to moderate in the future, growing by only 2.3 percent in 2026.

Our overall assessment is that most of the indicators we look at suggest payment rates are adequate, but relatively high growth in clinicians' input costs are a concern.

I'll now turn things over to Geoff.

MR. GERHARDT: I'll now turn to the update recommendation you discussed last month and that you'll be voting on today.

Before we get to the draft recommendation, I'll review key objectives and considerations. The key

objective is to maintain beneficiary access to quality care without unnecessarily high payment rates. In terms of considerations, beneficiary access indicators are relatively positive, suggesting that payments are currently adequate. However, clinicians face high-input cost growth relative to current law updates, which raises concerns that some clinicians may not be able to absorb those costs. And finally, low-income beneficiaries report having worse access to care than other beneficiaries.

The recommendation you discussed last month has two parts. In 2026, it would replace current-law fee schedule updates with a single update of the projected increase in the Medicare Economic Index minus 1 percentage point. Since the MEI is currently projected to increase by 2.3 percent in 2026, this part of the recommendation would result in a 1.3 percent increase to payment rates.

In addition, the recommendation would direct Congress to enact the clinician safety-net recommendation we included in our March 2023 report, which would increase the average clinician's fee schedule payments by an additional 1.7 percent. The combined effect of these two policies would be to increase average physician fee

schedule payments by an estimated 3 percent.

As we say more about in the next slide, the size of the increase would vary by clinician specialty. Primary care clinicians would see an average increase of 5.7 percent in fee schedule payments, and all other clinicians would see an average increase of 2.5 percent.

To help improve access to care for low-income beneficiaries, the Commission has recommended establishing add-on payments for all fee schedule services furnished to low-income fee-for-service beneficiaries.

We targeted service furnished to this population since they report worse access to care than other beneficiary populations, and clinicians do not always receive the full amount of Medicare cost sharing they're entitled to due to Medicaid payment policies.

Under our safety-net recommendation, when treating low-income beneficiaries, primary care clinicians would receive a 15 percent add-on to their fee schedule rates, and all other clinicians would receive a 5 percent add-on. The add-on payments would not result in increased beneficiary cost sharing.

This brings us to the draft recommendation, which

reads: "The Congress should, for calendar year 2026, replace the current law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the Medicare Economic Index minus 1 percentage point and enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries."

In terms of implications, relative to current law, our two-part recommendation would increase Medicare spending by 2- to $5 billion during the first year and by 10- to $25 billion over five years. It should maintain beneficiaries' access to care and maintain or improve low-income beneficiaries' access to care. In addition, the recommendation should maintain clinicians' willingness and ability to furnish care and should maintain or improve clinicians' willingness and ability to treat low-income beneficiaries.

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

DR. CHERNEW: Everybody, thank you. There has been so much work behind the analysis of this chapter.

It's really remarkable. So I appreciate the presentation.

For those at home, we've had a long discussion of this in a range of ways, and so we are now going to have a sort of quicker one-round set of comments where I'm going to ask all of you to make any comments you want and then give your vote, and we'll go around.

And, Lynn, you got in the kickoff queue, so you're going to go first, and then we'll just go around. If you want to change the order, send me a message. Lynn.

MS. BARR: Thank you. Thank you very much.

I do support this recommendation. I would just suggest that we clarify the wording of the recommendation to make it very clear that this is a reset of the payment, and that that is not exactly clear in the recommendation itself. So I just would recommend that we're being clear that we're resetting the baseline for the physician payment.

DR. CHERNEW: So just two quick things. The wording of the recommendation has to stay the way the wording of the recommendation is for a bunch of process reasons. We can be very clear about that in the text so it's clear and communicate that.

Larry.

DR. CASALINO: Yeah. I appreciate the work that went into this.

If we were just voting on MEI minus 1, I would probably vote no, but I think the safety-net recommendation is excellent, and the two combined, I'm quite enthusiastic about voting yes.

MS. UPCHURCH: I also support both parts of this recommendation with two caveats -- or not caveats but additional comments.

I do wish we would track the number of geriatricians and make that super clear to people. I mean, we're supposed to be helping Medicare beneficiaries, the vast majority of them being older adults. We have a shrinking group of geriatricians, not just geriatricians but advanced practice folks who are specialized and trained in geriatrics.

As somebody who did their residency in pharmacy and geriatrics, it really matters. In American geriatrics, four M's: medications, mentation, mobility, and what matters most to the older adult. I think it's really critical in our practices, and we're really not pushing it,

I don't think, in any of our recommendations. So I hope we will keep an eye on the number of geriatricians. There's an article in New York Times about it today.

And the second thing is I do get concerned that more and more people -- I love the fact that we have a safety-net add-on here for people that are eligible for low-income subsidy, because I do think concierge medicine is taking off, and that means people with money are getting the access they need, and I'm not sure that we can distinguish these things in our CAHPS surveys. So I want us to also keep an eye on that. Like, what does it mean for the Medicare beneficiary that doesn't have concierge care as we move forward in terms of access to providers?

But I support the recommendations. Thank you.

DR. MILLER: I support the recommendation.

A couple quick comments. One, I appreciate the letter that the AMA sent us, and I know that many folks have expressed concerns about the RUC, many other Commissioners have, and I think that we as a Commission should consider taking them up on their offer to attend a RUC meeting and see for ourselves what we think of the process.

A couple other small notes. I noted that we use physician compensation as a measure of adequacy of the fee schedule. As I've mentioned ad nauseam multiple times, considering that half of physicians are employed and that their income, therefore, is not really tied to what they receive on the fee schedule and is salaried, I don't really think that that is an accurate measure.

I'm also glad that we have included NPs and PAs in our measures because they have an important role, I think, in the Medicare care delivery system.

I think one other important thing that we should be thinking about is that we have been making recommendations for many, many years about payment, and we're talking about pricing 8,000 physician fee services, hospital services, home health services, SNF services, et cetera. We have largely in the fee-for-service system failed to transition to value, and we have failed to improve population health through fee-for-service. So I think that we as a Commission need to rethink how we promote population-based health, which is something that Secretaries across political administrations have supported.

Thank you.

DR. CASALE: I also support the recommendations and also appreciate the safety-net add-on payments as part of this recommendation. I think that's really important.

Just adding on to the comment I think Gina suggested about geriatrics, the staff does a great -- there's a lot of good information around access, but it seems like we need to continue to look for additional measures to understand access, as I think many of us anecdotally have heard of many challenges for access for Medicare beneficiaries.

Just to highlight one I know listed was the number of encounters per fee-for-service beneficiary went up, but we're not really sure that that means that access necessarily got better. It could certainly just mean that the clinicians are just scheduling more, because we don't know the quality of those encounters necessarily.

So that being said, I support the recommendations.

DR. DUSETZINA: I also support the recommendation, and I especially endorse the Medicare safety-net add-on payment component here.

DR. DAMBERG: I also support the recommendation.

I'm going to double down on what other Commissioners have said about the safety-net add-on payments. I think those are going to be critically important for trying to make more inroads and improving access for those people who are low income.

And I also want to underscore -- I think we've been talking a lot about access measures and feeling like the set being used are inadequate. So I hope in sort of future years, we're able to strengthen the set of access measures we have available.

MR. POULSEN: I'm also supportive and support the points that were made around the additional pay for low income.

I do think that something we may be underappreciating at this point is the access differential that we're currently defining as primarily between primary care and specialty care, may not capture some of the biggest areas, the biggest pinch points that we have right now, which are in some of the medical subspecialties. In terms of access, that I think is even more dramatically challenging than primary care right now.

So I think that I'm supportive of this for this round, but I think that's something we need to think about more assertively in the future. Thanks.

MR. KAN: I support the recommendation.

DR. KONETZKA: I support the recommendation because I think it represents a good compromise between several competing concerns. On the one hand, we have a still, you know, not -- not baseless but certainly still kind of hypothetical access problem if we let physician payments or other provider payments fall behind. This may be due to access measurement or lack of great measures of access, as Cheryl pointed out.

But on the other hand, there's a very real cost to beneficiaries in terms of higher monthly premiums that this payment increase will cost. And so to me, I'm just balancing this hypothetical with the very real cost to beneficiaries, and I feel like this recommendation strikes a good compromise. So I'm supportive. Thank you.

DR. SARRAN: I too strongly support the recommendations. I think this reflects really excellent work in our threading a variety of needles, notwithstanding Brian's concerns about the round-peg square, the whole

nature of fee-for-service payments as opposed to our desired goals for an increasingly large and aging population around holistic care and outcomes-based payments. Those are ongoing issues we will continue to grapple with.

In the meantime, we are where we are, and I think this is an excellent set of recommendations.

DR. NAVATHE: I strongly support the recommendation. Certainly, like my fellow Commissioners, strongly support the safety-net aspect.

I have two brief comments. I think one piece is I think reflecting upon this, the access piece, I think one of the key pieces for me in thinking through this recommendation is how will access be affected by any change in payment, I think, as opposed to other factors, because it's very highly multifactorial. And so I think the recommendation is a nice balance in getting that right from that perspective.

And the second piece is I think we oftentimes also think about the clinician supply, I should say, more broadly. I also think that that is a highly multifactorial piece. I think we worry a lot about that in the primary

care side.

I think the Commission has done some work on this and reflected some work around this, that the payment part of it may be one factor, but one factor of many, many factors, and it's unclear evidence-wise that increasing payments would certainly increase the choice of medical students to go into primary care or even in other specific specialties.

So thank you. Really support the recommendation.

DR. LIAO: I also support the recommendation, and within that support are kind of two components.

On the one hand, I appreciate the balance of the many objectives here. I appreciate that the access measures we do have access to are stable and have positive metrics there.

On the other hand, I recognize within that stability, the cumulative effects can be challenging, as we've discussed in the past.

I also appreciate, like other Commissioners, the limitations of the access measures we do have, be it what it is measuring -- is the measure showing adequacy? Is it just showing the absence of something very, very bad -- as

well as the disparities concerns and the opportunities we have to kind of measure access in different ways that may illuminate those further in one way or the other.

So with that, I can support the recommendation, as I think action -- as a point from which I think future action and discussion should begin.

DR. CHERNEW: Okay. So I'm hearing that after all these comments, we need to do a formal roll call vote. Is that right, Dana? And so, Dana, are there any other comments that we've received?

MS. KELLEY: Yes. I first have a comment from Robert, who says that he's supportive of the recommendation but does have concerns about the section on page 55 called physician compensation is increasing and the implication that compensation correlates with profitability when inflation is considered.

He presumes that compensation is narrowly referring to either salary, if employed, or take-home pay if in private practice.

The major drawback is that we may not be taking into consideration total compensation, especially for employed physicians, which includes employer benefits such

as insurance for medical, dental, and vision, short- and long-term disability coverage, sick leave and mandatory contributions to employer-based retirement plans.

Total compensation as defined by salary plus benefits may actually fall far short of expectations and is likely to be cross-subsidized by inpatient hospital revenues in many cases.

Otherwise, he says he thinks this is a well-written report and thanks the staff for the many updates that were made to the chapter.

Wayne enthusiastically endorses the recommendation, particularly the safety-net add-on payments.

And Betty says that she supports the recommendation and is enthusiastic about the safety-net add-on. She appreciates the new inclusion of information on the distribution of PCPs, PAs, and NPs across low- and high-income counties.

She agrees with Gina's comment on tracking gerontologists and adult gerontologist NPs.

She's also interested in the RUC. Whether in the manner Brian mentioned or some other, she thinks it's an

important area for us to follow up on.

And finally, access is clearly related to workforce, another important area for us to follow up on.

Shall we go to the vote?

DR. CHERNEW: Yes, perfect.

MS. KELLEY: All right. Voting on the recommendation that the Congress should, for calendar year 2026, replace the current law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the Medicare Economic Index minus 1 percentage point and enact the Commission's March 2023 recommendation to establish safety net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.

Voting yes or no. Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. CASALE: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert, can you give a thumbs-up or -down for us?

[No response.]

MS. KELLEY: Do we have Robert?

[No response.]

MS. KELLEY: All right. We'll circle back to Robert.

DR. CHERNEW: There he is.

MS. KELLEY: There he is.

DR. CHERNEW: You got a thumbs-up.

MS. KELLEY: Thumbs up. Thank you, Robert.

Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Josh?

DR. LIAO: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Greg?

MR. POULSEN: Yes.

MS. KELLEY: Betty, can we get a thumbs-up or thumbs-down?

Thumbs-up from Betty.

Wayne, thumbs-up or -down?

A thumbs-up from Wayne.

Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Thank you.

DR. CHERNEW: And so with that, I want to say one quick comment, and then we're going to take a quick break and come back and talk about the hospital fee schedules.

But the comment I want to make is there's a lot of nuance here, and I appreciate all the comments you've made. Both the support for the safety-net approach, I

could not agree more, concern about several other things about what we measure, how we say it, and issues that extend our type of analysis beyond this sort of simple update recommendation. And, again, I think the comments have been quite useful, and many of which we are working on.

But the overall point that I will say to the folks at home about how I would hear this recommendation is we believe that there is some justification or we're recommending some increase in the amount of money going into the physician fee schedule, and a portion of that increase should be targeted according to the principles laid out in our safety-net kind of recommendation. That's basically what we voted on.

And we will continue, as we always do, to both revisit this issue -- we will be doing it in a month for our June report -- and to consider all these other recommendations in the physician fee schedule. There's a lot of work to be done here.

So, again, thank you. We're going to take a break.

Oh, Paul wants to say one thing.

MR. MASI: Yep. Thanks so much, and this is a great way to start the day.

I just wanted to acknowledge for Commissioners and for those of you at home that the AMA has graciously extended an invitation to the MedPAC staff to attend the RUC meetings. And in the past, the staff have been able to attend, and we'll continue to appreciate their invitation.

DR. CHERNEW: And now we're going to take a quick break, and we're going to come back at 10:50, and we're going to talk about the inpatient and outpatient services' fee schedules.

So, again, thank you all.

[Recess.]

DR. CHERNEW: Welcome back, everybody. We are going to continue our march through the different fee schedules, and up next is the fee schedule for hospitals inpatient and outpatient services, and we are starting with Alison.

MS. BINKOWSKI: Thank you, Mike, and good morning to our audience. The audience can download a PDF version of these slides in the handout section of the control panel on the right-hand side of the screen.

In addition to the staff listed on the slide, I would like to thank Stuart Hammond, Pamina Mejia, and Nathan Graham for their assistance.

In today's update to the December presentation on hospital payments I will provide a brief overview of hospital use and spending under fee-for-service Medicare; review the payment adequacy indicators for fee-for-service Medicare payments to hospitals; briefly discuss site-neutral payments; and then present the draft recommendation presented in December.

As a reminder from December, to pay general acute care hospitals for the facility share of providing inpatient and outpatient services, fee-for-service Medicare generally sets prospective payment rates under the inpatient and outpatient prospective payment systems.

In 2023, over 3,100 hospitals were paid under these systems, and collectively payments, including those for uncompensated care and separately payable drugs, totaled nearly $180 billion.

The following slides summarize our assessment of the adequacy of fee-for-service Medicare payments under these two prospective payment systems.

More details on each of our fee-for-service Medicare payment adequacy indicators were presented in December and in your mailing materials, so today I will briefly summarize the results from each of the four categories of indicators.

The first category of payment adequacy indicators is beneficiaries' access to hospital care, which was positive in 2023. Specifically, the supply of hospitals was relatively steady at about 4,500; hospitals continued to have available capacity in aggregate, including an increase in employment and the aggregate occupancy rate remaining at 69 percent; the volume of fee-for-service hospital services per capita increased, both for inpatient and outpatient services; and hospitals continued to have a financial incentive to treat fee-for-service beneficiaries, as fee-for-service Medicare payments remained greater than hospitals' variable costs.

The second category of payment adequacy indicators is the quality of hospital care, which were mixed in 2023. Specifically, fee-for-service Medicare beneficiaries' risk-adjusted mortality rate improved slightly, while the readmission rate worsened slightly; and

most patient experience measure improved, though many remained low.

The third category of hospital payment adequacy indicators is hospitals' access to capital, which was positive in 2023, with gradual improvement projected. In particular,
hospitals' all-payer operating margin increased to 5.1 percent; hospital bonds and other measures of access to capital were positive, with the yield on hospital bonds increasing by less than the general market; and preliminary data for 2024 and rating agencies outlooks for 2025 suggest continued gradual improvement in hospitals' access to capital.

The fourth category of payment adequacy indicators is the relationship between fee-for-service Medicare payments and hospitals' costs. These indicators were negative in 2023. Specifically, hospitals' fee-for-service Medicare margin remained negative and relatively steady at -12.6 percent, or -13 percent when excluding Medicare's share of coronavirus relief funds. Furthermore, among the 6 percent of hospitals that consistently performed relatively well on certain quality measures while

keeping costs relatively low -- a subset the Commission refers to as "relatively efficient hospitals" -- the median fee-for-service Medicare margin was negative, at about -1 percent, or -2 percent excluding relief funds.

Looking forward we project hospitals' fee-for-service Medicare margin to remain low in 2025, at levels similar to those in 2023.

In considering how to update fee-for-service Medicare payments to hospitals, the draft recommendations aims to balance several objectives. These include maintaining payments high enough to ensure beneficiaries' access to care; maintaining payments close to hospitals' cost of providing high-quality care efficiently to ensure value for taxpayers; maintaining fiscal pressure on hospitals to constrain costs; and limiting the need for large, across-the-board payment rate increases by directing a portion of the increase in Medicare payments to Medicare safety-net hospitals treating high shares of vulnerable Medicare patients.

Last year, the Commission balanced those objectives by recommending a small across the board update above current law to all hospitals and a larger, more

targeted increase to hospitals based on their Medicare safety-net index.

As a reminder, in June 2023, the Commission recommended moving existing Medicare safety-net payments to the commission-developed Medicare safety-net index, or MSNI, which targets hospitals that serve more low-income Medicare patients. For each hospital, the MSNI is calculated from the three components shown on this slide. Higher values of the MSNI indicate greater financial vulnerability and reliance on the Medicare program.

In 2023, the Medicare safety-net index continued to be a better predictor of hospitals' all-payer margin than those used for current Medicare safety-net payments composed of disproportionate share hospital and uncompensated care payments, as shown in the figure in the right. Since 2023, the Commission has recommended moving to the MSNI, which would better target funds to hospitals most in need of additional Medicare funds.

Before we turned to the draft recommendation to update fee-for-service Medicare payments to hospitals, I will briefly discuss site-neutral payments.

For over a decade, the Commission has observed

that Medicare's payment rates often differ for the same service across ambulatory settings, such as hospital outpatient departments, or HOPDs, and freestanding physician offices. These payment differences encourage hospitals to acquire physician practices, resulting in the billing of services shifting from the freestanding offices to HOPDs where payment rates are usually higher.

This issue can be addressed through site-neutral payments, which improve incentives to provide care in the lowest cost setting in which it is safe and appropriate.

The Commission has twice recommended aligning Medicare payment rates for selected services that are safe and appropriate to provide in all HOPDs, when doing so does not pose a risk to beneficiary access to care.

Congress took a different approach for site-neutral payments through the Bipartisan Budget Act of 2015, which aligned payment rates for all services in new off-campus provider-based departments, by reducing rates for these OPPS services by 40 percent such that they are approximately equal to physician fee schedule rates.

To help policymakers understand the effects of expanding the site-neutral policy in the BBA of 2015; to

include OPPS services in all off-campus provider-based departments, we estimated the 2023 effects of applying payment rates of 40 percent of the standard OPPS payment rates to all OPPS-covered services in all off-campus provider-based departments.

Without a budget neutrality adjustment, we estimated that OPPS spending would have been $1.3 billion dollars lower, and beneficiary cost-sharing obligations would have been $0.3 billion lower. However, if a budget neutrality adjustment is applied with this site-neutral policy, there would be no change in aggregate inpatient and outpatient revenue, but there would be small distributional effects such as urban hospitals losing a small amount and rural hospitals gaining a small amount.

I now turn to the draft recommendation. The draft recommendation reads:

The Congress should:

For 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent; and redistribute existing disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index, or

MSNI, using the mechanism described in our March 2023 report, and add $4 billion to the MSNI pool.

The draft recommendation would increase spending relative to current law by $5 to $10 billion in one year and $25 to $50 billion over five years.

In percentage terms, the estimated combined effect of the two parts of the draft recommendation is an about 2.2 percent increase above current law in 2026.

This recommendation will help ensure fee-for-service Medicare beneficiaries' access to care by increasing hospitals' willingness and ability to treat beneficiaries, especially those with low incomes.

And with that I turn it back to Mike.

DR. CHERNEW: Alison and team, thank you. We are going to repeat what we did for the physician and other clinician fee schedule, which is we are going to have one round where everyone will talk and just could be very brief. Just say your piece. Then we are going to do a formal vote. And Greg, I think it is appropriately probably, with hospitals, we start with you.

MR. POULSEN: Let's see. I guess that the very, very brief point would be I think the recommendation, as

defined, including the disproportional share component, I think is positive, makes sense, provides an appropriate increase that reflects at least a lot of the increased financial stress and starts to maybe push us away from some of the expectation that we pay less than cost. So on that I would be supportive.

As part of the discussion here, we got into the site-neutral component. I think that's a very complicated one. I know we've been in one place in the past, and I think I've been consistent in saying that I'm uncomfortable with where we have been in the past. It's not part of this recommendation, so I'm supportive of this recommendation, and when we bring site-neutral up again in the future I'll have a different perspective.

DR. CHERNEW: So just for those at home, I know don't have enough time and we will go around. I just want to emphasize that this recommendation does not include a site-neutral component. We have done a lot of site-neutral work, as you are emphasizing, and I can say for many of those here, and particularly Robert, as well, this is a very complicated body of work, and we are very aware of the complicated connections that are imposed across fee

schedules in the site-neutral, and the challenges of how to do that.

So we will continue to think through that and continue to work with the Hill on site-neutral. It is very important that we have payment mechanisms that promote sort of efficient delivery of care, that we don't pay for services more than we can get more efficiently some other place. But understanding the ramifications of that on the providers is actually quite important.

So we had that debate. We appreciate the debate, and we will continue to have that debate. This discussion, as you point out, Greg, is not that debate.

But anyway, Cheryl.

DR. DAMBERG: I support the Chair's recommendation, in particular because the fee-for-service payments are below the hospital costs, even for the relatively efficient hospitals. So I think the recommendation makes sense.

I also am very supportive of the safety-net index, and using that as a mechanism to better target payments to Medicare beneficiaries who face particular challenges.

DR. DUSETZINA: Okay. I'm very much going to repeat what Cheryl said. I think the analysis showing the relatively efficient hospitals, that small percent, are so negative. But I think it does support the recommendation for the update.

I also wanted to just say thank you for the great comparisons of the safety-net index versus the DSH. I think that really helps to solidify and reemphasize why it's important to have a new approach to having those dollars flow with low-income beneficiaries.

So I am very supportive of these recommendations. Thank you.

DR. CHERNEW: Paul.

DR. CASALE: Thank you. I am also supportive of the recommendations and also particularly support the safety-net index, the use of the safety-net index.

In terms of, again, measuring access, I think we continue to look for ways to identify that. Volume of encounters again went up, but I'm not sure how much that really reflects access.

And then the quality measure is really important -- risk adjusted, morality risk adjusted admissions and the

CAHPS scores, and how to compare that to either other groups of beneficiaries I think would be particularly helpful. Just work going forward I think would be really important.

DR. MILLER: A couple of comments here. Our methodology here, historically and currently, is flawed. Historical work by CMS and ProPAC, specifically, analyst Jack Ashby, denoted cost shifting, which suggests that our HOPD base may be inflated.

An important technical note here that is distinct from other markets, we are analyzing two payment chassis together for two different service markets, which we do not do, and it's wrong. We should not be analyzing OPPS and IPPS together. They must be examined separately. I note that perhaps the IPPS update is too low and the OPPS update is too high.

We are also failing to integrate the Commission's prior site-neutral recommendations, which the Commission supported specifically for 57 APCs as recently as 2023. OPPS should be compared to the PFS and ASC payment chassis, noting that the recommendation might result in a decrease in OPPS and an increase in PFS or ASC payment. It does not

necessarily always have to be an across-the-board cut.

Site-neutral payment has bipartisan support with, for example, Senators Cassidy and Hassan unveiling a framework to support site-neutral payment. Organizations as diverse as unions, and to the Americans for Prosperity to the Heritage Foundation to Brookings, support site-neutral payments, and payers do too, with the BlueCross BlueShield Association, submitting a letter noting that we are failing to respect our site-neutral recommendation and analyzing these markets incorrectly.

I would also note that we are suggesting what is a combined 4.7 percent update. Therefore, I do not support the recommendation because it is not accurately calculated. Thank you.

DR. CHERNEW: Gina.

MS. UPCHURCH: Thank you. I do support the recommendation, both parts of the recommendation, and particularly, like many other Commissioners, have called out my affirmation of the safety-net index as opposed to DSH payments, the way they have been done.

I do also want to thank the staff for including more about 340B drug pricing. Two days ago, there was an

article in The New York Times about a Texas company that is sort of administering the 340B program and the incredible spread that is coming there.

And it is really hurting three groups of people with 340B. It hurts the clinic that was originally intended for, like FQHCs that have pharmacies. They are losing some of their penny pricing for various reasons. So that's hurting them alone.

Number two, it hurts retain pharmacy because it is driving more and more pharmacies to be 340B that are affiliated with hospitals to create even more money and income for the hospital systems. So I have concerns about it there.

And lastly, one of the things that I really care about is transparency, and that is not there with the 340B program.

So I really want us to keep our eye on the 340B program and what that means for hospitals, in terms of income, and what that means for other parts of the health care system.

Thanks so much. I do support the recommendation.

DR. CHERNEW: Larry.

DR. CASALINO: Yeah. I support the recommendation, as well, and like other Commissioners I think the safety-net index, that was really brilliant work done, to create that, and I hope it will be put into practice.

This is one of the few areas probably where Greg and I differ. I think site-neutral is extremely important. I just want to emphasize, as Michael would say, for the folks at home, that it's not just a matter of how much money hospitals get paid. It's a matter that the lack of site-neutral payments has led to the gross reorganization of the whole health care system.

So you have a doctor who could be in private practice one day getting paid X for seeing a patient, hospitalized the practice the next day, the payment is X plus a lot. And that's not the only reason but one important reason why so many doctors are not now employed by hospitals. And they are not just employed by hospitals but by health systems that are getting larger and larger, able to negotiate very high payment rates from health insurers.

And it may be a good thing, or it may be a bad

thing for physicians to be employed by hospitals, because certainly conceptually there are advantages and disadvantages to that. But if it happens, it should happen on its merits, not because there is extra pay for the same service.

I know that sometimes it isn't the same service, but by and large I think our work on site-neutral has been good, and I hope that we will continue to push that.

But I do support the kind of two-part recommendation.

DR. CHERNEW: Lynn.

MS. BARR: Thank you, and thanks to the staff for outstanding work.

I do support the recommendation. I want to reinforce the importance of Congress also looking at the safety-net index in both the physician fee schedule and the hospital fee schedule. This brings more money to the providers, and without it this recommendation is not as positive and as good as it should be.

Just an editorial comment. I am not convinced on site-neutral payments, that we have completed that discussion, and obviously there are differences of opinion.

I tend to side more with Greg. But I do recognize the issues of consolidation. And, you know, it's a little bit late. I mean, it's already happened, you know, and I'm not sure we can prevent it by fixing the site-neutral payments. But it is a problem, and we don't have any tools.

So I strongly support the recommendation. Thank you very much.

DR. CHERNEW: Josh.

DR. LIAO: I also support and I will just highlight two things. First, I echo other Commissioners on this idea of the medium margin being negative for even the "relatively efficient" hospitals. I think if we think about value as a construct of relatively good quality for much lower cost you might think of value promoting hospitals. That's concerning.

So I agree that the recommendation is a directional step in the right direction. And then also the safety-net index as a necessary piece.

DR. CHERNEW: Amol.

DR. NAVATHE: I support the recommendation.

DR. CHERNEW: Scott.

DR. SARRAN: I support the recommendations. I am

particularly pleased with the work and the incorporation around the safety-net index.

I'll briefly comment about some of the other points raised. I share my colleagues' concerns that our current realistic inability to parse a recommendation for inpatient versus outpatient is part of a broader discussion around how, I think, in many markets, both Medicare payment and the reality of commercial payments leads reasonable hospital executives to, relatively speaking, under-invest in needed inpatient services, whether those are needed because it's a particular challenged socioeconomic community or it's needed because it's a particular type of service, and I think especially behavioral services.

And at the same time, relatively speaking, over-invest in outpatient services where there is more than adequate capacity, supplied by an ambulatory, typically physician-led, sector. So I share that concern, but we are where we are in terms of our realistic construct under which we work and data with which we can work.

I also share the site-neutral concerns that have been raised. I think that is a continued body of work that we need to pursue, for a variety of reasons. And I also

share the concerns around the 340B program, that I think needs reexamination, as it is growing in many ways beyond its original intent.

DR. CHERNEW: Tamara.

DR. KONETZKA: I was waiting for you to say my name.

DR. CHERNEW: I couldn't find the button.

DR. KONETZKA: I support this recommendation, for reasons that were mentioned earlier. I think even the most efficient hospitals having negative margins seems unsustainable. And I think we expect hospitals to do a lot that's not really aimed at efficiency. We want to maintain access for a variety of services. And so I support the recommendation for that reason, especially with the safety-net index.

As for site-neutral, I think it's a really important theoretical goal to move toward, and I think also a practical goal eventually. So I look forward to the time when we actually have the data to be able to separate that and think about how to move forward on looking at the inpatient and outpatient separately. I realize we don't right now.

DR. CHERNEW: Kenny.

MR. KAN: I don't support the recommendation because I believe that we need two separate IPPS and OPPS recommendations.

My vote is consistent with the site-neutral policymaker rationale laid out in a December comment letter by the BlueCross BlueShield Association, which insures 1 in every 3 Americans.

Services provided under IPPS should be analyzed separately from services provided under OPPS, as those services are provided at different sites of care and vary in resource intensity.

I believe that it is important to compare payments to hospital outpatient departments to the appropriate market for outpatient services, which would include ASCs and physician services. Such a comparison, which might enhance separate IPPS and OPPS recommendation, would be consistent with MedPAC's earlier June 2023 recommendation, which were included in the recent Site Neutrality Framework, released by Senators Cassidy and Hassan.

DR. CHERNEW: Dana, are there any comments from

Robert, Betty, or Wayne?

MS. KELLEY: Yes, there are. Robert agrees with the recommendation, but he says the most profound limitation of this update is the focus on fee-for-service Medicare to the exclusion of Medicare Advantage, which is now the majority of Medicare beneficiaries. Eventually, we may need to recommend changes to current law and our own internal processes, so that we can opine on payment policies that take into consideration the entirety of the Medicare population and ensure relative efficiency in the shared set of base benefits associated between the two groups.

He thanks the staff for the detailed report and the substantial effort in pulling together the data and analysis.

And I have a comment from Betty, that she also supports the recommendation, in particular the disproportionate share safety-net index recommendation. She aligns with Larry's comments on site-neutral. It is very important to beneficiaries but invisible to them, if the current situation is not defendable, in her view. So she look forward to more work on the complex issue of site-

neutral and the broader issue of IPPS and OPPS.

Are we ready for the vote?

DR. CHERNEW: I want to say something before we go around. We will go around in a roll call vote in a minute.

MS. KELLEY: Okay.

DR. CHERNEW: The issue of site-neutral has come up a lot, so I want to both describe the thinking and why we only have one update recommendation. So the first thing I want to say is the issue of site-neutral combines an issue of level, should we make the payment site-neutral, and an issue of updates, should we update the different fee schedules at the same rates. We updated OPPS at the PFS rate, for example.

The work that we did on site-neutral in 2023, took the view that the bigger of those issues was the level issue, and the update part is complicated because it affects all services. And there was a lot of concern that many of you said about some services, and that was just a complicated analytical issue about how to think through what I would call site-neutralness in an update world, and how to combine that with both the fee-for-service update

and, for that matter, the ASC update, which we will talk about ASCs later. But it is very complicated. At a minimum, I would say, at both the level and the update work would have to cross-sectoral.

So the reason, in March -- I want to emphasize this -- the reason, in March, we have a single recommendation is twofold. Number one, to apply our criteria in a March way is unbelievably difficult, and I would argue challenging, because certain of our core criteria -- access to capital, margins -- I think are hopelessly conflated between the inpatient and the outpatient. So it is difficult to go through the March exercise separately by sector.

In order to do it by sector, you would then need to combine with the fee-for-service and the ASC. So, for example, I think we could have a discussion of this. I do not think it would be appropriate to take our principles that apply to our site-neutral work, which was take the higher-cost price, say outpatient services, and put it to the lower-cost setting. If we tried to apply that to the update, it would imply take the higher-price update, say OPPS, and bring it down to the fee-for-service update,

which is very flat. I don't think that would be appropriate. At a minimum, it would require substantially more analysis.

I also don't think it's necessarily the case that we want to move the fee-for-service update up to where the OPPS update is.

So I think, at a minimum, at a minimum, the work to try and figure out how to apply site-neutral in an update context, where there are different services, where you don't know what the right balance is, would require substantially more analysis in a way where there is complicated data issues, complicated access issues, and a whole bunch of things.

And I cannot emphasize this enough for those at home. It is not that we don't understand the complicated connections between the fee-for-service fee schedule, the hospital outpatient fee schedule, the ASC schedule, and for that matter, across post-acute settings. If those of you recall, we had enormous discussions in the post-acute sectors about how one unifies across services that could be provided by different types, and we spent a lot of time on unified post-acute, for example.

All of that work is really complex, and as I think those of you at home would realize, there are people in this room that differ on what they think the appropriate outcome would be.

So because we are required to have March updates, and because to try and figure out what we would actually really do if we wanted to have separate updates for inpatient and outpatient services, or more to the point, just figure out how we would understand what the inpatient profitability is and all other access, without getting that conflated, and how we would figure out what the outpatient update should be, acknowledging that that analysis inherently would be cross-sectional, cross-sector, and have a whole bunch of other challenges, that is a task of sufficient complexity, that to move through our statutory requirements and update we make one update, which I think those at home should read as we believe the hospital sector needs more money than is currently scheduled in current law, and we believe that that money should be targeted to hospitals according to sort of safety-net principles, for which I think there is sort of broad support.

And that is essentially all we are saying. We

are on record as saying that we believe that there are issues of site-neutral. We have a site-neutral recommendation, which, as Greg pointed out, was really challenging to get to. We certainly can do more site-neutral work, and when we talk about things that should be on the agenda for future cycles, which we can do in any Executive Session, certainly, though, ask everybody explicitly in April what they think is important, we can discuss how one might do that work.

But it is really complicated analytic work, and certainly much more than we could do in the context of a March chapter. So that would have to work through, as we do for complicated things, to a workstream that would get us to June, if we ended up sorting through that with a set of concrete principles about how we would separate out outpatient and inpatient updates, which I think would be challenging to get to analytically and challenging to get to amongst the Commission. But if we were to do that, we could then consider having separate updates.

But where we are now, given the conflation of the data for our criteria and the complexity and the different views of cross-sector work, that is why we have one update.

That was 20 seconds, according to Amol, who is timing me. I know he is timing me. By the way, I don't keep my time on my spreadsheet. Only Amol keeps my time.

But with that being said, and I do appreciate your patience in listening to that, we are going to go around the table and take a roll call vote. So, Dana.

MS. KELLEY: Okay. Voting on the following recommendation:

The Congress should,

For 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent; and redistribute existing disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index, using the mechanism described in our March 2023 report, and add $4 billion to the MSNI pool.

Voting yes or no. Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. CASALE: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert? I will look for a thumbs up or down. A thumbs up? Thank you. Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Kenny?

MR. KAN: No.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Josh?

DR. LIAO: Yes.

MS. KELLEY: Brian?

DR. MILLER: No.

MS. KELLEY: Greg?

MR. POULSEN: Yes.

MS. KELLEY: Betty? Thumbs up or down? She gives a thumbs up. Wayne gives a thumbs up also. Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: Mike.

DR. CHERNEW: Yes.

MS. KELLEY: Okay. Thank you.

DR. CHERNEW: And with that we are going to take a -- oh, Paul wants to say one more thing. I'm sorry. You're right here and I forgot.

MR. MASI: Great, and thank you all for that discussion. We appreciate the feedback and will, of course, take all that back.

I wanted to say a couple of quick words, because the issue of 340B has come up. And I just wanted to remind Commissioners that this is something that the Congress has explicitly asked MedPAC to work on in the past, where we were asked with a mandated report in 2015, to specifically look at these payment issues.

Congress gave us additional data in 2020, to refine some of those analyses. And then you will recall this past analytic cycle I think Kim and Nancy had the distinction of being the last session here. But they also presented some updated analysis around 340B.

So I just wanted to flag that, that's something that we are aware of and we hear interest in that issue.

As always, this is something where there are lots of different issues that we could work on in the future, and we take input, of course, from the Congress, first and foremost, and then also where Commissioners want to go. And so we will have that in mind as we think about future agenda items.

DR. CHERNEW: Now we're going to take a five-minute break, and we are going to come back for a discussion, or votes on a whole range of other sectors. So thank you.

[Recess.]

DR. CHERNEW: Welcome back, everybody. We are now going to do a series of rapid-fire sessions where we're going to go through each sector with a brief presentation and then a vote, and then we'll move on to the next sector.

And so who is starting? Carol is starting. So, Carol, go ahead.

DR. CARTER: Hi. Hello, everyone.

The audience can download a copy of today's presentation on the right-hand -- upper right-hand side of the screen.

During this session, we're going to cover the

payment adequacy assessments for skilled nursing facilities, home health agencies, inpatient rehab facilities, outpatient dialysis services, and hospice services.

We discussed the adequacy of Medicare's payments during the December 2024 meeting for each setting, and today's session is an abbreviated version of those presentations. Based on your discussions in December, we'll present the draft recommendations for each sector. Commissioners can find additional detail in each sector's briefing papers.

Turning to skilled nursing facilities, I will recap the payment adequacy indicators for skilled nursing facility services and then present the draft recommendation for your vote. More detailed information is in the paper, which has been updated to reflect your comments at the December meeting. For example, we added more information on the effect of the SNF co-payments on length of stay, readmissions that occurred during the SNF stay, Medicare margins for SNFs with high and low shares of low-income subsidy patients, and we noted that Medicare's high fee-for-service payment rates subsidize other payers, not just

Medicaid.

Here's an overview of the SNF sector in 2023. That year, there were 14,500 SNFs, most of which also provided long-term care that makes up the bulk of the services in this setting. The median Medicare share of total facility days was 8 percent.

In 2023, 1.6 million fee-for-service Medicare-covered stays were treated in SNFs, and the program paid $25 billion on that care.

Our access indicators show that the supply of facilities and volume declined, but neither reflects the adequacy of fee-for-service payment rates. Occupancy rates increased to about their pre-pandemic levels.

The high Medicare marginal profit indicates the providers that had a strong incentive to treat fee-for-service Medicare beneficiaries if they had capacity.

The measures of quality show little or no change.

SNFs have adequate access to capital, and the sector remains attractive to investors. The total margin improved compared to 2022.

In continuation of a decades-long trend, the average Medicare margin in 2023 was high at almost 22

percent. Factoring in expected changes to payments and costs, the projected margin for 2025 is even higher at 23 percent.

This brings us to the draft recommendation, and it reads: "For fiscal year 2026, the Congress should reduce the 2025 Medicare-based payment rates for skilled nursing facilities by 3 percent."

In terms of implications, spending would be lowered relative to current law, decreasing between $2 billion and $5 billion over one year and between $10 billion and $25 billion over five years. We do not expect adverse effects on access to care due to continued provider willingness and ability to treat fee-for-service beneficiaries.

With that, I'm happy to answer any questions, and I'll turn things back to Mike.

DR. CHERNEW: Brian, I think you have a comment, and then we'll go to our vote.

DR. MILLER: The AHA pointed out the differences in hospital-based SNFs, of which they told me that they're around 450. I think that that's something we should account for.

I'd also note that we don't account for MA in this marketplace, which is half of the market, and I know that there are lots of challenges with access to post-acute care and prior authorization.

DR. CHERNEW: Scott?

DR. SARRAN: Yeah, very brief comment. I will support the recommendation.

I just want it on record that we have ongoing work in this space that is really very important for our beneficiaries and the program, particularly the interactions of our payments with the Medicaid programs, particularly the need to ramp up the connection between payment and quality outcomes, and particularly, the third point is the important role that SNFs play in the lives of many, many beneficiaries who live there long term.

DR. CHERNEW: Thank you, Scott.

Dana, I think we're ready for the vote.

Scott, why don't you start, and we'll go around this way, this time.

DR. SARRAN: I support the recommendation.

DR. CHERNEW: Oh, actually, we're not -- I take that back. I was completely wrong.

Dana, you do the roll call.

I'm glad you support the recommendation.

Someone just checked me.

MS. KELLEY: Okay. Thank you.

All right. Voting on the recommendation as follows. For fiscal year 2026, the Congress should reduce the 2025 Medicare-based payment rates for skilled nursing facilities by 3 percent.

Voting yes or no. Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. CASALE: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert, I'll look for your thumbs-up or -down. Thumbs-up from Robert.

Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Josh?

DR. LIAO: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Greg?

MR. POULSEN: Yes.

MS. KELLEY: Betty, I'll look for a thumbs-up or -down. Thumbs-up from Betty.

Wayne? Thumbs-up from Wayne.

Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Thank you.

DR. CHERNEW: And with that, I think we're going to move on to home health, and I think that's going to be

Evan.

MR. CHRISTMAN: Thank you, Mike.

Next, I will recap payment adequacy indicators for home health, and then I will present the draft recommendation. More detailed information is in the paper you received, which has been updated to reflect your comments. Specifically, we added more information about the utilization of home health aides. We included data on the utilization of home health in rural, micropolitan areas, and we added additional information about our quality measures.

Before turning to our payment adequacy indicators, here is a brief overview of home health care and Medicare fee-for-service.

In 2023, there were about 12,000 agencies participating in the fee-for-service program. Those agencies served 2.7 million fee-for-service beneficiaries and delivered about 8.3 million 30-day periods of home health care, and total fee-for-service payments in 2023 equaled $15.7 billion.

Turning to our indicators, they are generally positive for home health care. Ninety-eight percent of

beneficiaries live in a zip code with two or more home health agencies.

The fee-for-service Medicare per capita volume decreased. The share of hospital discharges to home health care was higher than the pre-pandemic level.

For quality of care, the fee-for-service Medicare beneficiaries' discharge-to-community rate improved slightly, and patient experience measures remained high and were stable.

For access to capital, the all-payer margin was 8.2 percent. We note that the acquisition of home health agencies have slowed in recent years, but firms have continued to acquire home health agencies.

For payments and costs, Medicare margins in 2023 for fee-for-service were 20.2 percent, and the projected margin for 2025 was 19 percent.

This brings us to our draft recommendation. It reads: "For calendar year 2026, Congress should reduce the 2025 Medicare-based payment rate for home health agencies by 7 percent."

Relative to current law, spending would decrease by between $750 million to $2 billion in one year and

between $10 billion to $25 billion over five years. For implications, we do not expect adverse impacts on access to care, and providers should continue to be willing and able to treat fee-for-service Medicare beneficiaries.

This completes my presentation. I'll turn it back to Mike.

DR. CHERNEW: Great, Evan. Thank you.

Gina, I think you had a quick comment.

MS. UPCHURCH: Yeah, just briefly.

Thank you for this great work. I support the recommendation, but I do have concern about aides being less and less likely being able to go into people's homes for various reasons, and the Center for Medicare Advocacy link that was for 2019 article raised those concerns even more for me, and I didn't quite understand. They made it sound like a lot of people are eligible for the aide services, and they're not getting them. I didn't know if that meant through state funding or something like that, but just want to know a little bit more about that moving forward.

Thanks.

DR. CHERNEW: I think, Brian, you had a quick

comment.

DR. MILLER: Quick thought. One, I'm a little concerned that we're putting all these really important post-acute care markets, just sort of sandwiching them together into one short time period since for beneficiaries, yes, the hospital matters. Yes, ambulatory care matters, but post-acute care matters even more because post-acute care is what actually is getting you back towards your functional status.

I think that in the names of efficiency and transparency for these sections and all sections, we should post our last five years of recommended updates, whether Congress has implemented any of our updates, and then sort of we can use that as a Commission for thoughts about ways that we should change our strategy or just think differently about markets. And I think that DOGE should be taking a look at our work.

DR. CHERNEW: And I think you had one other comment to read.

MS. KELLEY: Yes. Robert has a comment regarding the ownership category. The lower median rate of successful discharge to the community by for-profit home

health agencies compared to nonprofits is concerning, Robert thinks. He believes we'll need to continue to stratify various measures by ownership category and track and trend their progress over time and thanks the staff for an excellent report.

DR. CHERNEW: Okay. So I think we're ready now for the roll call.

MS. KELLEY: All right. Voting on the recommendation as follows. For calendar year 2026, the Congress should reduce the 2025 Medicare-based payment rate for home health agencies by 7 percent.

Voting yes or no. Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. CASALE: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: I will look to Robert for a thumbs-up or -down. Thumbs-up from Robert.

Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Josh?

DR. LIAO: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Greg?

MR. POULSEN: Yes.

MS. KELLEY: Betty, thumbs-up or -down? Thumbs-up from Betty.

Wayne? Thumbs-up from Wayne.

Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Thank you.

DR. CHERNEW: And with that, I think we're going on to IRFs, and I think that's Laurie.

DR. FEINBERG: We will continue with the update to Medicare's payment for inpatient rehabilitation facilities, which I will refer to by their abbreviation "IRFs."

We will review the indicators for IRFs using the same framework as you've seen in the other sectors. The Commissioners expressed a consensus supporting the draft recommendation presented in December. This presentation summarizes information that was presented in more detail at our December meeting, and there is more information in the information in your mailing materials.

Those materials were updated to reflect Commissioners' discussion of questions at the December meeting. For example, we added a section describing factors that contribute to the lower margins in hospital-based IRFs.

The slide provides an overview of the IRF sector in 2023. There were 1,206 IRFs and about 404,000 stays. Medicare and its beneficiaries spent $9.6 billion on IRF

care provided to fee-for-service Medicare beneficiaries. Fee-for-service Medicare accounted for 51 percent of IRFs discharges.

In summary, our four categories of payment adequacy indicators for IRFs are positive. First, fee-for-service Medicare beneficiaries' access to care is positive. IRFs continue to have capacity that appears to be adequate to meet demand.

Second, the rate of successful discharge to community and the rate of potentially preventable readmissions by facility remained stable during the period fiscal years 2022 and 2023.

Third, about two-thirds of IRFs are hospital-based units that access capital through their parent institutions. For freestanding IRFs, the all-payer margin was 10 percent in 2023. Freestanding IRFs maintain good access to capital markets.

And fourth, Medicare payments and IRFs' costs indicators were positive. In 2023, the aggregate Medicare margin was 14.8 percent. We project a margin of 16 percent for 2025.

And so that brings us to the draft

recommendation. The draft recommendation reads: "For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rate for inpatient rehabilitation facilities by 7 percent."

To review the implications, on spending relative to current law, spending would decrease by between $750 million to $2 billion in one year and by between $10 billion and $25 billion over five years. Current law would give an update of 2.6 percent.

The impact on beneficiaries and providers, we don't expect any adverse effect on access to care or continued provider willingness and ability to treat fee-for-service beneficiaries, though financial pressure on some providers may increase.

I'm happy to answer any questions, and now I turn it back to Mike.

DR. CHERNEW: Laurie, thank you.

Brian, I think you want to say something.

DR. MILLER: A quick comment for all markets, including this one. I think that we should quantify the costs of regulatory compliance, whether it's Medicare conditions of participation, SNF requirements for

participation, or quality regulation. Doing this drives a lot of activities and a lot of expense for market participants. It's important that we see the cost of regulation.

Many of my colleagues may suggest that this is challenging or not able to be done. I'd point out that researchers, including Accounting Professor Ge Bai at the Johns Hopkins Hospital, for example, published the cost of quality regulation compliance with Medicare, both in terms of dollars and human labor hours. So I think that we should do this for each service market.

DR. CHERNEW: And, Dana, I think we're now going to do the roll call. Is that right?

MS. KELLEY: Yes.

All right. Voting on the recommendation as follows: "For fiscal year 2026, the Congress should reduce the 2025 Medicare-based payment rate for inpatient rehabilitation facilities by 7 percent."

Voting yes or no. Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. CASALE: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert, I will look for a thumbs-up or -down. Thumbs-up from Robert.

Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Josh?

DR. LIAO: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Greg?

MR. POULSEN: Yes.

MS. KELLEY: Betty, thumbs-up or -down? Thumbs-up from Betty.

Wayne? Thumbs-up from Wayne.

Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Thank you.

DR. CHERNEW: And with that, I think we are now going to be going on to dialysis, and I think we have a whole new line change.

And I think with dialysis, when you're ready, Grace, it's going to be you.

DR. OH: Thanks, Mike.

Next, we will turn to outpatient dialysis facilities.

More detailed information on our indicators is in your mailing materials.

Since the December meeting, we have made minor editorial changes and added text to clarify certain items as indicated in the memo that we sent you.

In 2023, there were roughly 262,000 fee-for-

service beneficiaries on dialysis receiving on average 2.8 dialysis treatments per week at around 7,700 facilities.

Total fee-for-service payments for dialysis services was about $8.1 billion.

The indicators assessing payment adequacy are generally positive, and you have seen all of this material in December.

Between 2022 and 2023, capacity as measured by in-center stations held steady while the number of Medicare beneficiaries on dialysis declined.

The 17 percent fee-for-service Medicare marginal profit suggests that providers have a financial incentive to continue to serve Medicare beneficiaries.

As for quality in 2023, ED visits, admissions, readmissions, and mortality remain steady for fee-for-service beneficiaries on dialysis, as did patient experience with in-center hemodialysis.

Additionally, the share of fee-for-service beneficiaries using home dialysis continued to increase.

Regarding access to capital, indicators suggest it is positive. The two large dialysis organizations have reported positive financial performance related to their

dialysis business for 2024, including improvements in productivity and earnings growth. The 2023 all-payer margin was 15 percent.

In 2023, the aggregate Medicare margin is negative 0.2 percent. The 2025 projected aggregate Medicare margin is zero percent. Historically, the fee-for-service Medicare margin has varied over time, including some periods in which it was negative or near zero and other periods when it was substantially positive, but beneficiaries' access to care remained positive throughout.

The 2025 projection does not include the TDAPA for certain ESRD drugs, which in the past has improved Medicare margins.

Based on our findings that suggest that outpatient dialysis payments are adequate, the draft recommendation reads: "For calendar year 2026, the Congress should update the 2025 Medicare-based payment rate for outpatient dialysis services by the amount determined under current law."

Based on current estimates, this would increase the base payment by 1.7 percent.

This draft recommendation will have no effect on

spending relative to current law. We expect beneficiaries to continue to have good access to outpatient dialysis care and for providers to continue to be willing and able to care for Medicare beneficiaries.

I'm happy to answer any questions and will now turn it back to Mike.

DR. CHERNEW: Okay. And, Brian, I think you have a comment.

DR. MILLER: I'd note that the 21st Century Cures Act is a natural experiment in favorable selection for Medicare Advantage, which showed that market penetration for ESRD has increased from 25 to 52.4 percent of the beneficiaries in the ESRD marketplace, which is around 1.67 percent difference from the general MA penetration, suggesting that favorable selection is low and that our Medicare Advantage model fails the test of internal validity. I'd note that ESRD patients have high morbidity and incur high expense.

I'd also note that I'm concerned about this recommendation because we suggest a net negative profit margin of 0.2 percent. I know that there's a bell curve in markets. Even though I know that this is a highly

concentrated market, I worry that our update is potentially inadequate.

DR. CHERNEW: Kenny.

MR. KAN: I will be abstaining from the vote because I'm struggling to reconcile applying the analytic rubric, which pivots off a negative margin in '23, but I'm also concerned about the market power of the duopoly in dialysis.

DR. CHERNEW: Okay. I think we're now ready for our vote.

MS. KELLEY: All right. Voting on the recommendation, which reads, "For calendar year 2026, the Congress should update the 2025 Medicare-based payment rate for outpatient dialysis services by the amount determined under current law."

Starting with Amol, yes or no?

DR. NAVATHE: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. CASALE: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

And just a quick comments. In the presentations going forward, it would be great if the update in current law could be stated what that is. Not everybody will know what that is.

MS. KELLEY: Okay. Thank you.

And, Robert, I'll look to you for a thumbs-up or -down. Thumbs-up from Robert. Thank you.

Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Kenny?

MR. KAN: Abstain.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Josh?

DR. LIAO: Yes.

MS. KELLEY: Brian?

DR. MILLER: Abstain.

MS. KELLEY: Greg?

MR. POULSEN: Yes.

MS. KELLEY: Betty, I'll look for a thumbs-up or -down? Thumbs-up from Betty.

Wayne? Thumbs-up from Wayne.

Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Thank you.

DR. CHERNEW: And with that, I think we're now going to go to hospice, and I think that's going to be Kim.

MS. NEUMAN: Good morning.

We're now going to review the indicators of payment adequacy for hospice.

There's more detail in your papers, which has been updated to reflect Commissioners' discussion and questions at the December meeting.

For instance, we included additional information on the Commission's 2014 recommendation to include hospice in the Medicare Advantage benefits package. We also included more discussion of CMMI's evaluation of the

hospice VBID model and Medicare Care Choices model, and we added information on hospice nurse visits by type of nurse; that is, registered nurse versus licensed practical nurse.

So here's a snapshot of hospice in 2023. There were over 6,500 hospice providers. These providers furnished care to over 1.7 million Medicare beneficiaries, including more than half of decedents. This involved 138 million days of hospice care, and beneficiaries on average received 3.9 visits per week from hospice staff. Total Medicare payments in 2023 equaled $25.7 billion.

So here, we have a summary of hospice payment adequacy indicators, which are positive. The number of hospice providers grew more than 10 percent in 2023. The share of decedents using hospice, the number of hospice users, and total days of care increased. Average length of stay increased, and median length of stay was stable. In-person visits per week were also stable. Marginal profit was 14 percent.

In terms of quality, the most recent CAHPS data were stable. Visits at the end of life were stable or increased slightly in 2023, although nurse visit frequency remained below the 2019 level.

Access to capital appears positive.

The 2022 aggregate Medicare margin was 9.8 percent, and the 2025 projected margin is 8 percent.

So this brings us to the draft recommendation, and it reads: "For fiscal year 2026, the Congress should eliminate the update to the 2025 Medicare base payment rates for hospice."

In terms of implications, the recommendation would decrease spending relative to current law by $250 million to $750 million over one year, and by $1 billion to $5 billion over five years.

In terms of beneficiaries and providers, we expect that beneficiaries would continue to have good access to hospice care and that providers would continue to be willing and able to provide appropriate care to Medicare beneficiaries.

So that concludes the presentation. I'd be glad to answer any questions, and I turn it back to Mike.

DR. CHERNEW: Great. I think if I'm following this right, Scott has a brief comment.

DR. SARRAN: Yeah, very brief comment.

I will support the recommendation, but I want it

on record that we do have a body of ongoing work around the quality component of hospice, particularly around ensuring that there is consistent, true excellence in symptom management and support of families during the very last portion of life.

MS. KELLEY: And, Cheryl, I think you had a brief comment?

DR. DAMBERG: Yeah. Thank you.

I also support the recommendation, and while I noted that the payment indicators are positive, there were also some other indicators that were concerning.

And to build on Scott's, you know, the 10 percent of caregivers who gave the bottom rating for pain management symptoms seems concerning.

And also the text in the report, I appreciated this about the need for oversight related to some of these outlier states and hospices with very long stays. I think we need to keep an eye on that.

DR. CHERNEW: Stacie?

DR. DUSETZINA: I also am supportive of these recommendations but agree with what Scott and Cheryl have emphasized here around the importance of quality measures

here. It's a time in your life where the quality of care is absolutely essential.

And one other thing, just thinking forward, there are some areas where there are needs for some somewhat higher cost services that are palliative in nature, not intended for curative that I don't think the current hospice budget necessarily supports. So I think that's an area that's going to be important in the future for thinking about people accessing hospice at the right time but also being able to get access to those services.

DR. CHERNEW: Okay. I think we're now ready for the roll call.

MS. KELLEY: All right, then. Voting on the recommendation, which reads: "For fiscal year 2026, the Congress should eliminate the update to the 2025 Medicare base payment rates for hospice."

Voting yes or no. Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. CASALE: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: Robert, I will look for a thumbs-up or -down. Thumbs-up from Robert.

Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Kenny?

MR. KAN: Yes.

MS. KELLEY: Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Josh?

DR. LIAO: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Greg?

MR. POULSEN: Yes.

MS. KELLEY: Betty, I'll look for a thumbs-up or -down? Thumbs-up from Betty.

Wayne? Thumbs-up from Wayne.

Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Yes.

MS. KELLEY: Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Thank you.

DR. CHERNEW: And so I just want to make a brief statement, and then we're going to take our break for lunch and we will be back. I think our first session after lunch is going to be at 1:10 on inpatient psychiatric facilities.

So first, for those of you listening at home, if you want to weigh in, please do so at MedPAC at meetingcomments.com. Let me say that again. It's meetingcomments.com at medpac.gov, or you can reach out to us in any other ways. And as has been pointed out, we have gotten letters and read them from many of you. We do appreciate that. So that's the first point.

The second point is I want to emphasize that the nature of the structure of this meeting is in no way indicative of our assessment of the importance of the sector.

Our general view is that we've had discussions of

these. We have annual discussions of these. And of course, we have discussions at length in December and there's ways you can reach out in a whole variety of ways. So we fully understand that the sectors are important. They are also important to beneficiaries in a range of ways.

But process-wise, we have a lot of material that we need to cover, and so this allows us to get that material covered.

So again, thank you for the comments that you all made, and we are now going to take a break and we will be back again at 1:10 for a discussion of inpatient psychiatric facilities. Again, thank you.

[Whereupon, at 12:01 p.m., the meeting was recessed for lunch, to reconvene at 1:10 p.m. this same day.]

AFTERNOON SESSION

[1:11 p.m.]

DR. CHERNEW: Okay, welcome back, everybody. We are going to start our afternoon session, which is going to focus on a bunch of non-update issues. But we are going to start looking at a topic we have discussed in the past, the coverage limits for freestanding inpatient psychiatric facilities. And I think it's Pamina starting, or is Betty starting? Pamina. Sorry, Pamina.

MS. MEJIA: Thanks, Mike. Good afternoon. In this session, we follow up on last November's presentation on Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities. The audience can download a PDF version of these slides in the Handout section of the control panel on the right-hand side of the screen.

This presentation is organized as follows:

Background -- beneficiaries affected by Medicare's limit on care in freestanding inpatient psychiatric facilities, or IPFs; improving access to IPF care by removing the 190-day limit; illustrative changes in Medicare spending from removing the limit in 2023; the

draft recommendation; and a discussion of continued work needed to improve IPF care.

In response to a congressional request, we previously analyzed the use of behavioral health care by Medicare beneficiaries, including information on Medicare's 190-day coverage limit on stays in freestanding IPFs. These analyses were published in the June 2023 report to the Congress.

During our March 2024 meeting, we presented on the types of care beneficiaries receive when they are near or at the 190-day limit. At that meeting, Commissioners expressed interest in a recommendation to eliminate the 190-day limit.

During the November 2024 meeting, we presented updated information on the effects of the 190-day coverage limit on beneficiaries' access to care and discussed the Chair's draft recommendation to remove this limit as well as a required reduction to IPF users' initial benefit period based on prior freestanding IPF use.

Today, we will review the information on Medicare's IPF coverage limits and vote on the draft recommendation.

The two limits of Medicare's coverage of treatment in psychiatric hospitals under Part A are a 190-day lifetime limit on days in freestanding IPFs -- inpatient psychiatric stays in hospital-based IPFs or general acute care hospitals do not count toward this limit; a reduction of inpatient psychiatric days available during the initial benefit period if the beneficiary is a patient in a Medicare-certified freestanding IPF on the first day of Medicare entitlement.

The number of IPF days available during the initial benefit period are reduced by the number of freestanding IPF days used in the prior 150 days. This reduction applies only to a small number of beneficiaries as only their first benefit periods are affected, and we do not analyze the effects of this limit during this presentation.

These provisions were established in 1965, with the implementation of Medicare, when the majority of inpatient psychiatric care took place in state and locally run freestanding facilities. The limitations were intended to restrict Medicare's coverage to the "active phase" of psychiatric treatment and to prevent states from shifting

financial responsibility for long-term custodial care to the federal government.

In 2023, about 40 percent of Medicare-covered IPFs days were in freestanding IPFs. This is shown in the bars on the left side of this slide that display the share of Medicare-covered IPF days by type of freestanding IPFs. The remaining 60 percent of Medicare-covered days took place in hospital-based IPFs and are not shown in the graph.

In 2023, only about 4 percent of Medicare-covered IPF days were in freestanding government-run IPFs, down from 8 percent in 2011. This is shown in the orange portions of the bars.

Over the same time period, the share of Medicare-covered days in freestanding for-profit IPFs, shown in the dark blue part of the stacked bars, rose from 23 percent to 29 percent.

A small but highly vulnerable group of beneficiaries is affected by Medicare's limits on coverage of days in freestanding IPFs. About 50,000 Medicare beneficiaries were at or within 15 days of the 190-day limit as of the end of 2023. The figure on the left shows

that Medicare beneficiaries at or near the limit were substantially more vulnerable compared to other Medicare beneficiaries who did not use any freestanding IPF days since their enrollment in Medicare.

The dark blue bars show that, among Medicare beneficiaries who were at or near the limit, 75 percent were disabled, 84 percent had low incomes, 37 percent were non-white, and 33 percent had a dual diagnosis, meaning they had diagnoses for schizophrenia or depressive disorders and substance use disorders in the prior year.

The dual diagnosis shares were based on fee-for-service Medicare beneficiaries only, while the shares for the other risk factors included fee-for-service and Medicare Advantage enrollees.

As shown on the graph in the gray bars, the shares were much lower among other Medicare beneficiaries who did not have any days in freestanding IPFs. The shares were also lower for beneficiaries who did have days in a freestanding IPFs but were not as close to meeting the limit. This is shown in your meeting materials.

Many beneficiaries at or near the limit may lack alternative coverage for services beyond the 190-day limit

in freestanding IPFs. As shown on the left side of this bar, among Medicare beneficiaries at or near the 190-day limit, 20 percent were enrolled in a Medicare Advantage plan with supplemental IPF benefits or were dually eligible beneficiaries aged 65 and older and would likely have Medicaid coverage of additional freestanding IPF days.

The middle gray section of this bar shows that 50 percent of these Medicare beneficiaries were dually eligible and younger than 65, and therefore subject to an Institutions for mental Diseases, or IMD, exclusion from Medicaid coverage of freestanding IPF days that is further described in your reading materials.

The 30 percent teal "all others" category is composed of non-dually eligible Medicare beneficiaries who were not enrolled in a Medicare Advantage plan with IPF supplemental benefits. Together, these 80 percent of Medicare beneficiaries at or near the limit may lack coverage for additional freestanding IPF days.

I will now turn the presentation over to Betty.

DR. FOUT: Patients who need long term inpatient psychiatric services may have difficulty accessing IPF care. The number of public IPFs had declined substantially

over time, and private freestanding psychiatric hospitals may be less able to take patients who have reached the 190-day limit and lack coverage.

In interviews conducted with a small set of IPFs last year, most interviewees considered the 190 days to be insufficient coverage, especially for patients with chronic behavioral health conditions. They noted that the limit increased the difficulty of finding suitable post-discharge placement options.

Beneficiaries may obtain inpatient psychiatric care from hospital-based IPFs and general acute care hospitals since they are not subject to the limit. However, hospital-based IPFs have declined in number over time and may not be available as an alternative. Acute care hospitals may not be appropriate for treating severe behavioral health conditions since they generally have shorter lengths of stay and fewer psychiatric visits.

To better understand how the use of inpatient psychiatric services is affected by the 190-day limit, we used 2023 data to compare service utilization by beneficiaries at or within 15 days of reaching the limit to a comparison group of similar beneficiaries who had 16 to

90 days remaining and therefore would be less or not affected by the limit.

To enhance comparability, we examined only fee-for-service beneficiaries who also had at least one freestanding IPF stay in the prior five years. We found the two groups to be relatively similar on shares of beneficiaries who were disabled, had low incomes, or were non-white.

Overall, we found that beneficiaries at or near the limit had, on average, 2.2 fewer inpatient psychiatric covered days than those further from the limit. This can be broken down into 5.2 fewer covered days in freestanding IPFs, 2.2 more covered days in hospital-based IPFs, and 0.8 more covered days in general acute care hospitals for behavioral health conditions.

These findings suggest that Medicare beneficiaries who were affected by the 190-day limit substituted some freestanding IPF care for psychiatric services in hospital-based IPFs and general acute care hospitals. And if the 190-day were removed, their overall use of inpatient psychiatric services would increase.

We illustratively show how the estimated increase

in inpatient psychiatric covered days if the 190-day limit were removed would change Medicare fee-for-service spending on these services in 2023. The estimated changes in covered days from the prior slide are copied to the first column of this table.

We computed the average per diem Medicare payment for beneficiaries for each type of inpatient psychiatric care, as shown in the second column.

We multiplied the two columns to obtain the average change in fee-for-service Medicare payment per beneficiary for each setting. By totaling the resulting amounts in the third column, we calculated that Medicare would spend an additional $1,260 per beneficiary at or near the 190-day limit if they were to change their psychiatric hospital use to be like those beneficiaries in the comparison group.

Multiplying this illustrative $1,260 per beneficiary by the total number of fee-for-service Medicare beneficiaries at or near the limit yields approximately $40 million in increased spending on inpatient psychiatric services from eliminating the 190-day limit.

Federal spending may change due to other

considerations, and this is further discussed in your reading materials.

We now turn to the draft recommendation, which is the same as what you saw in November.

The draft recommendation reads:

The Congress should eliminate both the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities, and the reduction of the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding inpatient psychiatric facility on and in the 150 days prior to their date of Medicare entitlement.

The implications of the draft recommendation is an increase in spending relative to current law by less than $50 million in one year and by less than $1 billion over five years.

We expect this recommendation would improve Medicare beneficiaries' access to inpatient psychiatric care at freestanding IPFs by increasing freestanding IPFs' willingness to treat beneficiaries with chronic and severe behavioral health conditions.

Eliminating the 190-day limit would improve access to IPFs for some of the most vulnerable Medicare beneficiaries. However, it is important to continue work to ensure that Medicare beneficiaries are receiving high-quality inpatient psychiatric care. This is especially important in light of recent investigations by the Department of Justice on care provided by some of the facilities owned by two large IPF chains.

IPFs serve vulnerable patients with complex needs, and greater transparency is needed to understand the services they provide and how the services should vary based on beneficiary characteristics, and the quality of the care provided. We have noted in the past that there is little information on the mix and types of staff employed by IPFs and how staff spend their time across tasks.

Transitions from the hospital to community is particularly challenging and important for IPF patients. Our prior analyses using 2018 data showed high rates of emergency department visits and hospital admissions in the 30 days following IPF discharge. IPF interviewees have noted the difficulty in obtaining psychiatrist visits following discharge from the IPF.

CMS is currently working on improvements to the IPF prospective payment system and quality reporting program. These include greater enforcement in the reporting of ancillary services, which we have previously found to be poorly reported by certain IPFs. This information is needed to calculate the costs of providing IPF care and understand the types of services beneficiaries receive.

IPFs will also need to collect patient experience survey data from IPF patients upon discharge. Items from this survey will be used to construct quality measures.

CMS is developing a claims-based measure, risk-adjusted emergency department use in the 30 days after IPF discharge, that will help assess care transitions from the IPF. IPFs will also begin to collect standardized patient assessment data upon admission. This would include information on resources and interventions needed and patient characteristics, which can be used to improve the payment system and in measuring quality of care.

We will continue to monitor use, spending and quality of care in IPFs, and we're happy to take any questions you have.

I now turn it back to Mike.

DR. CHERNEW: Thank you both. This is actually a really important topic, and I feel that our past discussions, which were extensive, there was a lot of agreement. So I am looking forward to the general sense.

So we are going to run this normally, although if I got this right there is no Round 1 questions. Is that right, Dana? So we are now going to jump to Round 2, and the first person in Round 2 is Stacie.

DR. DUSETZINA: Thank you. Excellent work on this chapter, and this will be short, but I can't imagine a more important thing for us to support. It is very clear that the people who are hitting this limit are people who are highly vulnerable and don't really have that many options. So I'm very enthusiastic about this, and I'm very supportive of the recommendations, but wanted to reemphasize what great work this is.

MS. KELLEY: Gina, you do have a question?

MS. UPCHURCH: Sorry. Yeah, a Round 1 question for you. On page 3 -- and first of all, thank you for this great work, and a really clear chapter. I certainly support both recommendations -- there is a sentence that

says, "Although Medicaid and Medicare Advantage plans with supplemental IPF benefits could serve as alternative sources of coverage for beneficiaries affected by the 190-day limit, Medicaid funding restrictions and low MA enrollment by these beneficiaries in these plans limit their use."

Can you talk a little bit about why we think there is such enrollment in the Medicare Advantage plans for people who need these?

DR. FOUT: We just know by looking at the numbers that the numbers of beneficiaries who are at or near the limit who are enrolled on these plans is very few. It was less than, I want to say less than even 5 percent of the beneficiaries who are at or near the limit and who were MA enrollees.

MS. UPCHURCH: So we don't know why.

DR. FOUT: Right.

MS. UPCHURCH: Thank you.

DR. CHERNEW: I think we are now back to Round 2.

MS. KELLEY: Yes, Scott.

DR. CHERNEW: Yes, Scott.

DR. SARRAN: Yeah. Thanks again for the

excellent work, and I strongly support the recommendations. If there is something that we've done that feels like a no-brainer, this is it.

I'm glad, in the work you've done, that you've highlighted the quality issues that this very vulnerable population experiences in a significant percent of the cases, including the post-discharge fragmentation of care. And it is not, of course, surprising, and in many ways this population has some common characteristics with beneficiaries living in a long-term care facility, in terms of the discongruence between the round peg-square hole kind of dynamic between, on one hand, the ideal system or systems of care and financing, which would be patient-centric, and the fragmented payer systems, particularly Medicaid and Medicare, that become benefit-centric and/or provider-centric.

And these very vulnerable populations who, of course, lack any reasonable ability to navigate a Byzantine system, they are not going to do well, and we owe them better. I think we, MedPAC, we, taxpayers, we all owe these populations better.

There are also populations, in common with the

long-term care living beneficiaries, populations -- and I say populations because there is some heterogeneity, clinically and demographically -- but there are populations that are left behind by large community-based Medicare Advantage plans, and largely left behind even by dual SNF plans. And Gina's question a moment ago about do we have a sense of why they're so underrepresented, if you will, in MA, is not surprising when you think about the active role a beneficiary needs to play in signing up for MA.

So other than being caught up, appropriately, in a dual demonstrate project where they are auto-enrolled, they are not likely to be able to actively participate in the enrollment process.

So where I'm going with this is, I am going to strongly urge us, subsequently -- and Mike, you mentioned we will be taking up at the April meeting some agenda setting -- to discuss how we can help lay out potential solutions that would better serve this population, or these populations. Thanks.

MS. KELLEY: Tamara.

DR. KONETZKA: I strongly support everything that Scott just said and really appreciate drawing the parallels

to other vulnerable, long-term care populations.

I just wanted to add one small point, which is, well, I'll repeat that I feel like it's a no-brainer to change this policy. It was based on sort of historical reasoning that doesn't really apply anymore. And I guess what I'll add to that is even if the intent originally was to sort of avoid Medicare taking on this sort of long-term part of this and to focus on the acute part, it's a really badly designed blunt tool to limit that, right. Because these are the people who exceed that 190 days, you know, it's not necessarily that they are in there for one long stay and in there for years, right. It's sort of repeat hospitalizations.

So even if you feel like there's some merit in the original motivation, I think it should be dipped because it's just really a bad tool to even get at that. Thanks.

MS. KELLEY: Lynn.

MS. BARR: Thank you so much for doing this work and bringing this important topic to light. I think we all really feel the pain of these beneficiaries and want to do something about it. I strongly support the recommendation

and I appreciate your work.

I had only one question. I guess it's semi-Round 1, which was you said in the slides that it's less than $50 million in the first year but then less than $1 billion in five years, and that seemed like a really big inflationary point. And I know that people are going to jump the billion dollars, and I'm like, hey, it's $50 million.

So I was wondering, that seemed like a high estimate.

MR. MASI: Betty basically pointed to me, so I'll start, but please jump in.

That's a great question, Lynn. So we, in developing these estimates of federal budgetary effect, we work closely with the Congressional Budget Office and get their feedback. And these are the two lowest buckets that they give us, for the one-year period and for the five-year period. We can work to see if we can get greater granularity in the future, but I think you point to an important thing, that there is a lot of distance below that $1 billion, and I think the one-year may be more instructive in thinking about longer term.

MS. BARR: Thank you. It's just a little hard to

see how we get to $1 billion on 50,000 beneficiaries.

DR. CHERNEW: I just want to emphasize for people at home, the framing is less than $1 billion. There is a lot --

MS. BARR: But people will read --

DR. CHERNEW: Yes, I understand. There is a lot less than $1 billion. And so I think to hear that, the reason is because our buckets don't give us a bucket that is in between less than $50 million and less than $1 billion. So it's just Bucket 2.

There are a bunch of buckets, and the buckets have thresholds. This is Bucket 2. The Bucket 2 is designed as a billion-dollar cap, but it's not like we picked a billion and said less than. It's because it's a bucket.

MS. BARR: Got it. You've got a $50 million bucket, and the next bucket is $1 billion.

DR. CHERNEW: Is less than a billion.

MS. BARR: Got it.

DR. CHERNEW: We are above the $50 million bucket but we are below the billion bucket. So we are just in Bucket 2.

MS. BARR: Got it.

DR. CASALINO: I assumed that that was the case, but maybe [inaudible].

[Laughter.]

DR. CASALINO: It's on. It's just that Mike was talking too. He was talking first, I have to admit.

DR. CHERNEW: If that were the case, a lot of people said, "Go on, Larry."

DR. CASALINO: But no, I was at fault. You know, I assumed that that's what it was when I saw that, but it might be nice -- and this isn't the only time this kind of thing comes up, although it's maybe the most glaring -- but maybe there could just be an asterisk, the explanation you just gave as a little footnote, Paul, so that people won't do exactly what Lynn was worried that they would do. Oh, a billion dollars.

DR. CHERNEW: Very reasonable. Brian.

DR. MILLER: Quick on-point response. Obviously, I'm super supportive of this recommendation as the right and humane thing to do.

We mentioned CBO helped us with math, which actually makes me a little less confident, given that CBO

mispriced CMMI effects, Part D, ACA Exchange enrollment, and a long list of other things. So I am actually more concerned about the estimate after hearing that. But I am supportive of the policy.

MR. MASI: Thanks for that feedback, and I appreciate that. And I just want to clarify that our authorizing statute instructs us to work with the appropriate budget offices in terms of getting feedback. So I just want to make clear that, you know, we have developed this process over time, specifically based on our statutory requirement.

DR. CHERNEW: I have one more comment in the queue, which is Betty, I think.

MS. KELLEY: I have Robert, as well.

DR. CHERNEW: Oh, okay.

MS. KELLEY: Yes. So I have two remaining comments, first from Betty. She strongly supports the recommendation and believes it's a great example of the need to modernize Medicare. The need for stringent quality measures, including staff and staffing mix, as well as other standard quality measures like 30-day post-discharge ED use, are essential.

And Robert says that he's quite enthusiastic about the recommendation and sincerely hopes that Congress will be able to eliminate the 190-day limit rather quickly. And he thanks everyone, staff and Commissioners alike, in getting us to this place.

DR. CHERNEW: All right then. Per our norm on recommendations, we are going to do a roll call vote, I think, Dana. So we are ready, I think.

MS. KELLEY: Okay. Voting on the recommendation, which reads:

The Congress should eliminate both the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities, and the reduction of the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding inpatient psychiatric facility on and in the 150 days prior to their date of Medicare entitlement.

Voting yes or no. Amol?

DR. NAVATHE: Yes.

MS. KELLEY: Lynn?

MS. BARR: Yes.

MS. KELLEY: Paul?

DR. CASALE: Yes.

MS. KELLEY: Larry?

DR. CASALINO: Yes.

MS. KELLEY: I'll look for Robert. Thumbs up or down? Thumbs up from Robert. Cheryl?

DR. DAMBERG: Yes.

MS. KELLEY: Stacie?

DR. DUSETZINA: Yes.

MS. KELLEY: Kenny has stepped out, so we'll get his vote when he returns. Tamara?

DR. KONETZKA: Yes.

MS. KELLEY: Josh?

DR. LIAO: Yes.

MS. KELLEY: Brian?

DR. MILLER: Yes.

MS. KELLEY: Greg?

MR. POULSEN: Yes.

MS. KELLEY: Betty, I will look for a thumbs up or down. Thumbs up from Betty. And Wayne? There he is. Thank you very much, Wayne. Scott?

DR. SARRAN: Yes.

MS. KELLEY: Gina?

MS. UPCHURCH: Enthusiastic yes.

MS. KELLEY: And Mike?

DR. CHERNEW: Yes.

MS. KELLEY: Thank you.

DR. CHERNEW: All right. So let's take about a 10-minute break-ish and come back at about 10 to 2, roughly speaking. And we will pick up with the Part D status chapter, which is a mammoth body of work. So, in any case, a 10-minute break, and then we'll be back. Thanks, everybody, and Pamina and Betty.

[Recess.]

DR. CHERNEW: Okay. Welcome back, everybody.

We have now, I think, a long-awaited complex chapter. I hope those at home are ready to see all the amazing work that has been done, but I think we're going to turn it over to Tara and start talking about Part D.

Tara.

MS. O'NEILL HAYES: Thank you, Mike. Good afternoon, everyone.

Shinobu and I are here to present the annual status report on Part D, Medicare's outpatient drug

benefit. This material will be a chapter in the Commission's upcoming March report.

As a reminder to the audience, a PDF of these slides is available at the right-hand side of your screen.

Today we will start by providing some background information and a current snapshot of the Part D program, followed by an overview of many recent changes as a result of the Budget Reconciliation Act of 2022, commonly referred to as the Inflation Reduction Act. We will review the redesigned benefit structure for 2025 and resulting plan bids and premiums. Next, we will discuss prices of Part D drugs. Lastly, we will quickly discuss concerns regarding the stability of the PDP market, which we first touched on in November and will discuss again later this spring.

The Part D program provides Medicare beneficiaries with access to prescription drug coverage by using private plans that compete to deliver pharmacy benefits. These plans may be standalone prescription drug plans, referred to as PDPs, available to beneficiaries using fee-for-service Medicare or a part of a Medicare Advantage plan, known as an MA-PD, which offers both medical and prescription drug coverage.

There are two types of MA-PDs, conventional plans open to all MA enrollees and special needs plans referred to as SNPs, which are available only to individuals dually eligible for Medicare and Medicaid, those living in an institution, or those with specific severe or disabling chronic conditions.

Plan sponsors and their pharmacy benefit managers, or PBMs, take part in a couple sets of negotiations. One is with pharmacies to set up networks and agree on payment rates for prescriptions and pharmacy fees. The other negotiation is with manufacturers of brand-name drugs over formulary placement and post-sale rebates.

Enrollees pay premiums based on plans' bids, reflecting their expected costs for providing coverage. Those costs are somewhat dependent on plans' abilities to negotiate lower prices with the aforementioned entities.

There are a few key features of the program that are intended to encourage both enrollee and plan participation. To encourage beneficiary enrollment, Medicare subsidizes premiums for basic benefits for all enrollees, plus provides additional subsidies for low-

income enrollees, referred to as LIS. There is also a financial penalty for late enrollment.

As for plans, while the program is intended to have plan sponsors bear financial risk for enrollee spending so that they have incentives to manage benefits, Medicare does share in that risk by providing reinsurance and risk corridors to limit plan losses and profits.

Payments to plans are also risk-adjusted to account for variation in spending due to health status. By limiting plan risk, Medicare helps keep premiums low, which is the key factor on which most plans compete for enrollees.

So how has that competition shaken out? In 2024, Part D enrollment surpassed 54 million and again increased as a share of all Medicare beneficiaries, reaching 80 percent last year. But just as we see more enrollees in the broader Medicare program choose MA over fee-for-service, that means more Part D enrollees are in MA-PDs than stand-alone PDPs.

PDP enrollment was down to 43 percent in 2024, falling 8 percent since 2020. Sixty-eight percent of all fee-for-service beneficiaries and one-third of all LIS

beneficiaries were enrolled in a PDP in 2024.

Enrollment in conventional MA-PDs reached 24.7 million, growing 34 percent since 2020, primarily among non-LIS beneficiaries. Seventy-three percent of MA enrollees were enrolled in conventional MA-PDs in 2024.

SNP enrollment, though still low relatively speaking at 6.3 million, grew 80 percent since 2020, with most of that growth being among LIS enrollees, 42 percent of whom are now in a SNP plan.

Across the two types of MA plans, 92 percent of all MA enrollees are in a plan with Part D coverage. Average enrollee premiums increased slightly in 2024, capped by the IRA's 6 percent limit on annual increases to the base beneficiary premium, which we will discuss later. Across all plan types weighted by enrollment, the average premium in 2024 was nearly $27.

Plan offerings in 2025 continue to reflect the shifts we are seeing in enrollment. PDP offerings fell again this year by more than a third, substantially reducing the number of plans available to fee-for-service beneficiaries.

There are four regions this year with just one

benchmark PDP for LIS enrollees. The number of conventional MA plans decreased by 7 percent. These plans are almost exclusively enhanced plans with supplemental coverage and generally enroll non-LIS beneficiaries.

The number of SNPs available increased 8 percent. Most of these plans are D-SNPs for dual-eligible beneficiaries. Because 90 percent of SNP enrollees receive the LIS and LIS enrollees face very little cost if enrolled in a basic plan, most SNP plans provide basic coverage with no supplemental benefits.

Medicare's program costs increased 11 percent from 2022 to 2023, totaling more than $112 billion. Most of the spending was from cost-based reinsurance payments as 4.8 million beneficiaries reached the catastrophic phase. Beneficiaries paid more than $16 billion in premiums in 2023 and nearly $19 billion in out-of-pocket expenses.

Overall, program satisfaction remains high according to surveys, focus groups, and CAHPS measures, despite a continued decline in star ratings. MA-PDs received an overall CAHPS rating of 88 versus 82 for PDPs, and respondents rated their ability to get needed prescription drugs at 90 for MA-PDs and 88 for PDPs.

In Part D, we are concerned with beneficiaries' access to both plans and pharmacies. While we noted the significant drop in the overall number of PDPs, it is important to consider plan availability at the beneficiary level.

In 2025, beneficiaries in every region have access to at least 12 PDPs and roughly 30 MA-PDs, and as mentioned, every region has at least one benchmark PDP, and most enrollees have access to MA-PDs with no premium.

We have also heard concerns regarding pharmacy closures, which could impede access to medications and other important services.

While focus groups and external surveys do not suggest widespread issues, we have seen studies finding certain neighborhoods, particularly those whose residents tend to be non-white, may be more likely to experience pharmacy closures. Pharmacies have been and continue to face myriad challenges, including low reimbursements from PBMs, the pharmacy DIR rule change that went into effect last year, and not specific to Part D, competition from online retailers, particularly those with their own pharmacies and quick delivery. We will continue to monitor

pharmacy access for adverse effects on beneficiaries.

2025 is a year of substantial change in the Part D program, and these changes seek to address longstanding concerns.

Roughly a decade ago, the Commission began discussing concerns with the growing reliance on cost-based payments and diminishing plan liability, which resulted in weakening plan incentives to manage enrollee spending. Further, beneficiaries had no limit on their cost-sharing liabilities, which created affordability issues for high-cost enrollees and led to concerns of medication adherence.

The Commission thus recommended, in 2020, a reform to the benefit design to increase plan liability, reduce incentives for the use of high-price, high-rebate drugs, and provide financial protections to beneficiaries.

In 2022, Congress passed the Inflation Reduction Act, which included a redesign of the benefit structure that reflected some of those recommendations, along with several other drug-related provisions of which the Commission has not made recommendations.

Before focusing specifically on the benefit redesign, we wanted to provide an overview of the many key

Part D-related policies of the IRA, most of which have now been implemented.

Beginning in 2023, Medicare began requiring manufacturers to pay a rebate if the price of their drugs sold through the program rises faster than inflation. In addition, plans must now provide insulin at no more than $35 out-of-pocket per month, and adult-recommended vaccines must be provided at no out-of-pocket.

In 2024, cost-sharing in the catastrophic phase was eliminated, growth in the base national average premium was limited to 6 percent, and the eligibility for the full LIS benefit was expanded to those with incomes between 135 and 150 percent of the federal poverty level.

This year, the new benefit structure took effect, which increases plan liability, reduces Medicare's reinsurance liability, provides beneficiaries a $2,000 out-of-pocket cap, and changes drug manufacturers' liability for costs.

In 2026, prices negotiated by the Secretary of Health and Human Services for ten Part D drugs will take effect, with additional drugs added in future years.

And now turning to the new benefit design. The

redesign provides beneficiaries with a $2,000 annual out-of-pocket cap. It increases insurer liability, particularly in the catastrophic phase, by reducing the program's reinsurance coverage. It eliminated the coverage gap and extended the manufacturer liability into the catastrophic phase.

This new benefit design applies to all beneficiaries, including those with a low-income subsidy, though LIS beneficiaries will see these changes phased in over six years. These changes have numerous implications for program spending, which Shinobu will now discuss.

MS. SUZUKI: In the next few slides, we'll provide preliminary information on initial plan responses to the IRA changes, focusing on 2025 bids and premiums.

As Tara just discussed, the IRA benefit redesign was expected to increase basic benefit costs and decrease the shared benefits paid by Medicare's cost-based reinsurance. We see that plans' expectations about costs are directionally consistent with that redesign. In 2025, total expected benefit costs increased by 42 percent, while average expected reinsurance decreased by 55 percent.

Bids are plans' expectations about how much it

would cost to provide the basic benefits, excluding the reinsurance. For 2025, national average bid increased by nearly 180 percent. That is a big increase, and we will come back to this increase shortly.

For 2025, national -- excuse me. Medicare and enrollees share the expected benefit costs through subsidies and premiums, respectively.

Base beneficiary premium is enrollees' share of the expected benefit costs. Law limits the annual increase in the base beneficiary cost -- base beneficiary premium to no more than 6 percent. So enrollees' share rises by $2 from about $35 to $37.

The remainder is paid by Medicare, whose total subsidy is expected to increase by 53 percent. Under the redesigned benefit, the direct subsidy is expected to be a much bigger portion of Medicare's subsidy, reversing the historical trend towards greater reliance on cost-based reinsurance payments. Average direct subsidy is expected to grow from $30, or about a quarter of Medicare's total subsidy, to $143, or about 80 percent of Medicare's total subsidy.

One thing to keep in mind is that both the 2024

and 2025 amounts shown are average of plans' expectations, which could differ from actual spending.

Multiple factors explain the increase in plan bids and expected benefit costs in 2025. As we discussed, both the increase in the generosity of the basic benefit and the shift in Medicare's payment from cost-based reinsurance to capitated direct subsidy was expected to increase plan bids. With 2025 being the first year with the newly redesigned benefit, plans likely faced greater uncertainty around the increase in utilization and cost in preparing their bids.

There are other policy changes that may have affected plans' expected costs and bids. For example, in 2025, the method for calculating the true out-of-pocket cost changed, which could lower cost-sharing paid out-of-pocket for some individuals to an amount that is substantially below the amount set in law.

Aside from the IRA changes, expected benefit costs also reflect plans' expectations about the underlying price and utilization trends that are affected by changes in the pharmaceutical market, such as approvals of new drugs or new indications for existing products.

Direct subsidy is also affected by the IRA policy that limit annual increase in the base beneficiary premium to no more than 6 percent. When the 6 percent cap is not binding, law sets BBP to equal 25 percent of the total expected benefit costs, including reinsurance, shown in the first column in the table. The remainder, 74.5 percent, is paid by Medicare.

Without the cap, BBP would have been $56. With the cap, shown in the second column, BBP is $37, which amounted to 17 percent of the expected total benefit cost of about $220, which is shown at the bottom.

Direct subsidy, and therefore Medicare's total subsidy, is increased by $19, the amount by which BBP is reduced because of the 6 percent cap. Medicare's total subsidy of $183 with the cap is 12 percent higher than the amount without the cap and results in higher overall Medicare subsidy rate of 83 percent.

Capping the annual increase in BBP does not necessarily limit increases in individual plan premiums, which may increase by more or less than the BBP.

After reviewing plan bids for 2025, CMS was concerned that large increases and variation in PDP

premiums could result in disruptive enrollment shifts that destabilize the market and, in response, implemented a demonstration for PDPs.

The demonstration has three components. First, it lowers total Part D premium by up to $15 for each participating PDP. Second, it requires participating PDPs to limit the increase in their total Part D premiums to no more than $35. Finally, it provides a more generous protection from losses under Part D's risk corridors.

CMS noted that this demonstration could be extended for at least two additional years as plans adjust to the IRA changes. CBO estimated that this demonstration would increase federal spending by about $5 billion in 2025.

With nearly all PDPs participating in the demonstration, average premiums remain stable, but individual plan premiums vary widely.

Part D's cost trends have increasingly been driven by single-source drugs and biologics. Our price index showed that gross prices for single-source drugs have grown more rapidly than other drugs covered under Part D, growing by over 7 percent per year between 2014 and 2023,

and that has contributed to growth in Part D expenditures. In 2023, single-source drugs accounted for 80 percent of total gross Part D spending, up from 70 percent in 2014.

It has also affected Part D enrollees who need expensive medications. In 2023, over half a million enrollees filled a prescription with sufficiently high price to meet the annual out-of-pocket limit with a single prescription, an increase from just $33,000 in 2010.

Several IRA provisions aim to restrain price increases in Medicare. One example is the Medicare Drug Price Negotiation Program, which focuses on prices of single-source brand-name drugs.

For the ten Part D drugs selected for the negotiation program, CMS estimated that negotiated prices achieved discounts ranging from 38 percent to 79 percent relative to wholesale acquisition costs. However, there is uncertainty about the savings that will be achieved in 2026, the first year in which the negotiated prices will apply. Since savings must be considered in the context of prices net of rebates and discounts, the actual savings amounts could differ from those estimated by CMS.

While we continue to monitor the program, as it

evolves in response to the many changes made by the IRA, we want to note that understanding the full impact of the IRA changes will take time. IRA changes are expected to have wide-ranging impacts on Part D stakeholders.

Improved affordability of medicines for enrollees financed by Medicare and enrollees through higher premiums and policies to restrain price growth are likely to affect revenues for pharmaceutical manufacturers and could affect their decisions about future R&D and the number of new drugs brought to the market, as well as launch prices of new drugs.

As we discussed, an early look at the 2025 plan bids and offerings shows a mix of expected and unexpected effects. Analyzing the effects of the IRA will take time, and we expect the initial year of data to provide an incomplete picture of the effects of the IRA, and in some cases, isolating the impact of any given policy will likely be difficult.

As we discussed at the November meeting, there are concerning trends that raise questions about the stability of the PDP market. We are seeing some of these trends continue in 2025.

The number of PDP offerings in each region continued to decline, which has implications for the choice of Part D plans for fee-for-service beneficiaries and for LIS beneficiaries, and it also has implications for the choice of premium-free PDP options.

It would also affect Medicare's ability to auto-enroll LIS beneficiaries into PDPs that are premium-free to them in the least disruptive way possible.

Other concerning trends we discussed in November includes how the basic premiums charged by PDPs tended to exceed those of MA-PDs and how PDPs on average had higher costs but lower average risk scores than MA-PDs.

That brings us to discussion. First, we'll be happy to answer any questions about the material in this presentation. Second, we're interested in your feedback on the presentation and mailing materials. In the spring, we'll present findings from our continued work examining issues affecting the long-term stability of the PDP market.

That concludes our presentation, and we'll now turn it back to Mike.

DR. CHERNEW: Great. Thank you very much. This is such a complicated topic. But I think we're going to

start with Round 1 to get at least some clarification, and if I have this right, Gina is the first person in Round 1.

MS. UPCHURCH: First of all, you heard it from me already, but thank you so much for laying out very complex issues in a really clear manner, and some examples you used were really helpful, so thank you so much to you both for your work.

My Round 1 question has to do with how TrOOP is counted through out-of-pocket. So it's changed, as you mentioned. We know that the drug manufacturers' discount, in the old design, no longer count. So the 10 percent, the 20 percent no longer counts. Okay, understood.

However, it used to be that charities or SPAPs, State Pharmacy Assistance Programs, that kind of thing, did count, and it still does, so that's the same.

The thing that's different are these supplemental or these enhanced plans, and I'm going to give everybody an example, because I see this. We do SHIP counseling. So if I help somebody that takes Eliquis, and it's $580, say, if they have a co-pay, it could be $45. But 25 percent of the standard benefit would be $145. So what counts towards TrOOP in the new redesign is $145, not $45 that the person

is paying. That's just an example of how it works.

So that means somebody that's taking more brand-name meds that are expensive, that have a co-pay, versus co-insurance, the more expensive drugs they take, the less they are going to pay out-of-pocket for the year. And I think there's something very wrong with that.

So I guess my question to you is, for Round 1, who pushed the changes in how we count TrOOP? And is it just when it's a co-pay versus a co-insurance, or does it also include drugs that aren't normally covered by Part D, or is it just that co-pay/co-insurance issue that's changed with TrOOP?

MS. SUZUKI: So this is in law, as you know, and the supplemental benefits do have to count towards true out-of-pocket. The way CMS has done this is to compare the defined standard benefit cost-sharing, which is the 25 percent you just mentioned, to whatever the cost-sharing is on an enhanced plan. So if it's a co-pay of $45, and that's lower than the 25 percent co-insurance, that differential will count on top of the $45 a bene pays.

I don't think it's different when there's a co-insurance as long as that co-insurance is lower than the 25

percent defined standard.

MS. UPCHURCH: That's a good point. I'm just wondering why it changed. Because before this wasn't the case, and one of the exciting things about the redesign was that it was going to be easier to explain. And the Plan Finder does not show you that. So all you know is you tell Ms. John, "Oh, I know you take really expensive medicines, but you're going to only owe $600 this coming year for your medicines, including your premiums, not $2,000." And they're like, "What?" And you can't even explain it to them.

So I'm just curious. If that's going to stay in place, however it got put in there, is there any way that the Plan Finder can reflect that so health insurance literacy can be improved.

MS. SUZUKI: On the Plan Finder, my understanding is that there is a tab that shows the alternative if you did choose -- oh, I'm sorry. Maybe I'm thinking about the wrong thing. But it does show you when you reach the threshold. So it may not show you the details of the calculation, but it does say you have reached the threshold in April if you continue --

MS. UPCHURCH: It does, but when you try to explain it somebody, you cannot. And I know a lot about it, and I really can't explain it. Thanks.

MR. MASI: And to answer your question, Gina, about -- I think you asked who pushed this or how this came to be. And I saw Shinobu looking at me during that part, so I'll jump in. I think we would decline to speculate who, but I think it is fair to point out that this was not part of MedPAC's 2020 recommendation for Part D redesign.

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

MS. BARR: I actually have three Round 1 questions, so thank you for this great work, and Shinobu, I'm blown away by how well you guys understand this and can answer our questions.

So three quick questions. We talked about pharmacy closures, and have you looked at -- I apologize, I did not get this out of the paper, but have you looked at rural? Because that's where I hear, there's a lot of problems with the rural pharmacies, and part of it is 340B. They cannot deal with 340B. But I've heard anecdotally that many, many rural pharmacies, local pharmacies, have

closed, and hospitals are trying to buy them. So do you have any data on that?

MS. O'NEILL HAYES: Well, first I want to say if you have specific data sources that you want to share with us, we would love see those. One of the challenges is not only understanding the closures but also understanding the net effect, because we have seen numerous studies that point out while there are closures, there also are openings. And so it's important, of course, to keep that in mind, what is the actual net effect change. And so that's one thing.

And then I don't know that I have seen specific rural versus urban studies done. I've seen a study that looked at specific cities. They were all urban areas. And then we have also seen studies that looked at like the racial makeup of different neighborhoods. So that's one kind of breakdown that we've seen. But I don't know that I've seen one specifically focused on rural versus urban.

MS. BARR: So most of the rural communities that I worked with, several hundred communities across the 44 states, most of them either had one pharmacy or no pharmacies. I don't remember any of our clients have two,

but I was shocked at how many didn't have a pharmacy at all. And so I think if you looked at it by RUCA or something, that you might see -- and it has definitely been something that I've had accelerating -- this is anecdotal. You've got the data. I can't tell you -- but accelerating amounts of closures. I think my friend over here probably has a comment on that, as well.

MS. O'NEILL HAYES: Yeah, and I will add we have read lots of articles that include anecdotes, that really do touch on the rural issue. But in terms of having like conclusive, broad, actual data to rely on as opposed to just anecdotes would be helpful, of course, for our purposes. But we have anecdotally seen concerns in the rural area.

MS. BARR: Great. I don't even know how these hospitals function without a pharmacy or a pharmacist, but they do, and it's really, really disturbing.

The second question is, there was a PDP sort of update by CMS within the last week or two. Didn't CMS come out with some new rulemaking about PDPs versus MA-PDs, yeah, freestanding PDPs? Or did I just imagine that? Maybe I dreamt it. Like I thought they were --

MS. UPCHURCH: Special enrollment period stuff?

MS. BARR: Yeah. I was just wondering if CMS is making -- because there seems to be some recognition of the problem with freestanding PDPs that CMS seems to be trying to address, but I wasn't really clear on whether or not that was what was happening. And it just came out in the last few weeks.

MS. SUZUKI: And I think we are aware, but we will follow up with you with the details once we have the full information.

MS. BARR: Great. I had a hard time understanding it. I'd love to learn more about that.

And my third question is, as you're looking at costs and everything, I understanding we're covering semaglutide now, have you like thought about the cost of that, and is there room for -- I mean, have some forecasts around that?

MS. SUZUKI: So we have been following issues around GLP-1s and the coverage issues as well as different indications that are added onto the drug. We have been sort of following the issue to understand what implications it has for the plans. One we saw last year, the expansion

of indications, and I think there are a lot in the pipeline for other conditions, as well.

So it is something that we are focused on. I think this is where plans, utilization management or formulary decisions, are going to have a big effect as well as what happens on the legislative side. There is a lot of interest in GLP-1 coverage issues. We will keep following this issue.

MS. BARR: Wonderful. Thank you for this excellent work. I really appreciate it.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Tara and Shinobu, for a very comprehensive set of reading materials.

So I have what may be a very simple question, and I'm probably going to use all the wrong language, but hopefully you'll help sort it out.

My understanding is you showed some of the data around the basic benefit and the costs basically going up for the direct subsidy. So there's kind of a shift from the reinsurance to the direct subsidy. But the overall contribution, in some sense, from the Medicare program is going up, in part, at least in part because the premiums

are capped at 6 percent growth.

So those additional dollars that the Medicare program is contributing, I was just curious, are those coming from general tax revenues, or what is the source of those funds?

MS. SUZUKI: Part D is financed by the SMI Trust Fund general revenues. Oh, it's funded through the SMI Trust Fund, which is funded through the general revenues.

DR. CHERNEW: The SMI Trust Fund.

DR. NAVATHE: Great. Thank you.

MS. KELLEY: All right. I have a question from Robert. He says thank you for the excellent report. It was mentioned that there's a large variation in Part D plan bids related to the Inflation Reduction Act. The national average bid also increased by 180 percent. He is trying to understand if this was specifically referring to the winners of the final bid as opposed to all bids, regardless of whether the bid won or lost.

MS. SUZUKI: So the national average bid reflects all plan bids, and it's enrollment weighted. That's what determines the national bid, which is used to determine the base beneficiary premium and the direct subsidy. So I

wouldn't offer it's winners or losers. It's just the average. There were low bids and high bids, according to CMS. We have not seen the bids prior to the demonstration, but we don't know the exact distribution.

MR. KAN: So on this point, if you see one of the slides, can we go to the slide where you showed the direct subsidy jumping from $30 to $143, please. There are two main sources of authority, and that explains why there is such a wide variation. First and foremost, all the actuaries have a guess as to what the direct subsidy will be, and depending on who you talk to, yes, it's true, it takes 10 actuaries to change a light bulb.

So you have that dynamic going on. On top of that you have the out-of-pocket selection factor going from $8,000 down to $2,000. How do you think about what, in actual circles, we call induced utilization? So the combination of that and a whole host of other variables would explain the wide dispersion in bids, if that helps.

DR. CHERNEW: And the hope is once the utilization experience arises, there will be much less of that second part of uncertainty.

MS. KELLEY: That's all I have for Round 1,

unless I've missed anyone.

DR. CHERNEW: I think that's right, and I think Stacie is the first in the queue for Round 2.

MS. KELLEY: Yes.

DR. DUSETZINA: I know that's a shocker. Thank you so much for this excellent chapter. I always love reading this chapter every year, and this one was a real heroic effort, given how many changes have occurred and how much you had to explain.

So I have a couple of very minor, kind of more editorial things that I just wanted to note throughout and then a few broader comments.

The first is just like a, this would be great information because I don't think I know it. On page 33, you talk about the premiums for higher-income individuals, or have income-related premiums. It would be great to say how much that is, or like a range for that. It's just something that I don't know off the top of my head, but I think it would be nice context for people to know.

On page 42, you mention the number of enrollees who are high-cost enrollees who met the threshold with one fill. And you said that that was more likely to happen for

people without LIS than with LIS. And I was kind of sitting there scratching my head for a minute, trying to figure out why that would be the case. And my guess was that a lot of the high-cost LIS group is there because of many, many drugs that they're filling. So as a proportion it's lower. But it just kind of made me scratch my head. So it might be worth pointing out that the way that you get into that high-cost category could be because of many drugs versus, you know, just one or two very high-cost.

On page 44, where you go through the price indices, and 45, there are two data not shown pieces. One is the generic index and then one is the net price index. And I would if data were shown, just from a like wish list of, you know, often when we see information on trends in the Drug Price Index that it combines the brands and the generics, so everybody is like, oh, drug prices don't go up. So I think as much contextual information as we're allowed to have in there, the better, even if it makes the chapter a little longer.

To the broader comments, one is about the expectations of the bids versus what actually happened, and providing maybe a bit more context for readers. I could be

wrong about this, but one of the reasons I think that the projection of costs was so far off of what actually happened this year was partly because of GLP-1s and the new indications and anticipation of spending. So they were like how plans think about the uptick in demand for very high-cost drugs with the cap that might be different than how maybe CBO was thinking about that.

But I think it would be nice to maybe put a little bit more context in there, to what extent we can, about that. I know it is in the piece, but it kind of feels like it comes pretty late. And I think that it sort of helps to explain why that, in 2022, the estimate was so different than what happened when we actually get to the point of the bids.

To Gina's first Round 1 question about the supplemental benefits, I think you all do a good job of getting into the weeds there, but probably more detail in that explanation, where you talk about how much you pay and how much is counted towards your TrOOP would be nice. Because it took me multiple spreadsheets for a while to try to get the math worked out on this, including how the deductibles get contributed and the co-insurance.

And it really is a problematic kind of function of the new benefit design, the whole issue of if you have a higher-cost drug and a co-pay, you can get to the cap without spending $2,000.

In some work that I've been doing, it looks like that's going to have spillover effects on how many drugs have co-insurance instead of co-pays. So that has real implications for beneficiaries and how plans think about coverage. So I think it's really important.

I also share the concerns about the standalone PDP market, and I think that you do a nice job pointing to the Premium Stabilization Demonstration project. I feel like that really was needed in the case of the standalone market because of how high those premiums are relative to MA plans today, and also that that would be a huge disruption for Medicare beneficiaries who are trying to stay in the fee-for-service program. So I do really appreciate that information that's in there.

And also, yes, the note about the lack of benchmark plans. It seems highly concerning that there are some places that only have one benchmark plan. So again, I think it's important to monitor, as you all have said.

Absolutely phenomenal work. I love this chapter. I look forward to reading it again in the near future.

DR. CHERNEW: You will get the opportunity.

MS. KELLEY: Gina.

MS. UPCHURCH: All right. Just to follow up with my Round 1 question and building off of what Stacie just said, I am concerned about allowing these supplemental benefits to count towards a person's TrOOP. I do think it can drive public pharmacy. I think it can drive the use of more expensive medications when less expensive alternatives are there. So I have concerns about it, and I want to go on record as having stated that.

The second thing is about the MP3 program, which is the Medicare Prescription Payment Program, that is supposed to help people with expenses, you know, spread out throughout the year. You know, I think it separates the consumer even more from actual drug prices, and I do think it will also contribute to polypharmacy and the use of medicines when less expensive alternatives are there, and potentially not even needing the medicine in the first place, but it doesn't cost you anything, or it costs you very little. So price sensitivity, I'm very concerned

about that, as somebody who has studied geriatrics and medication adverse effects.

I am also concerned about the administrative costs of it, because we have to pay for these plans to implement. You know, what are they going to do when Ms. Jones doesn't pay her insurance company a premium? Are they going to go to her house? Are they going to kick her off the plan? How is that going to work, and what are the costs to the plans that are then borne by everybody else? And also costs to the pharmacies that have to tell people about this. So I just want to keep an eye on the Medicare Prescription Payment Plan.

So I just came up with an article in the Journal of American Geriatrics Society about Part D, and I'm very concerned about the late enrollment penalty for people in safety-net pharmacies, whether you use an FQHC, community health center, rural health center, free clinic. You thought you were at a government institution getting your medications. The VA is creditable coverage, you know, federal benefits, creditable coverage, but these safety-net things are not creditable coverage. They are going to have late enrollment penalties. And with penny pricing going

down because 340B is being exploited, and is messing it up for some people, it means that more and more people are going to have to probably turn to Part D, but the late enrollment penalties are so big they are not going to have access. So I really want us to keep an eye on that.

I do think there is abuse and spread of 340B beyond its original intent, and I want us to keep an eye on that. I don't want to throw the baby out with the bathwater, for rural health centers, community health centers, FQHCs, hospitals that have very expensive medicines that people couldn't afford otherwise, that they could pass on to people. But you have got to check on the baby. You're not throwing out the bathwater but you want to check on the baby, and we need to keep close eye on 340B.

Last two comments. When Medicare D began, they said they were going to pay pharmacists to be part of a team to make sure, there are two things with Medicare D -- improving access to medicines and medication appropriateness. We have never really paid attention to Medicare appropriateness. When I say "we," it's a collective "we," not just we in MedPAC, but the benefit

itself. The medication therapy management services that are out there, they're not that meaningful. They're with people you're not in a relationship with. A lot of them are call centers. They send you things in the mail.

So pharmacists were told it's going to be pay for performance, but oh, by the way, you owe us money. And they used to take to off up front, right. I mean, excuse me. They take it off on the back end. It was called clawback. Now, not because of the Inflation Reduction Act, but because other laws, they take it off up front. So if it really is pay for performance, you would think that some pharmacies that are doing pretty well are getting payments now on the back end, because they're doing such a great job. I've not heard of one payment coming to a pharmacy for doing a better job on these metrics. So that tells you how meaningful that was, and what that really was. It was just a fee to pharmacies, and that's the way to create savings for other people, by stripping it out of the pharmacies.

Are pharmacies getting any bonuses for their contributing to patient care and to better outcomes? I don't see it.

And the last thing, I just want to be clear, because this gets used a lot, and we see it all the time. We call them preferred pharmacies. They are preferred because they are often vertically integrated. They don't necessarily cost the plan less, and they don't necessarily cost the beneficiary less. Mail order used to always be less expensive. It is definitely not.

So for many plans, many people, it costs you more to go to a preferred pharmacy, more to go mail order. So I just think we just have to keep an eye on that. And they do steer people to certain pharmacies, even though the pharmacist can't steer people to certain plans. The plans are definitely steering people to preferred pharmacies that sometimes cost the consumer more, and we've got to keep an eye on that.

Thanks for great work.

MS. KELLEY: Greg.

MR. POULSEN: Yeah, let me pile on with the gratitude to Tara and Shinobu. This is great stuff. Great report, clear, informative. I think this is the best description I've seen of the IRA and its consequences, both

expected and unexpected, so thanks for that. It was great.

I think that, you know, with the Medicare subsidies way up, Shinobu, you gave a number of different ways of measuring that, and every one of them is eye-popping and disconcerting, the plan bid increases equally jarring. Attempts to stabilization are both expensive and complicated. The number of out-of-pocket limit people -- the number of people that hit out-of-pocket limit up 15 times, those are big, big numbers.

The trouble with the PDP market and viability options declining, there's a lot going on here that's concerning, and then when we look at the potential eclipse to -- or whatever comes next, because we don't know what might just be around the corner, multiply these kind of concerns, and we've just got a whole series of very troubling things.

And it seems to me -- and I've been on the Commission now for about three years, and I've looked for the opportunity to talk about what the underlying issues might be, and I think they're deeper than Part D. In fact, if we look at the total Part D expenditures of $128 billion in 2023, but in addition to that, Medicare paid some $33

billion for Part B drugs in addition to that -- and the other thing that I don't think we have a great handle on is drugs paid for in Part A and within DRGs, and hospitals have spent roughly $115 billion for drugs.

How many of those went into DRGs within Part A? I don't know. Looking at my own organization and extrapolating from that, it's tens of billions, though. It's a lot of money.

So as we look at that, I think you could come up with a fairly credible argument that we collectively -- HHS, CMS spends as much for drugs in Part A, B, C, and D as they do for professional fees. I don't know if it's higher or lower, but it's in that magnitude.

And when we look at the amount of effort that we put into defining the amount that should be paid for professional fees and all these ones that we talked about earlier today that are far less money than this, it seems like maybe we should take a different way of looking at the underlying cost of medications, because they're enormous and they're growing. And they're growing by far the fastest. We all know that. They're growing by far the most rapidly of any of the sectors.

But we just don't have a place to look at them yet, and I wondered about talking about this in April. But I'm not quite sure where it fits there either, so sorry for taking us hopefully 20 degrees off and not 90 degrees off of our approach here.

But the thought that I have is, as we look at this, we don't look at any of the underlying cost metrics, all the things we looked at in every other sector, which brings me to another point.

When pharmaceuticals get discussed in many venues, including sometimes here in MedPAC, we look at drugs, defining their value from a clinical perspective or what costs we may be avoiding by using those drugs. But we don't do that for any of the other sectors we look at. We don't define the payment to a neurosurgeon based on the clinical benefit that she provides. Instead, we determine the impact our payment has on supply of neurosurgeons or physicians more broadly or hospitals more broadly or nursing homes more broadly.

We look at the payments to hospitals based on the underlying costs, and this morning, we concluded that although we're actually paying less than the total cost to

provide the care, we won't materially harm the access to hospital care, so that's what we're recommending.

And without understanding what the underlying costs are for the pharmaceuticals that we provide, again, as potentially the second or at least the third biggest expenditure category in total that we have to deal with, especially when the evidence is definitive that Medicare pays far more, in some cases multiples more than the federal governments and other countries pay for the same medications, it seems like something that we need to put our arms around in some way at some time. And I don't know exactly how we should do that. It's not part of this product.

And so again, I am grateful for the product that we have here. I'm grateful. I should also say I would be remiss to not go without saying I think it's very clear that we should be in awe of the brilliant accomplishments that pharmaceuticals have made. None of us would want to be without what we have today. so I want to be very clear on that. I'm not critical of that.

But I don't think that gives us a reason not to expect that the similar accountability that we have for

every other sector, all of which also do marvelous and good, capable work in behalf of our beneficiaries, I think we need to find a way to get our arms around the benefits, the costs, and the associated accountabilities that we should have in the group, not just for the insurers that are distributing those services, but for the underlying manufacturers as well.

DR. CHERNEW: So I'm going to say something first on this point, and then you can say something second on this point.

This would be a wonderful retreat topic. I think the issues of how to think about that and what to do is important. So that's the first thing.

The second thing is one thing that makes the prescription drug market different is the prevalence of patents and the way we think about innovation and where we think about payment versus cost.

Now, that does not mean that there's not innovation in other sectors. As you know, I've been very interested and concerned about how we pay for AI services and a bunch of things. So it's certainly not the only sector where that matters, but I would venture to say it's

probably the most salient in that sector.

And balancing your comment about we want new drugs and we want innovation with your comment that we need to think about what we're paying relative to cost is sort of where the core conundrum comes in.

So I say this -- I hope we don't devolve into a big discussion of that because, per your point, that's not exactly what comes up in a status chapter, but to the broader point, it is something that we need to -- I don't know -- pick a gene or keep our eye on or think about. That, I think, is in fact spot on, and we will just need to decide how to go about doing that because that's a non-trivial, analytic discussion.

MR. POULSEN: No, I realize that it's far from trivial, and I also recognize that we don't have a natural place for it to rest in our current rubric, and that's why I had to figure out the least disruptive place to potentially put it.

DR. CHERNEW: I surely made things worse.

Larry wanted to say something on this point, and then I want to --

DR. CASALINO: Yeah, I want to, because Greg was

absolutely brilliant and tactful in the way he raised a really important issue, so tactful, I want to make sure that we're -- well, I'll be more blunt, right?

[Laughter.]

DR. CASALINO: I think, Greg, what you're asking is should we do what we do in other sectors, which is try to get some framing of how much does Medicare have to pay for Part A, B, and D drugs to get the amount of innovation. That would be nice to have. This is, of course, a much-debated question, and there is literature on it but not something that, at least in my time on the Commission, we've talked about.

I think you didn't say this, but I think you mean that there's no reason why we couldn't engage in looking at that issue if we wanted to. And I think you were implying that maybe we should, since it -- I agree. We've got such fantastic drugs, and the pharmaceutical industry has done an amazing job in getting antiretroviral drugs, anti-coronavirus drugs, and others, many others.

Still, it's striking to a physician, I think, to hear that, whoa, we're paying more for drugs than we're paying for me, right? And, you know, probably those drugs

are worth more than me. Anyway, I think that's a blunt way of saying that I agree with you.

DR. CHERNEW: And so we're going to move on. I will point out we don't have a prescription drug fee schedule. That other activity is part of a fee schedule activity, which we don't have in this case. Other issue. I'm not going to belabor it. Let's just move on to the next person in Round 2.

MS. KELLEY: Brian.

DR. MILLER: Thanks. And for ease of administrative operations, in order to reduce administrative costs, I saved my on-point responses to now.

So on-point response to Lynn about pharmacies. There was a nice Health Affairs article on pharmacy closures showing net closures. From 2010, there were 16,132 pharmacies. They noted in 2021, there were 15,996. So there is a net small difference, but that discounts a lot of churn, which is extremely disruptive to beneficiaries.

Independent pharmacies actually increased slightly during that time by 3.5 percent, and that was about half that marketplace. But, again, noting that churn

is, of course, disruptive. If you have one pharmacy in your county and it closes and then five years later, one opens, there is, of course, no net change in pharmacy, but you did not have a pharmacy for several years.

To Gina's point about payer-provider challenges, there is a giant gap in antitrust thinking about how to address payer-provider vertical integration. It's something which I recently laid out a framework for with my colleague Kevin Hahm, who is the former head of the hospital mergers section at the FTC.

On Greg's point, I agree that we should measure drug costs in Part A. I disagree with the assertion that it will make the fraction of hospital spending that much smaller, such that pharmacy will bump up in terms of number of market share of Medicare expenditures.

I'd also be cautious about us making innovation measurements when it's clear that other organizations have had trouble measuring product innovation. Product innovation, such as reformulation, a lot of people might poo-poo, but if your drug goes from Sub-Q to oral, that's a big difference. If your drug goes from a tablet or a capsule to a liquid, it might not seem like a big deal to

us, but if you have difficulties swallowing because you've have a stroke or you have dementia or some other condition, that reformulation is actually really important. So I think that innovation is something that we should generally be supportive of.

I'd also note that mortality is cheap. So we want to be careful about encouraging too much frugality.

On-point responses done. I had some questions about this chapter, which I wanted to say was amazing. I had to have several cups of caffeine and -- I'm not going to lie -- a little bit of Tylenol to fully digest it because it was so dense, and that's an amazing accomplishment, because this is a very hard marketplace.

So just a couple questions. I noticed that we mentioned negotiation. Do you think that the IRA is going to reduce innovation incentives for pharmaceutical product manufacturers and developers?

MS. SUZUKI: I think we do provide some information about potential impact on pharmaceutical manufacturers, and we've looked at a couple studies that looked at what impact it might have. I think there's a lot of uncertainty about what exactly will happen in the

pharmaceutical manufacturers, depending on how the prices compare to the prices they would have sold and the market shares that they retain.

DR. MILLER: But I am asking about incentives for innovation, which is new product development.

DR. CHERNEW: Go ahead. I will say something, but you go ahead first.

MS. SUZUKI: We do note that it would likely have effects on their revenues and could potentially impact decisions about R&D and product line.

DR. MILLER: Okay. So I think we should probably say that directly.

Another question, I noticed we used the word "negotiation." My question is, do you think that negotiation tied to an excise tax of 95 percent for nonparticipation in the negotiation is, in fact, a negotiation?

MS. O'NEILL HAYES: We use the name of the program included in the law when referring to it.

DR. MILLER: I guess I would challenge the assertion. I don't think that we should label it as a "negotiation" because it is actually not really a

negotiation when we look at the details.

I think one of the things that we should note in here is that IRA is using functionally centralized administrative pricing through inflation rebates and what is described as negotiation but is, in fact, not actually a negotiation. And where we are potentially marking the beginning of the transformation of the life sciences industry, which despite the many challenges and problems in regulatory and payment and occasionally IP arbitrage that the industry -- parts of the industry has committed, is actually one of the massive sources of innovation which has transformed clinical care. Drugs for, say, so-called gold-directed medical therapy and heart failure can prevent people from getting hospitalized, can reduce mortality. My colleague mentioned antiretroviral therapy. I presume he was talking about HIV drugs, which transform a death sentence into what is a chronic disease that is routinely managed in the outpatient setting.

In other areas where we have centralized administrative pricing, such as physician fee schedules or hospital payment, we have essentially destroyed innovation and have destroyed innovation in service delivery. If you

look at labor productivity growth in the hospital industry, it has not existed for 25 years. That is a product of government over-regulation and administrative pricing. In contrast, during that same period, the pharmaceutical industry has produced over 1,200 new drugs.

On to talking about the stand-alone PDP market, I had a couple questions, and I share my colleagues' concerns that the market is destabilizing, and that is bad for beneficiaries, because I don't think we want to force beneficiaries into Medicare Advantage plans if that is not the right plan for them. They should have fee-for-service being a viable option.

It can also be bad for independent pharmacies. I think it is important that patients and beneficiaries have some degree of choice.

I also know that many of us have expressed lots of concerns about prior authorization being burdensome and painful, and I agree. I think that process reform for prior authorization, specifically record submission, for example, with clear timelines could be very helpful. My concern is that the push to eliminate prior authorization could have -- in markets like this, could be problematic.

Do you think that eliminating prior authorization, as some have proposed, could further destabilize the stand-alone PDP market, which is already seeing skyrocketing premiums?

MR. MASI: Just to ask a clarifying question, could you help us understand which proposal to eliminate prior authorization?

DR. MILLER: We have expressed lots of concerns about prior authorization and prior discussions over the past year or so with the Commission for whether it is drugs or items or services, whatever it is. Do you think that potentially restricting prior authorization more could further drive up stand-alone PDP premiums?

And I am not necessarily a fan of prior authorization. I am just trying to understand the impacts on stand-alone PDP plans.

MS. SUZUKI: So if I could respond, on the utilization management in general, we have been generally supportive of giving plans tools to manage spending, particularly when they are, like now, managing a bigger portion of the benefit.

In our recommendation from 2020, we did encourage more tools, especially on the specialty side, to see

whether they could manage better if they had the ability to differentiate preferred specialty drugs versus not preferred because that was an area where it seemed like everyone was charging one co-insurance, and it was difficult to prefer a product over another.

So I think it might be a little bit different in Part D where private plans are providing the service and we give them some portion of the payment as a capitated payment and we want them to manage. But CMS does review the formularies to make sure that they are covering necessary drugs and that they meet the standard.

DR. CHERNEW: I'm sorry. I want to try and answer some of that question before you go to the next part.

There's sort of two threads of what's going on here. There's a status report part of this, which is here's what's going on and here's what we see. Then there's what we think is the normative conclusions in a whole range of ways of aspects of that status.

At this stage, per Shinobu's response and I think per the implication of your question, Brian, and where I think you're going -- and you can say in a minute if I'm

right, I would agree with -- is there is a complicated balance between allowing the tools for prior auth to get efficient utilization and understand that that helps keep costs down, which is broadly a good thing, versus a concern that it's being applied in ways that are detrimental to people's health and a whole bunch of things.

And so I think in the spirit of Greg's comment, this is worthy of broad Commission discussion about where it is. I don't think at this stage we've asked the staff to weigh in on their normative position about policy. I think we should have a discussion about the normative policy ramifications of that, and I really relish having that discussion. But we haven't taken a position beyond what Shinobu said, which is the acknowledgment that these tools do serve a meaningful economic purpose.

I hope that's helpful.

DR. MILLER: That's right. So part of the reason I'm asking is the stand-alone PDP market is clearly suffering, and if you want fee-for-service Medicare, you have to buy a stand-alone PDP plan.

At the same time, the stand-alone PDP plan market, which is already largely a commodity product, no

offense to the stand-alone PDP plan -- it's factual, it's a commodity product -- now has a greater financial responsibility. Just from the Part D redesign, Part D redesign is a good thing for beneficiaries. So they have more financial responsibility. They have limited tools that they can use. You can restrict formulary, or you can restrict networks. You can use more mail-in formulary. You can encourage biosimilar use, which arguably they don't necessarily always do a great job of. But there are limited tools. UR, or utilization review, is one of them. Yet at the same time, for an individual beneficiary, a patient, a clinician, whether it's a pharmacist, doctor, whether it's a pharmacy, utilization review frankly sucks, because it's hard.

So the question is, if we're trying to ensure a viable stand-alone PDP market, which I think we all want to have, because we all want people to be able to have fee-for-service as an option, yet at the same time we also recognize that having an appropriate check to prescribing habits and practices, what is the balance? How can we parse that? It seems like one of the opportunities to parse that is process reform for prior authorization, so

having more transparency, having more clear timelines at least, right? Like, if you have a prior authorization request, knowing what the time is, having an electronic way which is simplified and integrated either into point-of-sale pharmacy systems or electronic health records so that you can eliminate administrative overhead and automate some of that administrative process.

So in this case, technology could help us all, and probably someone right now is working on a business or several businesses related to this as we speak and discuss this. So sorry to put you on the spot.

Another question I had is about the redesign, which again, you know, makes sense, right? Because beneficiaries had a huge doughnut hole.

When I saw the 180 percent number, it sort of blew my mind. It seems like we all agree that that is a problem.

And then I saw from the data that we presented, that plan offerings decreased by 35 percent from 2024 to 2025. And if my caffeine-powered notes are correct, that was 709 down to 464 plans, which is still objectively a lot but is also a huge decrement.

And I guess my worry about this -- and I'm curious what you all think -- do you think that this is signaling a potential market spiral downwards? Because again, like the 464 is a big number, but that's a pretty big decrement.

MS. SUZUKI: This is something that we'll come back to in the spring. I think in November, we sort of outlined some of the mechanical aspects of the MA versus fee-for-service that may be contributing to some of this difference in how plan sponsors are bidding and how they're able to use certain rebates from the Part C program. But we can definitely continue this conversation because we are talking about this in April.

DR. CHERNEW: Yeah.

DR. MILLER: And one final question regarding the premium stabilization demo. Have we done any preliminary work or do we have any policy thoughts as to what do we think should happen after 2027 to avoid premium increases when the demo expires? Have we started any workstream on that?

MS. SUZUKI: So I think Mike mentioned earlier that this is something that plans will learn as soon as

they start to get claims for the 2025. I think utilization history is one of the big uncertainties they had, and once they have that data, their bids may start to stabilize. And that's when we may start to see whether there's additional changes needed, that sort of thing.

DR. CHERNEW: Just quickly, we're about 15 minutes in here, and so I would just say there's a lot of important stuff here, Brian, and you raised many of those things. Right now, we feel like we're at the early stages of the implementation of the IRA, and we're not trying to draw any normative conclusions and think about what to do. We're just trying to say as best as we can factually what some of the issues are. So I appreciate you raising them, but many of your questions are things that will be happening later.

But, Kenny, I hope your on-point point is really, really on-point because --

MR. KAN: Outstanding chapter. Thank you.

Best IRA primer, especially in describing the first-order, second-order, and third-order effects.

For future status updates -- and I note the word "future" -- can we look at the impact of innovation, both

in terms of launch of new -- launch prices of new drugs, especially Lenmeldy is now costing four and a quarter million dollars, and then the pipeline?

Thank you.

MS. KELLEY: Scott, did you have something on this point?

DR. SARRAN: Yeah, just briefly. I really wasn't going to have much to say about this chapter, because I was still trying to make sure I digested it fully, and it's truly excellent work, because it, among other things, made it digestible.

But I'm just going to reflect for a moment on some of our recent discussion, and I feel like we've had some scope creep here in our discussion. So it's a Part D update, lots of excellent work, lots of, again, material to digest, but somehow this has become a discussion about, you know, the potential intersection of pharma profit versus innovation, of the role of the federal government in regulation, of agnosticating, you know, down the road many years about what's going to happen in a market that is still responding to a very complex law that is going to play out over many years.

And I would just urge us all to try to keep our comments focused more on the Part D update, of which there is a lot to -- again, a lot of great work, a lot of good thinking to be had.

DR. CHERNEW: Yeah, to be clear, Part -- thank you, and I agree with that, but I will say Part D status. As I said, this is just status.

So, Amol, you get the next status comment if I have my list here right.

DR. NAVATHE: All right. Thank you, Tara and Shinobu, for a fantastic set of reading materials. Again, echo the comments of many of the Commissioners that it's a very, very complicated topic, and you've done a really admirable job of putting it together into something that is actually as condensed as it is. So thank you so much for your efforts on that.

I actually have a question, and then I have a comment. And my question is, in part, related to -- I guess partly related to my Round 1 question. But as we're looking at the kind of financials of the program, I noted that we show historical program spending. I think the most recent annual increase in program spending from '22 to 2023

that we show is around 11 percent or something like that. And this discussion, the reading material -- discussion of the reading materials as well as this discussion kind of made me wonder, do we have -- do we or have others provided projections of what we think overall program spending in Part D will be in 2024 or was or, slash, will be, I guess, in 2024, 2025, given the different changes in the IRA, given product innovation with GLP-1s and other things like that?

MS. SUZUKI: So I don't have the numbers off the top, but the trustees provide projections going forward. For 2023, the 11 percent growth partially reflects the GLP-1 increase in use among the Medicare population. It was also due to the IRA provision that made insulin copays to be no more than $35 and the vaccines that were free. Those were not in plan bids, and I think this is noted somewhere in the mailing material. But these were additional costs that plans would incur that was not reflected in the bids.

So CMS provided additional subsidies to cover those costs, and that's part of the reason why the basic benefit was richer in 2023 but was not in the bids, and therefore, there was additional cost that was added on to

the total.

DR. NAVATHE: I see. Okay. So that's super helpful, but I guess it doesn't sound like we have projections.

I'm partly just responding to the fact that it's so multifactorial, right? There's changes in the medications that are happening. There's changes in the practice patterns. TrOOP calculation is changing. The out-of-pocket cap is changing. There's so many things changing.

So part of me was just -- and you can answer no if we don't have it, but I was just kind of curious, like, if there's projections that are trying to synthesize this into what is happening to Part D spending overall in 2024, 2025, kind of going forward, that we've done or that others have done, I was just kind of curious if we have some sort of top-line sense of that.

MS. O'NEILL HAYES: I think the CBO and the trustees' reports would be the best places to look. For instance, I'm looking at the trustees' report from last year. The new report will come out in a couple of months, but, you know, they do make estimates. They have an

intermediate, a low-range, and a high-range estimates, and they kind of walk through some of the various assumptions that they include in those three different estimates. So that gives you, like, total Part D expenditures where they expect premium totals to be per capita spending, so on a per-beneficiary basis. So you can see some of that detail in there.

DR. NAVATHE: Okay, great. Thank you for that. That's really helpful.

And is that also broken out in terms of how that spending breaks out across beneficiary, across Medicare program, and across plans, manufacturers, et cetera?

MS. O'NEILL HAYES: Not quite to that level. It's primarily, like, Medicare's portion, but then it does also include beneficiary premiums, what they would pay, but it doesn't have, like, manufacturer and plan-level spending. It's not aggregated that way.

DR. NAVATHE: Okay.

MS. O'NEILL HAYES: Or disaggregated, I should say.

DR. NAVATHE: Well, so, thank you for that.

I think I'll give my comment now, which hopefully

I'll keep relatively brief. I think partly it is very striking, like, how many different moving parts there are here. The benefit design change obviously changes a bunch of the incentives.

To some extent, I would find it helpful -- again, I don't think it's necessarily for this chapter, this year, per se, but there's some of these changes that I think, from what I understand, we would think that some of them are related to uncertainties, you know, based on things like Kenny pointed out, you know, what he's calling induced demand and what have you, that will likely lessen over time. The uncertainties will lessen over time. And there's other aspects that are kind of permanent changes that are likely to impact the program.

It would be -- I don't know if it's possible, but at some point, it would be nice to have like a table that basically highlights which of these are related to this kind of stability of learning versus what are pieces that are kind of permanent, just to organize all the different factors that are at play here, because there's so many.

That being said, my broad reflection are kind of three things. One, I think it is notable that the Medicare

contribution, if you will, through the subsidy, total subsidy is going up. And I think while in some ways, we described this in the reading materials as well, the response to some extent of this new benefit design is in reflection upon how much less financial exposure or responsibility that plans had, plan sponsors had starting with kind of inception of the program all the way through more recently. I think this change also did not mean that the federal government suddenly stopped contributing nearly as much. In fact, it was very striking to me in the numbers that you provided that actually that number went up pretty substantially.

Notwithstanding the other pieces that you're talking about in terms of the premium stabilization demonstration project and the insulin, there's so many factors here. So I think that was one kind of a big striking point.

I think also the way that you presented it kind of brought attention to this complexity and the stability of the market vis-a-vis MA-PD, vis-a-vis vertical integration, the ACC risk score, like all those pieces, again. The way you kind of highlighted that I think is

really fundamentally important, and I think it's great the way that we have characterized that. And I know we've talked about other work, and that's kind of on that topic. And I hope that the Commission takes that on going forward.

Thanks.

MS. KELLEY: Okay. I have comments from Robert and Betty here.

Robert says that unlike with the payment update work, he likes the fact that we know the spend across fee-for-service with the stand-alone PDPs and MA, including the cost sharing. Hopefully, we can move closer to that kind of model in the future with Part A and B, especially as it relates to the annual payment updates.

And Betty says that she thinks this is great work presenting such complex interconnected material so clearly is masterful.

She wants to agree with Gina's comment on 340B. She sees it as in our lane for consideration, and the gaming of the program away from its original intent by way of loopholes is very troubling to her. She appreciates that that would be a separate line of work if undertaken in the future.

Next, I have Cheryl.

DR. DAMBERG: I'm going to pile on and say what a tremendous chapter this was. A lot to consume, but also just so much content in there that's really valuable for everyone in the policy community.

I am concerned about the decline in freestanding prescription drug plans and, you know, really look forward to the Commission continuing to monitor this and think about the many factors, as Amol pointed out, that are contributing to the destabilization of the market and, in particular, the role of rebates and creating unfair competitive advantage.

I want to plus-one on a comment that Gina made about the steering that's going on within vertically integrated organizations to preferred pharmacies and, you know, our ability to try to monitor the spend and comparing, you know, prices paid in those spaces versus independent pharmacies or non-vertically integrated. I don't know whether it's possible to do that. I'm not a Part D expert, but it would be interesting to better understand that, because I also have heard that anecdotally.

You know, there were so many changes in this law, and they're all going to have sort of different consequences and intersect with each other. But I do think it will be really interesting to monitor the changes plans are making to manage the greater risk they're assuming and whether that sort of plays out in beneficial ways or potentially harmful ways. So just something to spotlight moving forward.

MS. KELLEY: Larry -- oh, I'm sorry. Larry, before we go to you, I think Stacie had something on this point.

DR. DUSETZINA: Yeah. I completely neglected to make a comment before on the issue around the MA-PDs versus the PDPs, and I think Cheryl's comments are spot on there, that even though we see this tremendous amount of variation and high bids and premiums from the standalone PDPs, we don't see MA-PDs responding in the same way. These are the same companies. They have the same other external risks. They just have rebates to buy down and keep the premiums low.

And I think those artificially low premiums, while, you know, I don't blame people for really being

excited about a zero-dollar premium plan or really rich benefits, but they don't really create a sense that these are -- you know, it's not like an apples-to-apples comparison. It is really expensive to stay in traditional Medicare versus being in MA, and I think this is something that having the rebate dollars be able to buy down those premiums creates this artificial sense that the benefits are lower cost than they really are.

MS. KELLEY: Larry.

DR. CASALINO: It really is super, super work. Can't say enough about how much you're including and how well you organize it and how hard you try to make it clear to us how the program works.

Actually, Stacie's comment leads very well into what I was about to say. I think there's a good reason to be concerned about destabilization of the standalone PDP market and, therefore, really, of the Medicare, traditional Medicare program, right, because if you can't get drug coverage, you can't stand traditional Medicare, practically speaking.

And we're going to be talking, I think, in the future. You guys are going to be doing more work on

standalone PDPs and stabilization of that market.

I think there comes a time to not get lost in technical details, right, and call a spade a spade. I don't believe there is going to be a way to stabilize the PDP market as long as Medicare Advantage plans are getting MedPAC calculations, $85 billion in extra payments a year, some of which are used to create the zero-premium Medicare Advantage prescription drug plans. As long as that's the case, there's no competition. There's no way to stabilize, really, the standalone PDP market.

So we can talk about technical things that can be done, and that might help on the margin. But I think, without kind of stepping back and looking at the big picture, I think we'd be wasting our time talking about stabilizing the PDP market if we don't consider that faster. How can you compete with zero-premium plans?

Another way to say it is if you're a traditional Medicare Advantage enrollee, you're paying extra taxes to support the higher Part B premiums that result from the extra payments to Medicare Advantage plans, and you're paying for a PDP drug plan. So you're basically paying your money twice, in two ways, through taxes and through

the paying for the PDP plan in order to stabilize the market for the insurance product you're in, traditional Medicare. And that is, I think -- I don't think I'm exaggerating. I think that literally is the situation. I don't think we want to lose track of that.

DR. CHERNEW: Okay. So despite all the various things, we are perfectly on time. So thank you to you all. Thank you to Shinobu and Tara.

I'm going to make a general overview comment about all of this. The first point is -- and I will emphasize again. I said it a few times. This is a status chapter. We were just reporting the status. Many of the comments pointed out a number of problems. So let me try and put them into a few typologies.

There's a core issue with just prescription drug markets and innovation, in general, and that's difficult, and there's a lot of things there. And we can -- I think it might be -- we will have in the April executive session, a discussion about what things should be on the agenda for next year, and we can put that in the queue. You guys can say what you want about that. That's completely reasonable.

There's an issue about a whole bunch of stuff regarding things that the IRA did and what are their impacts, and so I will take the blame here on the understanding of our -- again, this is a Michael problem, which is, there's a lot of Michael problems -- is that we should wait and describe the set of things that were going on and what we were seeing and do it in as little -- as least normative way as possible for right now and then take our stab if we want to say anything normative or say there's a problem or not a problem at a later date once we actually have some evidence to see how all the IRA was playing out. So, again, I think it's a Michael problem that we didn't decide to jump right in and start critiquing a whole bunch of things with the IRA while we're still in the middle of so many aspects of implementation of the IRA.

It may be, when we talk later, that you want to jump into that sooner or later, and I'm all ears for when folks want to do that.

And the third one that I will mention is this issue of the standalone Part D market or, more broadly, the interplay between Medicare Advantage and Part D. And I think many of you said exactly what I believe, that it's

very hard to be outside of MA if your opportunities for drug coverage outside of MA are problematic, and that is a much more holistic view of things that we can discuss.

I think we should separate out what I would call market function problems in Part D that we want to stabilize. The risk adjustment isn't working. We need to stabilize that part of things from other distortionary effects, like MA plans are buying down Part D premiums, and so it's just hard to get them to -- that's not a problem that's, like, in the structure of the Part D market. That's a problem that has to do holistically with how the system is designed, to the extent that you believe it's a problem. And, again, we can have that discussion.

And so, again, tomorrow we're going to talk about the MA market and its -- I will emphasize, again, its status, and I think hearing these thoughts are important because they will play into discussions of which and when we want to take up sort of this broad issue.

It's very easy, and I think everybody appreciates -- and for those of you at home, I'm not sure you fully appreciate the complexity of the chapter -- doing just the status work to understand what's going on is challenging.

We have issues of how the rebates are playing out. We have issues with the benefit design changes. We have, you know, issues with -- there's a bunch of other stuff going on in the IRA that we didn't talk a ton about here.

And so this is a mountain that we're at the beginning of with a lot of different paths to get different places, and I look forward to hearing from all of you about which ones you think we should prioritize when and how we should go at them, and then we will do that.

But for now, it's 3:25, which is exactly the time. So we are going to take a five-minute break, and we're going to come back, and we're going to go through our discussion at 3:30, starting at the ambulatory surgical centers.

So, again, thank you, and we'll be back in five.

[Recess.]

DR. CHERNEW: Okay, everybody. We are going to go through the ASC work, and I'm about to turn it over to Dan. I'm pausing slowly because I'm hoping at any moment Kenny walks into the room and we can record his vote on the IPF chapter. But I'm not seeing him. Dan, go ahead.

DR. ZABINSKI: Okay, it's been a long time since

I've done this, so I hope this is like riding a bike.

In this session, we will discuss a status report on ambulatory surgical centers, or ASCs. For the broader audience, a PDF version of the slides is available on the control panel on the right side of your computer screens.

The topics we cover in this presentation include background information on ASCs; fee-for-service Medicare beneficiaries' access to ASC care; the growth in ASCs' fee-for-service Medicare payments; and the change in the quality of care in ASCs to Medicare beneficiaries.

This slide presents some background on ASCs to provide some context for the rest of this presentation.

The general purpose of ASCs is to provide outpatient surgical procedures that don't require an overnight stay. The most common types of procedures include cataract, gastroenterology, and pain management, while knee and hip replacement services as well as cardiology services increasing rapidly.

Also, in 2023, fee-for-service Medicare service volume and revenue had large increases.

For most services covered under the ASC payment system, CMS bases the ASC payment rates on the relative

weights from the outpatient prospective payment system, the OPPS, which is the payment system for most services provided in hospital outpatient departments, or HOPDs.

The general process of setting the payment rate for a service under the ASC system is to multiply the OPPS relative weight for that service by a conversion factor that's specific to the ASC system.

The ASC conversion factor, however, is much smaller than the OPPS conversion factor. Consequently, for most services, ASC payment rates are 46 percent lower than the analogous OPPS payment rates. These lower payment rates for ASCs means that relative to HOPDs, ASCs are less costly to the Medicare program.

Other benefits of ASCs relative to HOPDs include, first, that ASCs offer efficiency to physicians because they can customize their surgical environments and hire specialized staff. For patients, ASCs offer lower cost sharing, easier scheduling, and less time in surgery.

An overview of the status of ASCs in 2023 includes that the number of Medicare-certified ASCs was about 6,300; 3.4 million fee-for-service beneficiaries were served; the number of surgical procedures provided to fee-

for-service beneficiaries was 6.4 million; and Medicare fee-for-service payments to ASCs were $6.8 billion. Also, the ASC payment rates have received an update of 2.9 percent in 2025, which is the same update that hospitals received under the OPPS.

This slide indicates that ASCs had strong growth in fee-for-service Medicare in 2023.

Regarding beneficiaries' access to ASC care for 2023, we found that the number of ASCs increased by 2.5 percent, which was slightly larger than the annual rate of growth from 2018 to 2022.

In addition, the share of fee-for-service beneficiaries served in ASCs increased by 5.1 percent and the volume of ASC procedures per fee-for-service beneficiary rose by 5.7 percent. The growth of both measures was much higher in 2023 than the annual rate of growth from 2018 to 2022.

Except for first-year Commissioners, we've shown this figure before, but I still find it amazing.

This chart shows that even though the number of ASCs has been steadily increasing, the geographic location of ASCs is very uneven. Among states, the number of ASCs

per Part B beneficiary, which includes both MA and fee-for-service, varies from a low of 1.3 ASCs per 100,000 beneficiaries in Vermont to a high of 35 ASCs per 100,000 beneficiaries in Maryland. A factor that appears to affect the number of ASCs in a state is whether the state has a certificate-of-need, or CON, law and how restrictive that law is.

Also, even though Maryland has a CON law, it is an outlier in terms of ASC concentration. The all-payer global budget revenue model for Maryland hospitals appears to be the driving force behind the high concentration of ASCs in Maryland services provided in ASCs don't apply to hospital global budgets.

There is also a difference in ASC concentration between urban and rural areas, where urban areas are defined as being in a metropolitan statistical area. In 2023, 94 percent of ASCs were in urban locations, and only 6 percent were in rural areas. From conversations with industry stakeholders, we found out that an underlying reason for this discrepancy between urban and rural areas is that rural areas often lack the surgical specialists and population density to support the ASC business model.

On this slide, we show differences between ASCs and HOPDs in terms of the share of patients who have certain characteristics. For example, we found that among the fee-for-service beneficiaries receiving surgical procedures in ASCs, 8.9 percent were dually eligible for Medicare and Medicaid, while HOPDs had a higher percentage of those beneficiaries, at 15 percent.

We also found that, relative to HOPDs, ASCs had lower shares of fee-for-service Medicare beneficiaries who were under age 65, indicating that they were eligible for Medicare based on disability, and patients who were age 85 or older.

ASCs' growth in fee-for-service Medicare payments has been strong in recent years, but in 2023 that growth reached a new level, as Medicare payments per Part B fee-for-service beneficiary rose by 15.4 percent in 2023.

Much of this growth in ASC Medicare payments was from increased provision of relatively complex procedures such as knee arthroplasty, hip arthroplasty, and percutaneous implant of neurostimulator electrode arrays. The increased provision of complex services was likely due, at least in part, to CMS's decision to move some complex

procedures off the inpatient-only list.

Since 2012, the ASC payment system has had a quality reporting program called the ASCQR. In recent years, we have not presented data on ASC quality measures because CMS had made substantial changes to the ASCQR measures, which resulted in very few measures being available for quality comparison across years.

For this year, thought, the number of available measures is still limited, but we believe there is enough quality data to make useful comparison.

Specifically, the ASCQR now has data on four outcome measures for 2022 and 2023 that measure the rate of hospital visits within seven days after different types of procedures. The data indicate there was virtually no change in all four measures from 2022 to 2023.

An issue regarding ASCs that we've frequently addressed in the Commission's payment adequacy work from 2010 through 2024 is that ASCs are the only health care facilities that don't submit Medicare cost data. Some -- but I emphasize not all -- stakeholders have argued that submitting cost data would be overly burdensome on ASCs because they are small facilities.

However, other small facilities such as rural health clinics, home health agencies, and hospices all submit cost data. In addition, submission of cost data is important. Without it, CMS cannot create payment rates that accurately reflect ASCs' costs, and CMS cannot create an ASC market basket that could be used to update ASC payment rates. Also, while the indicators of ASCs' status are strong, MedPAC cannot estimate fee-for-service Medicare margins.

In response to the lack of cost data from ASCs, the Commission has recommended that ASCs collect and submit cost data.

A summary of the status of ASCs in 2023 is that, first, the number of ASC facilities increased. Also, the volume of ASC services and Medicare revenue rose in 2023, with the growth in Medicare revenue accelerating. In addition, ASC concentration varies widely among geographic areas, so access to ASCs might be difficult in some areas.

Note, however, that services provided in ASCs also can be accessed in HOPDs and, in some instances, in physician offices. However, the cost to Medicare and beneficiary cost sharing are always higher in HOPDs than in

ASCs.

Also, relative to HOPDs, fee-for-service Medicare beneficiaries treated in ASCs are less likely to have Medicaid coverage, be disabled, or be age 85 or older. We also found that measures of quality did not change from 2022 to 2023. And finally, the lack of cost data from ASCs prevents estimation of fee-for-service Medicare margins.

For today's discussion, we'll address the Commissioners questions about the material covered today and in your paper, and we would like to hear any suggestions for future work.

Thank you, and we turn back to Mike for questions and discussion.

DR. CHERNEW: Dan, thank you so much. I think we're going to jump right into Round 1, and I think Cheryl is first.

DR. DAMBERG: Thanks, Dan, for great work. I had a question on Table 10.3. It was the table you showed in your slide deck. There you note that duals are more often getting the procedures in the HOPD versus the ASC, and I was kind of curious, who do you think there is that differential? Is it because these ASCs aren't located in

the areas where duals live? Are they steering those patients away to HOPDs because of cost sharing issues? What's going on?

DR. ZABINSKI: I'm not sure about the latter part of what you asked, whether they're steering away or not. I don't know. But I can say for certain that ASCs, you know, I've seen these charts -- in fact, I made one once -- where social risk factors, areas with high social risk factors, low income, bad housing, low education, have low concentration of ASCs than areas with higher income and better risk factors have higher concentrations for ASCs. So I think that's probably a driving factor of this result.

DR. DAMBERG: And I think it would be helpful if you could put that context in the chapter. And I also note on that table, while in the text you point out that there are differences by disability, I didn't see disability in the table, so I don't know whether you want to add that.

DR. ZABINSKI: I mean, under 65, that indicates -- I mean, you know, what I should do is put under 65 and like in parentheses, disabled.

DR. DAMBERG: Thanks.

MS. KELLEY: Tamara.

DR. KONETZKA: Thanks, Dan. I have three quick questions. First, on page 15, when you were discussing these lists of like inpatient-only procedures and how some of that has changed over time, I guess I had a vague memory of there being inpatient-only procedures, which makes sense, but then you also reference these hospital outpatient department-only procedures. And I'm wondering if you know the rationale for that. Is there a perception that if a procedure can be done in both places that it's somehow safer, or that more complex people should be in the hospital outpatient department?

DR. ZABINSKI: Yeah. In my viewpoint it's because CMS kind of uses different logic on deciding what's covered in HOPDs versus what's covered in ASCs. CMS, for HOPDs they say everything is okay unless it look like it shouldn't be there. And for ASCs it's like nothing is okay unless we say it's okay to put it there. And generally those two things overlap, but there's a small set, in this case of 320 items, where there's not an overlap.

It's just the process that CMS uses to decide what's covered in each setting. They don't use the same method.

DR. KONETZKA: Okay. So you don't feel like there's a translation to -- I'm sorry. I'm making you speculate. But you don't think there's a translation to sort of the perceived safety of doing something in the hospital outpatient department versus in the ASC.

DR. ZABINSKI: As far as I can tell it's not intentional. I've never seen anything where CMS explicitly says that.

DR. KONETZKA: Okay, thanks. That seems --

DR. CASALINO: -- the clinicians feel that way.

DR. KONETZKA: But the clinicians may -- okay. But they would feel that way about that set of services or about basically a lot of --

DR. CASALINO: If someone starts having a heart attack while you're doing their colonoscopy, they'd rather you be in an HOPD than in their ASC.

DR. KONETZKA: And is that proximity to the hospital then, to deal with these things.

DR. CASALINO: Partly that.

DR. KONETZKA: Okay.

DR. ZABINSKI: I mean, I'll add this. HOPD, if it's on the inpatient-only list, it's not allowed to be

done in the HOPD. But CMS has an explicit covered procedures list, a CPL, for ASCs, and it's, again, a little bit different. And the construction of those two lists, you know, have different guidelines.

DR. KONETZKA: Okay. Thank you. Two more quick questions.

One is on the new quality measures, one of them was screening for social determinants of health, sort of indirectly related to the duals question that Cheryl brought up. But are ASCs expected to do anything with that information? What's the expectation, that they do a screening? It seems like an odd role for them maybe, but is there any expectation of what they are going to do with that?

MS. KELLEY: Ledia, go ahead.

MS. TABOR: That is a new measure that CMS is implementing actually across all of the quality reporting programs, that it is measuring just basically -- it's trying to ask providers to start screening for these things, but there is no expectation that anything is done with them yet. So kind of like a first step of asking providers to start screening, with potential expectation in

the future that actions should be taken.

DR. KONETZKA: Okay. Thank you. Final thing, in the chapter -- and I'm sorry, I know this question comes up a lot, but when I read the chapter, my sense was, and I think I just missed it, because in the presentation you said one of the tables was about MA, or mixed MA and fee-for-service. Just a general question of do we have a sense of utilization of ASCs under MA separately?

DR. ZABINSKI: Not really. Here is one thing that I do know, is that, what hit us, UnitedHealth, you know, they're owners of Optum Health. Optum owns a ton of ASCs. And my understanding is that's to get the MA, and well, basically the managed care patients in general, to use ASCs rather than HOPDs. But other than that, I don't know.

DR. CHERNEW: There was a purchase, so Optum bought SCA, Surgical Care Associates, and this will be the subject of a ton of academic research about what happened there. But a lot of that hasn't yet come to fruition.

MS. KELLEY: Greg, I'm sorry. I think you had something on the inpatient-only.

MR. POULSEN: Yeah. I was actually trying to

sort of catch the eye of our physicians over here, because you talk very clear experience that -- just to the point that you were making, that when there's a patient who seems to be at higher risk for whatever reason -- age, heart conditions, anemia, I mean, almost anything -- they would much rather have them right next door, in case something goes sideways.

So I don't know how much good data there is, although I think your table indicates that, if you look at the age groups, for example, it's very clear. The over 85 are going to be much more likely to be at an HOPD than the people that are younger.

I'm sure there's better data than I have at my fingertips, but I suspect when we see it, and I suspect the anecdotes would just reinforce the fact that clinicians are going to be more comfortable when something looks like it could be scary, including the physicians who are owners of those ASCs.

MS. KELLEY: Lynn.

MS. BARR: Thanks, Dan. Great work. I really enjoyed the chapter. Just two Round 1 questions. So the Maryland story is great. I mean, you know, sure, let's

give them a capitated budget and see what we could do elsewhere.

What was number two? So Maryland was like 30 percent, right, but what's number two?

DR. ZABINSKI: I know, let's see, Georgia, I think.

MS. BARR: Do you remember their percent?

DR. ZABINSKI: Oh yeah, about 20.

MS. BARR: About 20.

DR. ZABINSKI: Yeah.

MS. BARR: So like 50 percent more.

DR. ZABINSKI: Maryland's so far ahead, nobody's second.

MS. BARR: Okay. So 20 is like the rational range out there, their unique payment model.

And then on quality, there was a quality discussion you had about the data. Can you compare that to HOPDs?

DR. ZABINSKI: Those measures, no. I don't remember which measure it is. There is one measure that overlaps with HOPDs.

MS. BARR: Just one?

DR. ZABINSKI: Just one.

MS. BARR: Could we add that one?

DR. ZABINSKI: Yeah, I could probably grab it, yeah.

MS. BARR: And again, context is always so important. Is that good or bad? I don't really know. So if you have any further information to say, oh, this is good, this is bad, or, you know, we don't really know because we can't risk adjust it. Thank you.

MS. KELLEY: Paul.

DR. CASALE: I think a lot of this has already been asked by others, around the differential use of ASC versus HOPD for difference with dual eligible, age, et cetera. And I agree that it's multi-factorial, and I appreciate Greg's comment, and agree wholeheartedly that decisions -- part of the decision, for sure, is around clinical risk.

So is it possible to get any data, whether it's using the HCC scores or something to get a sense of the clinical risk of the beneficiaries, and see if there's a difference between those treated in ASC versus those in HOPD.

DR. ZABINSKI: Yeah. Let's see, a couple of things on that. Years ago -- I've been doing ASCs for a long time, even before the Commission; I don't know you knew that -- I've been doing ASCs a long time. And I used to have a partner, Ariel Winter, who always -- occasionally would do that, do a comparison of HCC scores for ASCs versus HOPDs. But I also did do one not specifically for this chapter but for site-neutral work that we did a couple of years ago.

So yeah, we have something fairly recent on that, but it's always been the case that, yeah, the ASC patients look a little healthier than the HOPD patients.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Dan. I have what may be a bit of a ticky-tack question, but hopefully it's straightforward.

In one of the footnotes about cost sharing you note that there is not a limitation on co-insurance for ASCs, like there is in HOPD, and there is a subset of these procedures where the co-insurance can actually be higher. And these are so-called device-intensive procedures.

So what I was wondering there is while the cost-

sharing for the beneficiary varies for these, the payment that's going to the facility and the payment that's going to the physician, that's not going to vary. Is that right? Meaning relative, I guess, to what would otherwise be the HOPD-ASC difference. Only the cost sharing piece that's changing.

DR. ZABINSKI: That is correct.

DR. NAVATHE: Okay. Thanks.

MS. KELLEY: Okay. I think that's all I have for Round 1, unless I've missed anyone.

DR. CHERNEW: I think Round 2 is going to start with Brian.

MS. KELLEY: Yes. Go ahead, Brian.

DR. MILLER: I'll be brief. Great chapter. Seems to be very interesting focus factory. I notice a couple of things. One is I think we should explore as a Commission recommending -- and we don't have to do this right now -- explore the potential of suggesting elimination of the inpatient-only list. That seems to be regulatory definition regarding the practice of medicine, which seems unusual, and inhibits clinical innovation, which we desperately need. As I have mentioned before on

this topic, I am opposed to cost requirements, small business, and it's one of the few small businesses left in health care.

I think that there is another payment policy opportunity for us here for site neutrality with ASCs, and not just ASCs versus HOPDs but ASCs versus the physician fee schedule, or the PFS, and to think more dynamically, because often we think about site-neutral as decreasing from one fee schedule to another, which makes all of us budgetary nerds feel good, which is also not necessarily entirely realistic. Maybe the answer is splitting the difference to encourage neutrality of procedures across clinical sites, and then where clinicians feel it's most appropriate would then perform them.

Some people might accuse me of suggesting site neutral lite. Thanks.

MS. KELLEY: Scott.

DR. SARRAN: Excellent work, Dan. So a couple of quick observations and a couple of quick sort of suggestions. I think we want to acknowledge that by and large ASCs represent a remarkable success story in American medicine. The incremental improvements in convenience for

the patient are huge. In and of themselves, as I think all the data suggests, when selection is appropriately managed, as it is typically by the physician, safety is quite there.

I think we do have to acknowledge our concerns, appropriate concerns about appropriateness, particularly when it's a physician-owned center and you've got an obvious potential conflict of interest. So I think that's an aside, but again, convenience, safety, in some instances out-of-pocket costs are lower. Physician productivity is higher, and that's not a small or insignificant issue, as well.

So again, remarkable success story.

Yet we constantly, I think, I certainly do here, hospital execs complain about, justifiably perhaps, about ASCs cherry-picking, if you will. It's a value-laden term, but I think we know where they are coming from. And there is, of course, a reality to that, right. The hospitals get the sicker, more complex patients and have a higher cost structure, versus the ASCs serving safer, simpler patients, in ways that are measurable, in ways that are not measurable, and have a lower cost structure.

But I think where we want to keep going with this

is not to hurt the ASC sector in order to level that playing field, but rather to ensure that hospital outpatient departments are appropriately compensated for, again, an older, sicker, more challenging population and a necessarily higher cost structure, because of the complete level of services they have to have immediately available.

So I think we just want to kind of capture that, that our goal is not to artificially level the playing field by penalizing ASCs.

So my suggestions in terms of next bodies of work, I think we absolutely need cost data. As Mike pointed out, and others pointed out, it's not undoable. It's not unnecessarily burdensome to supply cost data, and neither, of course, for us to reasonably opine on recommendations for updates. So I think that's for sure.

I think ongoing work, and there is some underway, about capturing appropriateness measures, again, you know, particularly physician-owned ASCs. There is so much potential conflict of interest. That makes sense.

I think this also points back to the site-neutral work. We've pointed back there several times today. This is one more reason to keep going down that road.

And, as was earlier discussed, I think, although this is going to be a longer-term project, understanding hospitals' cost structures and contribution margins as they differ between outpatient and inpatient will be important long term for us to add the most value we can add about these different sectors.

Thanks again, Dan.

MS. KELLEY: Tamara.

DR. KONETZKA: Thanks. My suggestions are really just sort of emphasizing or reinforcing things that you already mentioned in the chapter, that I think are particularly important, or maybe pushing those a little bit.

One is I do think, especially as the conditions treated in ASCs change over time, I think it's really important to harmonize these quality measures across hospital outpatient departments and ASCs. You know, it speaks to appropriateness, but we really need to be able to compare outcomes across the two settings.

Also, I would suggest we sort of monitor these riskier procedures, even if they are now a small percentage of what's being done in ASCs, but as they start to grow.

So I immediately reacted to the growth in cardiology, still small but growing fast. And, you know, even if there's not sort of the numbers to really put that in a quality measure, I think we should sort of keep looking at those numbers over time, and see, as the number of conditions and as the sort of riskiness of conditions treated in ASCs grows, do we see quality changes or outcome changes on those margins.

And then my third point is that you had a nice description of the literature on the effect of ASCs on hospitals. Some of that literature is kind of old. I think it's really important, and I'd love to see us continue to monitor that. Not that we'd want to not encourage ASCs, if they can do these things more efficiently. But if we, for example, start to see a lot more cardiology procedures performed in ASCs, and cardiology, as we know, is a sort of really profitable area for hospitals, I'd like to just be able to sort of monitor any research that comes out or the numbers that we have on how this seems to be interacting with hospital profitability over time.

And finally, I agree, we need cost data. Thank

you.

DR. CHERNEW: I just want to say one thing in response to that, and I think it's very important, and Greg, maybe you'll jump in, or Robert. Don't assume that ASCs are somehow different from hospitals in an ownership sort of way. So there is a version in which a hospital system could have an ASC and an HOPD, in a bunch of ways. So there's a distinction between, our fee schedules are a reflection of how we paid for things in the past, and there certainly are a lot of independent ASCs. That comes up in the chapters a lot, independent ASCs. But there are also complicated connections between them.

I think the point about the interplay between ASCs and hospitals, and for that matter, physician markets and stuff, is actually quite important. I'll say more about that at the end. I just wanted to say that now because I do think there's some connection.

MR. POULSEN: Since you sort of invited that, I will jump in and say yeah, we have both. And that's why I know for certain that the patients who show up in the ASC, they may end up with the same diagnosis, but the patients do not look the same. And the patients that are, I don't

want to say more complicated because they aren't always, to Paul's point. They don't always look more complicated. But to the clinician who's seen them, they see risk factors that say, you know, I really would feel more comfortable with more backup.

So even though we, as a system that has both, but also for many of these people has insurance responsibilities, we would like to see them in the lowest-cost environment. So in some ways we're agnostic as to where they end up, and they tend to filter based on clinical need in a way that is not simple. It wouldn't be easy to predict in advance.

But there's no question that the patients that we get in the HOPDs are noticeably likely to be more expensive. Forget the cost of the ASC versus the HOPD. The cost to the patient and the needs that they have, the likelihood that something requires an extended period of time in recovery or something else, tends to be different between those two, and I don't know how to solve for that, except to say that they are not the same.

MS. KELLEY: Paul, did you also have something on this?

DR. CASALE: Yeah. A lot of great conversations. Just on point to a couple of things. To your point, Michael, which I agree with, there are a lot of partnerships between hospitals and independent practices. I think there is also a growing partnership between private equity and private practices. I think you need to also be tracking that, as well, as it relates to activity in ASCs versus HOPD.

But my original point was -- and Scott, I think it's an important point about appropriateness -- having worked in cardiology on this a long time, the appropriateness criteria is pretty tricky. It's not hard to, or it's challenging to sort of identify and track. And it's one, it's the appropriateness of the procedure, and then you may have also been alluding to appropriateness of it being in an ASC versus in an HOPD. So I think those are important points, but I think we certainly should try to track that data if we can. But it can be challenging.

MS. KELLEY: Josh.

MR. MASI: Lynn, did you have a comment on this point?

MS. KELLEY: Oh, I'm sorry.

MS. BARR: I was just going to say, my experience with hospitals is that there were a lot of joint ventures with ASCs. So I'm not really sure how we're even defining hospital ownership, because when you do a joint venture with physicians on an ASC, you do not own that ASC. The physicians will do what they wish. So I think that it's complicated and not clear.

MS. KELLEY: Josh.

DR. LIAO: Dan, I'm also one of the newer Commissioners, and I did not know you've been working on ASCs for a while, but now I do, and I appreciate you for it, and the good work that's in this chapter.

I just want to underscore a few things, a few things other Commissioners have mentioned. First, I also think while we want to avoid bargaining where we can, I think cost data is critical, for reasons that Scott and others have described, and I echo some of the things that Greg mentioned earlier, about having kind of symmetry across different sectors and care sites.

The second thing is I also agree with Tamara and others about kind of the more comparative data we can have for ASCs and hospital outpatient departments, the better.

My last comment is really around kind of seeing the emphasis on quality measures, what CMS is doing to increase those measures, some of the directions you've pointed to in the chapter, which I think are good, in particular around the social drivers, recognizing that SDOH 1 and 2, which I think are those two measures that Tamara asked about, are not, to my knowledge, completely used across programs, hospital IQR, and thinking about them in other programs. So I think having that comparison will be good, particularly because of the findings you showed related to kind of the lower likelihood of treating disabled Medicaid-insured and older Americans.

And then the final thing is I was thinking a lot about the kind of procedures you showed in the chapter, eye procedures, spine injections, spine procedures, joint replacement, cardiology, and a lot of those are preference sensitive. So just to add to that idea of appropriateness, I wonder if there is a way to kind of signal or explore the potential for kind of shared decision-making. So again, not particularly why, but I think of analogs like ACO Quality Measure 6, which is like a general shared decision-making.

There is a CTM-3 measure, that is used in BPCI and other programs related to kind of transitions of care, moving between care sites. And then certainly there are early analogs with lung cancer screening around using decision aids particularly. But I think using claims-based appropriateness with some shared decision-making could help, particularly for these procedures we see there. Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, Dan, one thing I always enjoy in your presentation is your sense of humor, because at this time of day it's much appreciated.

Three quick points, one in terms of cost data. I don't know if we've talked about this before, but there are ASCs that are relatively small businesses, right. They're standalone, one physician runs one ASC. That doesn't mean they're poor. But a lot of ASCs, and I don't know if it's the majority now, but some, a very substantial amount, are owned by large corporations, and in some cases PE-backed large corporation. So the idea that it's too burdensome for them to submit cost data is about as ludicrous as it could possibly be. I thought this was what private equity

firms are really good at. But oh gee, we can't do that.

So one possible approach to a recommendation could be, as we have been doing, ask for cost data, but emphasize that for a lot of ASCs, part of organizations that are big, they are not like these tiny, mom-and-pop ASCs, and they should be able to do this in their sleep. They just don't want to do it, for obvious reasons.

I think for standalone ASCs, it could also be required, but maybe there could be some longer time frame before that would happen. I don't think we want to be driving small ASCs out of business with overly burdensome things, but we could give that more consideration and certainly could postpone it somewhat.

Second point about HCC scores, just a minor point. So I think you mentioned that HCC scores have generally looked better or lower, or risk scores have looked lower for ASC patients than HOPD patients, which is fine. But I suspect that to the extent that MA is preferentially referring patients, or preferentially going to ASCs, that would make the risk scores higher, right. So the fact that the HCC scores are generally lower, they would probably be even lower if they were coming out of

traditional Medicare where there is less diagnosis recording.

And the last point, in terms of site neutrality, clearly there's cherry-picking going on, and some of it is financial. So dual eligible are more likely to get sent to the HOPD. That's not surprising. That's the way the whole health system works.

But cherry-picking, clinically, that has kind of a bad sound to it. But actually, in this case I think it's actually a good thing. I think this is a situation in which, for individual patients, I think physicians probably are much better risk adjusters than HCC scores. They can tell pretty well who is more likely to have problems.

And even, as Greg, I think, said earlier, even if you own the ASC, you really, really, really don't want something bad to happen to the patient in the ASC you own. Even if you're not an altruistic physician, there are a lot of reasons not to want that.

So I think the clinical cherry-picking is not necessarily a bad thing. But I've been a very strong proponent of site-neutral payments, but I think to the extent that it is the case that more complicated people,

for whatever reason, are more likely to wind up in HOPDs, that needs to be taken into account, I think. So just to say if ASC rates are lower, payment rates are lower than the HOPD payment rates for colonoscopies, that's how HOPDs should be paid, that might be too radical. On the other hand, I wouldn't throw up my hands and say, "Oh God, this is an unsolvable problem. We can't do site-neutral." I think there's got to be a not-very-difficult way. It would be approximate, there's no way for it to precise, to give a bit more margin or a bit higher payments to HOPDs, assuming that they're higher risk patients, even though it probably can't be precisely measured.

But that difficulty, I think, should not be permitted to stand in the way of moving towards site-neutral payments.

MS. KELLEY: Stacie.

DR. DUSETZINA: Great. Thanks. To Larry's point just then about thinking about the differences in patient-seeking services, not to suggest our Medicare safety-net index would fix everything, but that would be another good example where having those dollars flow to the places taking care of low-income beneficiaries would potentially

help out with some of the challenges.

Dan, this is fantastic work. I especially appreciated the quality measures section, and was thinking, when looking at Table 10.8, the measures that are currently available, how incomplete they are, not all that helpful for most people and most of the services, or even most of the centers, when you think about the single services that they're providing. Like having a patient burn or fall might not be quite as reasonable if you're thinking about a bunch of cataracts, things like that.

So I really appreciated the idea of these additional measures and the suggestions that were made, and I think things like the more global measures, where you can compare across sites of care are really important, and I do hope that they eventually get adopted, especially noting the pieces you picked out around infections and then the guideline-related outcomes measures for specific types of procedures. I think those are just really mission critical, and without them it feels like we don't have a really good handle on quality, or even comparative quality, on measures that actually measure to patients seeking these services.

Excellent chapter. I really appreciate it.

MS. KELLEY: I have a comment from Betty, who says that this is nice work, and she really appreciates it. She strongly supports the comments on cost data collection and also quality outcome reporting. Beneficiaries can't easily discern this information. Why isn't such reporting a condition of participation? If you want to be reimbursed by Medicare, you need to play by the rules applied throughout the rest of the U.S. health system.

I think that is the end of Round 2. Oh, I'm sorry, Cheryl, please go right ahead.

DR. DAMBERG: Sure. I just wanted to add to what Stacie just said around the quality measures. You had noted appropriateness measures. So those are guidelines concordant. But I think it would be nice to do some signaling to CMS to kind of expand the development of appropriateness measures, criteria, around a lot of these different procedures, to get at whether this is high-value or low-value care.

DR. CHERNEW: Okay. I'm going to make one comment, and then I think we'll go to Kenny to wrap up the vote.

So a few things. This has been a great conversation. Dan, it's terrific work, so I very much appreciate it. My general take on this is as follows. The first part is we don't want to ossify the delivery system because of the idiosyncrasies in our fee schedule. We need to allow there to be some version of innovation when you can do things safely in other places. I think that's one type of innovation that really is both important and is a good aspect of the health care system.

On the other hand, we certainly worry about if bad quality is being delivered in those places. There were some comments about that. And to Tamara's point, which I think is spot on, there are connections between these systems. So you could destabilize, what works in a particular case, could destabilize whole other parts of the system, based on how we set the payments up for other parts of the system.

So there are a few sort of broad problems. One of them is setting the payment for ASCs is hard because, as Greg pointed out, the case mix stuff is just really, really, really challenging. And we struggled with that when we did aspects of our site-neutral work, in a whole

range of ways, and I think we will continue to struggle with that aspect of the case mix thing.

The case mix thing also makes site-neutral type payments also, generally speaking, hard. If you thought that the sorting was really just reflecting different cases, the notion that it's a common service and your site-neutraling payment for the same thing doesn't apply. And we have struggled with how to do that, in a range of ways. Which is why, when we try and address those types of issues, we would do that in a broader, more holistic view, and that's even before talking about the role the physician fee schedule plays, acknowledging the heterogeneity amongst ASCs.

There is going to be a bunch of academic research in this area, that I think several of you pointed out. We should continue to follow it, and you know that I'm going to say this -- yay. We do try and rely heavily on the academic work to understand what's going on. There's other, what you would call statistical identification strategies to sort through, like what's happening at market levels, when these types of things are entering in. So we will continue to do that.

So ASCs, I think in some ways, are the tip of the spear of a range of other types of services that are moving into new settings, freestanding infusion centers, to name one. I think technology, which is amazing, has enabled us to do things safely in nontraditional settings. But the dynamics of how we think about that are really challenging the way that we've set up our fee schedules and what we can do and what we can observe.

And I will just say, editorially, it's one reason why I've been a big proponent of population-based payment models, where you allow organizations to do all of this sorting without trying to figure out exactly who should be where, or measuring the exact quality of specific things. Because the other problem with quality measures is you might then cherry-pick who -- I won't say cherry-pick -- the sorting might reflect where the risks are in ways that may or may not be appropriate.

So I think we do want to have some level of flexibility in the system, but right now we are having a discussion, as we always do in January, that could end up being, by the way, the fee schedules go.

So we will save these broader conversations for

what I will say broader discussions that will be prioritized with a whole bunch of other potential broader discussions that we would have.

So with that said, as a matter of sort of housekeeping, Kenny, you had to step out when we were doing our vote on the inpatient psych stuff. So I think Dana is going to say your name, and then you get to vote.

MS. KELLEY: Okay. So voting on the recommendation that reads:

The Congress should eliminate both the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities, and the reduction of the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding inpatient psychiatric facility, on and in the 150 days prior to their date of Medicare entitlement.

Voting yes or no, Kenny?

MR. KAN: Yes.

MS. KELLEY: Thank you.

DR. CHERNEW: And now we feel like things are clean. We've got all of our boxes checked. And there's

nothing like having all of your boxes checked before you go to dinner.

So we are now going to -- sorry, I was having a heart attack.

DR. NAVATHE: He did say yes.

DR. CHERNEW: Yes, as did everybody. We are going to now adjourn, but first, for those of you at home that want to chime in, please let us know your thoughts. You can do it at meetingcomments@medpac.gov, or otherwise reach out to us and give us your feedback. We do appreciate it.

So again, we are adjourned, and we will be coming back tomorrow morning, 8:30, starting with Medicare Advantage. So there we go. Thank you all.

[Whereupon, at 4:23 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, January 17, 2025.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 17, 2025
8:30 a.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
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P R O C E E D I N G S

[8:30 a.m.]

DR. CHERNEW: Hello, everybody, and welcome to our Friday morning MedPAC session. We have two really important chapters, and we're going to start with a really, truly outstanding voluminous body of work that we've been doing for a long time on Medicare Advantage.

And so for the status report presentation, I think we're starting with Stuart.

MR. HAMMOND: Good morning. This presentation provides an update on the status of the Medicare Advantage program. The audience can download a PDF version of these slides in the handout section of the control panel on the right side of the screen.

In today's presentation I will present our analysis of the latest data on MA enrollment, plan availability, and MA supplemental benefits. I'll also present an overview of the structure of the MA market and discuss our ongoing concerns regarding the MA quality bonus program. Andy will then introduce MA plan payment policy and provide an update on the trends and variation in MA risk coding intensity, and Luis will provide an update on

favorable selection in MA and will present our comparison of MA and fee-for-service spending, which includes the effects of both favorable selection and coding intensity.

As you all know, the Commission is required by law to make payment update recommendations for providers paid under Medicare's traditional fee-for-service payment systems. The law also requires the Commission to report on the status of the MA program, including a review of MA payment policies, risk adjustment methods, the impact of risk selection, mechanisms for promoting quality and access to care, and other issues.

This year's report is informational only and does not include any new recommendations.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional fee-for-service Medicare program. For beneficiaries, the primary tradeoff between MA and fee-for-service is access to the supplemental benefits MA plans provide versus a broader choice of providers and fewer constraints on utilization in fee-for-service.

The Commission strongly supports the inclusion of private plans in the Medicare program. Beneficiaries

should be able to choose among Medicare coverage options since some may prefer to avoid the constraints of provider networks and utilization management by enrolling in the traditional fee-for-service program, while others may prefer features of MA like reduced premiums and cost-sharing liability.

In addition, the Commission has expressed concern about the fee-for-service benefit design and has made recommendations to give beneficiaries better protection against high out-of-pocket spending and to create incentives for beneficiaries to make better decisions about the use of discretionary care. Because Medicare pays private plans a partially predetermined rate that is risk adjusted for each enrollee rather than a per-service rate, plans should have greater incentives than fee-for-service providers to deliver more efficient care. However, the Commission has also recommended important reforms to improve Medicare's policies for paying and overseeing MA plans.

Medicare beneficiaries enrolled in both Parts A and B have the choice of enrolling in an MA plan or in fee-for-service Medicare. As of 2023, the majority of eligible

beneficiaries are now enrolled in an MA plan.

In 2024, 54 percent of eligible Medicare beneficiaries were in MA, a substantial and growing difference from the 26 percent enrolled in MA in 2010. The Affordable Care Act of 2010 established changes to MA payment rates, essentially phasing in a reduction of payment rates by 10 percentage points between 2011 and 2017. Despite some initial projections that the decrease in MA payment rates would result in enrollment declines, MA enrollment has continued to grow rapidly.

In 2024, MA enrollment grew by 6 percent to 33.6 million enrollees. The proliferation of MA enrollees has coincided with an increase in the number of plans bidding.

MA enrollment is nationally concentrated in a small number of large for-profit insurers that compete in most markets across the country. High enrollment concentration, particularly at the local level, can be a cause for concern if it dampens the competitive pressures that might otherwise drive insurers to maintain or improve quality, make care delivery more efficient, lower premiums, or provide supplemental benefits.

This figure shows the concentration of MA

enrollment at both the national and local levels. On the left, we show the share of MA enrollees enrolled in the three largest insurers nationally. In 2024, three insurers -- UnitedHealth, Humana, and CVS Health -- enrolled 57 percent of all MA enrollees. These are shown in the top three segments of the left-hand column.

The green segment shows that the remaining 43 percent of enrollment is shared among all of the other MAOs.

On the right, we show local enrollment. The top three segments of the column show the average enrollment shares of the three largest insurers in a typical county, regardless of whether the insurer is one of the three largest national organizations. The three largest insurers in a county typically enroll over 80 percent of MA enrollees in the county.

In addition to being highly concentrated, the MA market is also becoming increasingly vertically integrated, with plans and providers frequently owned by the same organization. However, there is a large amount of heterogeneity across the industry. This figure shows the percent of plan expenses that MA organizations expect their

members to receive from an entity owned or controlled by the same parent organization.

The left-most cluster of bars shows the level of vertical integration for the five largest non-provider-owned organizations for 2022 through 2025.

The middle cluster of bars describes provider-owned organizations, and the right-most cluster describes all other organizations.

We find that vertical integration is generally highest in provider-owned plans. However, vertical integration of large national organizations has increased since 2022. The integration of other organizations, shown on the right, appears to have been comparatively low and relatively stable since 2022.

Medicare beneficiaries have a large number of plans from which to choose, and MA plans are available to almost all beneficiaries. For 2025, nearly 100 percent of Medicare beneficiaries have at least one plan available in their county. Ninety-nine percent have access to a zero premium option that includes the Part D drug benefit.

Special needs plans for beneficiaries who are dually eligible for Medicare and Medicaid, also known as D-

SNPs, are also widely available. Ninety-five percent of beneficiaries live in a county with at least one D-SNP available.

The average Medicare beneficiary can choose from 42 plans sponsored by eight organizations in 2025, similar to the numbers available in 2024. The total number of plans available increased relative to 2024.

Most MA plans have funding through a plan rebate to provide supplemental benefits to their enrollees in addition to the required Part A and B benefits. The level of rebates, currently at 17 percent of total payments, reflect the difference between plan bids and the benchmarks used to determine MA payments. This figure shows that the average rebates will reach an all-time high of $211 per member per month in 2025, as shown in the orange solid line.

However, the trend in rebates differs for special needs plans, shown in the darker dashed line, and conventional plans, shown in the gray dotted line. The average rebate for conventional plans declined slightly in 2025 to $188 per member per month. For special needs plans, rebates have continued to climb in recent years,

reaching a record high of $267 per member per month in 2025.

MA plans report in their bids a projection of how they anticipate using the rebates they receive from Medicare. Plans project using the largest share of rebate dollars to reduce cost sharing for Part A and Part B services. However, the share allocated to non-Medicare-covered services, such as gym memberships and discounts on dental services, has grown in recent years. Coverage for these supplemental benefits varies widely by plan, and we do not have reliable data on enrollees' use of the benefits, making it unclear whether the benefits are providing good value to the enrollees and to the taxpayers who fund the Medicare program.

Quality in MA is incentivized and evaluated through the Quality Bonus Program, or QBP. The Commission has, for several years, concluded that MA quality cannot be meaningfully assessed through the current QBP, which does not promote the use of high-value care and should not be used as the basis for distributing bonus payments.

In our June 2020 report, the Commission recommended replacing the Quality Bonus Program with a

value incentive program that would address several of the QBP's flaws, which include assessing quality for large contracts with geographically dispersed enrollment, using too many measures, and not providing beneficiaries information about plan quality in their local market. Fixing the QBP is important because it accounts for at least $15 billion in annual bonus payments paid to MA plans. We will continue to monitor quality indicators in MA and evaluate alternatives to the current system.

I'll now turn things over to Andy.

DR. JOHNSON: Thanks, Stuart.

I'll now briefly go over the MA payment system. Payments to MA plans are the product of a plan's base rate and the average risk score for plan enrollees. The base rate is determined by comparing a plan's bid and benchmark. MA plans submit bids each year for the amount they think it will cost them to provide Part A and B benefits.

Benchmarks are the maximum amount Medicare will spend in a county. Counties are divided into quartiles, and benchmarks are calculated as the fee-for-service spending in the county multiplied by the quartile percentage, which ranges from 115 to 95 percent.

A plan's benchmark can be increased by quality bonuses of 5 percent or 10 percent in some counties for plans achieving a rating of four or more stars. Nearly all plans bid below their benchmark, and so plans are paid a base rate equal to their bid, plus a rebate, which is calculated as a percentage of the difference between the bid and the benchmark.

Demographic characteristics and diagnoses are used to calculate a risk score for each beneficiary. Risk scores are an index of predicted spending relative to national average spending, which is assigned a risk score of 1.0. Risk scores increase MA plan's base payment rates for enrollees expected to have higher than average spending and decrease rates for enrollees expected to have lower spending.

Also, risk scores are used to standardize the fee-for-service spending estimates that are the basis for their benchmarks so that spending estimates for each county reflect spending for a beneficiary of average risk.

The risk adjustment model is developed using fee-for-service beneficiary data, so risk scores reflect fee-for-service diagnostic coding patterns and spending that

would occur in fee-for-service Medicare.

Two phenomena distort spending predictions when MA tendencies differ from fee-for-service. First, coding intensity results from MA diagnostic coding patterns that differ from fee-for-service, and second, selection results from MA enrollees having spending tendencies that differ from the average fee-for-service beneficiary independent of the effects of coding intensity.

Each year, the Commission compares spending on MA to what Medicare would have spent if MA enrollees were instead enrolled in fee-for-service. This comparison accounts for differences in health status, including the effects of favorable selection, and differences in diagnostic coding, geographic distribution, and Medicare service coverage between the two programs.

We compare MA and fee-for-service spending in three steps. First is a base comparison incorporating the effects of payment policies other than risk adjustment. Then we add the effects of differences in MA and fee-for-service coding intensity and a favorable selection of Medicare beneficiaries into MA.

We will describe the effects of each of these

over the next several slides, and Luis will summarize our overall estimate of MA and fee-for-service spending at the end of the presentation.

First, the base comparison of MA and fee-for-service spending captures aspects of MA payment policy other than risk adjustment, such as changes in the accuracy of the fee-for-service spending projections that are the basis for benchmarks, the distribution of MA enrollment across county benchmark quartiles, and changes in the share of enrollment in plans receiving a quality bonus. This base comparison uses MA payments and local fee-for-service spending data that has been adjusted to have the same risk score profile as MA enrollees.

For years when historical data are available, we use actual payment data, including non-claims fee-for-service spending, as well as risk scores and enrollment data for MA and fee-for-service beneficiaries with both Part A and B.

For years when these data are not available, we use spending estimates from MA bid data and CMS's projection of local area risk standardized fee-for-service spending.

These two methods produce very similar estimates of MA and fee-for-service spending within 1 percentage point of one another for all years we analyzed, except for two years that were affected by the pandemic.

For most of the past several years, this base comparison has found that MA payments are similar to fee-for-service spending before accounting for the effects of coding intensity and favorable selection.

Next, we turn to coding intensity. MA plans have a financial incentive to document more diagnoses than providers in fee-for-service Medicare, leading to larger MA risk scores and greater Medicare spending when a beneficiary enrolls in MA.

MedPAC uses the demographic estimate of coding intensity method modified to account for differences in Medicaid eligibility and institutional status. More details on this method are included in the technical appendix and Chapter 13 of our March 2024 report.

We have data available to estimate coding intensity through 2023, and we project coding intensity estimates for 2024 and 2025. We base these projections on the most recent five-year trend and an updated estimate of

the effect of the V28 risk model. We now estimate that coding intensity is 8 percentage points lower under the V28 model than under the prior model. This estimate is based on data prior to the implementation of V28 and therefore does not reflect plans efforts to optimize coding for the V28 model. We now estimate for our projections, we apply a V28 impact estimate that reflects the phase-in of the model, one-third in 2024 and two-thirds in 2025, and accounts for the offsetting effects of planned behavior and higher expected coding trend under V28.

For 2025, MA risk scores are projected to be about 16 percent higher than they would be if MA enrollees were instead in fee-for-service Medicare.

In this figure, the number of the top of each bar show our coding intensity estimates for each year. The Secretary is mandated by law to reduce MA risk scores to account for coding differences, but this adjustment, shown in dark blue, does not account for the full impact. After accounting for CMS's coding adjustment, remaining coding indifferences, shown in orange, generate higher payments to MA plans. For 2025, net of the coding adjustment, we project that MA risk scores to be about 10 percent higher

and payments to be $40 billion more due to MA coding intensity.

New risk model versions have reduced coding indifferences in the past, and we account for the impact of the V28 risk model in our 2024 and 2025 projections.

The main point demonstrated by this figure is that MA coding intensity remains large and continues to generate higher payments to MA plans.

We also remain concerned about the uniform coding adjustment, given the variation in coding intensity across MA organizations. Each bar in this figure shows one MA organization's coding intensity relative to fee-for-service for 2023. The coding adjustment, reducing MA risk scores by 5 percent, generates payment differences by penalizing MA organizations left of the vertical line and by failing to prevent the higher payments to organizations right of the higher vertical line.

Higher coding-intensity organizations have a competitive advantage. They receive larger payments than other organizations for enrolling the same beneficiaries. Because of these higher payments, they can offer more supplemental benefits and attract new enrollees simply

because of their coding efforts.

Note that the penalized organizations tend to be smaller, representing 15 percent of all MA enrollees, while the higher paid organizations tend to be larger, enrolling 85 percent of all MA enrollees. Even among the 10 largest MA organizations, shown here by the dark blue bars, there is a 26 percentage point range in coding intensity.

We also assess the share of coding intensity that is driven by health risk assessments or chart reviews. Health risk assessments often document conditions that are not reported on a physician or hospital encounter and can rely on patients' self-reporting of medical conditions.

Chart reviews allow plans to submit additional diagnoses based on a secondary review of a patient's medical record.

In fee-for-service Medicare, chart reviews are not used at all, and health risk assessments are provided less often than in MA and only through an annual wellness visit.

The figure shows payment years, reflecting diagnoses submitted from services in the prior year. We identified coding intensity associated with health risk

assessment or a chart review when there was no physician or hospital service documenting the same diagnosis during the calendar year.

Overall, health risk assessments and chart reviews accounted for roughly half of all coding intensity between 2020 and 2023.

Several studies have used a variety of sources and methods to estimate the effects of coding intensity, and the results generally align with MedPAC's coding intensity estimates and growth rates.

One study found that controlling for differences in health status using Part D prescription data, MA risk scores increased about 1 percent per year faster than fee-for-service risk scores.

A second study from the CBO applied a difference-in-difference approach to risk score data and found that risk scores for MA stayers grew 1.2 percent faster than fee-for-service.

A third study using county-level data found MA coding intensity was at least 6 percent through 2011, compared to MedPAC's estimate of 5 percent for that year.

Fourth, the GAO used a risk score prediction

model to estimate coding intensity of between 4 and 6 percent for 2010 through 2012, which matches MedPAC's estimates for those years.

More recently, two studies assessing the health risk assessments and one assessing chart reviews found estimates of the impact on MA coding intensity that are consistent with MedPAC's results.

Finally, one study implemented MedPAC's method of estimating coding intensity and found similar coding-intensity estimates and rates of growth for 2015 through 2020 and similar impacts of health risk assessments and chart reviews.

We continue to investigate why MA and fee-for-service coding practices differ, and one factor is likely due to the different incentives for coding diagnoses in MA and fee-for-service. Although it is not possible to attribute a specific share of coding intensity to differing incentives, we tried to assess the role of differing incentives by looking at follow-up rates of coding for chronic conditions in MA and fee-for-service Medicare.

Follow-up coding rates are defined as the share of beneficiaries coded with a condition in 2022 who are

then coded with the same condition or a related higher severity condition in 2023.

For chronic conditions with differing MA and fee-for-service follow-up rates, we considered the influence of relative MA and fee-for-service coding intensity, the severity of the condition among related conditions, and the prevalence of the condition overall.

We think this measure is the best available way to assess the impact of differing incentives because it somewhat limits the effects of discretionary or fraudulent coding.

The House Committee on Appropriations requested that the Commission report on differential coding in MA and fee-for-service and the effects that differing MA and fee-for-service incentives have on relative rates of diagnostic coding and on payment.

We found that follow-up coding rates were somewhat lower for fee-for-service beneficiaries for most but not all of the 52 chronic conditions we identified.

Twelve chronic conditions had rates that were more than 5 percentage points higher in MA and two chronic conditions head rates that were more than 5 percentage

points higher in fee-for-service. Our analysis suggests that while diagnoses are coded incompletely in both programs, incomplete coding may be somewhat more common in fee-for-service.

We caution that neither MA nor fee-for-service coding practices are likely to produce accurate diagnostic coding, given that we found incomplete diagnostic coding in both programs and because clinical discretion may be influenced by incentives to code more thoroughly.

Finally, we note that because the risk model is calibrated on fee-for-service spending and diagnoses, higher MA coding intensity for any reason increases payments to MA plans. Again, we project overall coding intensity will raise payments to plans by $40 billion in 2025.

In 2016, the Commission recommended policies to address both the higher payments and the competitive advantage for some organizations due to higher coding. The Commission's strategy first focuses on addressing the underlying causes of coding intensity by removing health risk assessments and by using two years of data to improve diagnostic documentation and then would apply an adjustment

to account for any remaining coding intensity.

We have found that chart reviews are another underlying cause of higher MA coding intensity. MA organizations use health risk assessments and chart reviews to varying degrees, which contributes to the variation in coding intensity across organizations. Eliminating these underlying causes is a necessary component of fully addressing the effects of MA coding intensity on payments and plan competition.

Now I'll turn it over to Luis.

MR. SERNA: Prior to the effects of coding intensity that Andy mentioned, risk scores for MA enrollees can overpredict their spending relative to what would have occurred in fee-for-service. Every beneficiary has a risk score that predicts what their spending will be in the next year based on demographics and diagnoses.

Risk models, which are calibrated using the fee-for-service population, are imperfect; there is a distribution of actual spending for individuals with each risk score. Some beneficiaries have lower than expected spending while others have higher than expected spending. Favorable selection can occur if beneficiaries with lower-

than-expected spending on average choose MA over fee-for-service.

The effects of favorable selection are absent any intervention from plans. Favorable selection occurs if risk-standardized MA spending would have been lower than the local fee-for-service average. This means that risk scores would overpredict MA spending and lead to higher payments.

MA plans may influence favorable selection through features that are not prevalent in fee-for-service, such as preferred networks and prior authorization. In contrast to comprehensive Medigap coverage, MA plans also have an incentive to require at least some cost sharing for many services to avoid unnecessary care.

Beneficiaries may respond to these plan tools by self-selecting into or out of MA. Perceptions of limited networks and prior authorization may influence their choice of coverage. In addition, beneficiaries who expect to seek more care may prefer fee-for-service in combination with comprehensive Medigap coverage. On the other hand, those who seek less care and extra benefits may prefer MA.

To the extent selection occurs, it allows plans

to bid lower than fee-for-service spending before producing any efficiencies in care delivery. This creates both higher payments for plans and introduces bias in the comparison of risk-standardized spending between MA and fee-for-service enrollees.

We emphasize that selection is separate from coding, and the two effects are additive.

In March 2024, MedPAC estimated that favorable selection alone led to substantially higher payments than fee-for-service annually. MedPAC has examined the effects of favorable selection in multiple years, and we continue to refine our estimates. We updated our method this cycle to use a broader fee-for-service population to estimate changes in selection during MA enrollment. This change allows us to better account for the effect of selection for decedents and account for differences in mortality rates between MA and fee-for-service. More information can be found in the technical appendix in your mailing materials.

Now, we show our estimated selection effect annually from 2016 to 2022, which accounts for both enrollment attrition and mean reversion over time.

Overall, we estimate that the effect of selection

increased from 2016 to 2020, but decreased from 2020 to 2022 remaining above 10 percent after 2017. In 2017, selection resulted in spending for the fee-for-service population being 12.2 percent higher than MA spending, and the effect of selection was 10.1 percent in 2022. Given various changes in CMS's HCC model over this time and the effects of the pandemic, it is unclear whether the effects of favorable selection will increase or decrease in future years.

To better understand favorable selection by beneficiary characteristics, we now present analyses using a simple version of our favorable selection method that compares the fee-for-service spending of beneficiaries who switched from fee-for-service to MA in 2022, or "recent switchers," with the risk-adjusted spending of beneficiaries who remained in fee-for-service, or "fee-for-service stayers." We refer to this pre-MA entry spending relative to fee-for-service as a selection percentage, where a selection percentage below 100 indicates favorable selection.

Here, we examined whether the level of risk score that beneficiaries had before entering MA, and whether that

influenced the level of favorable selection in 2022. Each bar represents a set of beneficiaries based on their risk score in the year prior to enrolling in MA. In 2022, MA entrants had higher levels of favorable selection as their risk scores increased. For example, beneficiaries in the three highest categories of risk scores, shown by the bottom three bars in the figure, had the lowest selection percentages, 85 percent and below, meaning the highest levels of favorable selection. This corresponds with beneficiaries with a high severity of chronic illness having the highest average levels of pre-entry favorable selection. This suggests that if MA plans continue to enroll populations with higher levels of chronic illness, favorable selection can occur, even among those beneficiaries.

Next, we look at whether the level of MA penetration influenced the level of favorable selection in 2022. While some observers have posited that favorable selection will decrease as the share of Medicare beneficiaries enrolling in MA continues to increase, we found very little difference in selection between markets with low MA penetration and markets with high MA

penetration.

In 2022, MA entrants in markets with penetration of at least 70 percent had a pre-entry selection percentage of 89 percent, the same selection percentage as markets with MA penetration of less than 20 percent. Thus, we do not find evidence that increasing MA penetration will directly affect future levels of MA favorable selection.

Our estimates of favorable selection are consistent with a substantial body of research that suggests risk scores, on average, overpredict spending for the MA population. While the methods and sample populations of these studies widely differ, estimates of favorable selection range between 7 and 16 percent. Again, this is before any coding differences occur between fee-for-service and MA.

Some studies have found evidence of favorable selection using indirect measures, such as mortality and Part D event data. One 2023 study found that new MA enrollees were disproportionately higher in counties where CMS overpredicted risk-standardized fee-for-service spending.

Other studies have examined more directly using

the risk scores and spending in the year before beneficiaries switch from fee-for-service to MA. This approach is appealing given that an increasing share of MA enrollees were once in fee-for-service. Using this method, one recent white paper by Lieberman and colleagues estimated selection equivalent to 14.4 percent of MA revenue in 2023.

A recent white paper by Teigland and colleagues examined a sample of beneficiaries prior to Medicare enrollment at age 65 and calculated pre-entry spending and HCC risk scores for MA and fee-for-service enrollees. This indicated that MA enrollee risk-standardized spending was 12 percent lower than fee-for-service prior to Medicare enrollment.

In addition, one study by Fuglesten-Biniek and colleagues found substantial favorable selection for MA plans when beneficiaries disenroll from MA and switch into Medicare fee-for-service.

Now we turn to our overall estimates of MA bids, benchmarks, and payments relative to what fee-for-service spending would have been for MA enrollees. We include uncorrected coding and favorable selection into our

analysis so that the MA and fee-for-service populations are comparable. With these adjustments, we project that benchmarks in 2025 are 130 percent of fee-for-service spending.

Plan bids in 2025 are an estimated 100 percent of fee-for-service spending.

Overall, we estimate that coding and selection cause MA payments to be 20 percent above fee-for-service spending in 2025.

We estimated MA payments relative to what fee-for-service spending would have been for MA enrollees over a longer period, from 2016 through 2025. Here, we show MA payments as a percentage above or below fee-for-service spending.

Prior to the effect of selection and coding, the dark blue bars show that MA payments were generally similar to fee-for-service spending since 2017, when ACA benchmarks were fully phased in. During the pandemic in 2020 and 2021, there was some divergence due to prospective payments being less accurate.

The orange bars show the estimated effect of favorable selection, which contributed to MA payments being

at least 8 percent above fee-for-service spending since 2016. The grey bars show the estimated effect of coding, which increased from 2016 to 2022 before leveling off in 2023. The sum of all three effects is shown at the top of the stacked bars.

We estimate MA payments were at least 13 percent more than fee-for-service spending for comparable beneficiaries in each year.

We estimate that MA payments are at least 20 percent above fee-for-service spending from 2022 through 2025. Given the increasing share of Medicare beneficiaries enrolled in MA, these differences translate to a substantial amount of MA payments above fee-for-service spending in dollar terms.

Here, the percentages above or below fee-for-service spending are converted to dollars. Since 2016, we estimate that MA plans will have been paid $527 billion above fee-for-service spending. These payments above fee-for-service spending are driven by favorable selection and coding intensity, which we estimate accounted for the largest share of payments above fee-for-service spending.

For the next steps, we will answer your questions

on the topics presented today. We plan to publish this material in the March MA status chapter. As we mentioned earlier, we also plan to publish a technical appendix to the March chapter, covering our methods for estimating the effects of MA coding intensity and favorable selection.

Now, we'll turn it back to Mike.

DR. CHERNEW: Wow. So a few general things before we go around. The first one is I really want to compliment you on the extent to which you benchmarked the analysis you have done with what's in the academic literature and a bunch of other work. I think that's too broadly for what we do, but I think it is, in this area, important to understand that there has been a range of work in this area by a lot of people, and you have spent an extensive time benchmarking. I think that's important.

The second thing I want to compliment you on, before we go to questions, is there have been a lot of issues about whether sicker or healthier people can have adverse selection effects, for example, and I think the analysis by risk score and the analysis by MA penetration is, I think, particularly useful in addressing some of the debate around this issue, so I appreciate that.

That's going to be the end of my compliments because of time, and I think we should start by going around with Round 1, and if I have this right, Kenny, I think he got in the queue last night. Kenny.

MR. KAN: Thanks, Mike. I have two Round 1 questions. On page 4, if we can go to that slide page please, there is a reference to give beneficiaries better protection against high out-of-pocket spending to be comparable with MA's required maximum out-of-pocket benefit. As a January 2024 study by Wakely Consulting estimated this to be worth 2.8 percent, likely resulting in negative selection for MA plans.

So on page 31, where you show a 20 percent additional payment differential, help me understand, how is that reflected in the math, and if not, should we, as I believe that most actuaries would?

MR. SERNA: So our comparison is the comparison of payments. We don't try to compare hypotheticals such as what a hypothetical maximum out-of-pocket would be in fee-for-service. That would be a different measurement, an important measurement, but something where there is a limit due to data availability.

One thing is we would have to understand the right Medigap data. We'd have to understand beneficiary-level liability. We'd have to understand beneficiary liability also on the MA side, for services that were out-of-network or that were denied, and try to compare what each program pays for, and that gets to be challenging, partially because of the hospice benefit, as well. So for hospice enrollees, obviously Medicare fee-for-service takes over the A and B liability, in that sense. Even if an enrollee is still enrolled in MA, they obviously receive the supplemental benefits.

So there are a lot of challenges around that. But for our purposes we are comparing program spending in MA and fee-for-service.

DR. CHERNEW: Can I just add one other thing? The benefits in MA and TM are different. The out-of-pocket max is one of many ways in which they're different. The selection estimate itself isn't saying anything about the generosity of benefits. It's just talking about what would have been spent if these people were in TM. And so I understand that there's an out-of-pocket max difference. There are a lot of differences. But the core math is about

what would have been spent in TM, and that question is not affected by the generosity of MA benefits. It might be affected by who is in MA. That could be true, which could affect selection. What we are estimating is who is actually in MA, given all the MA differences.

So we're not making a comment on value. We're just making a comment on spending.

MR. KAN: I appreciate the comment, Mike, but if I am a new MA entrant, that's what I want to know. I know I have a cap. Maybe that's me. But what I'm understanding you say, Luis, is that due to data complexity it is not adjusted in the estimates. Is that fair?

MR. SERNA: It wouldn't be adjusted in the estimates. Again, what Mike said. The estimate is an estimate of what program spending would have been had MA enrollees been in fee-for-service.

I think what you're talking about is beneficiary liability, and I think that's an important measure, but that's something that we haven't looked into. That's something that has its challenges, for the reasons I stated.

MR. KAN: Okay. Let's move on to question 2, in

the interest of time. On Slide 31, and page 3 of the detailed chapter's Executive Summary, we reference a 20 percent payment differential. Can we please include a statement of the following: This 20 percent estimate should not be mistaken for an estimate of plan profits, because a portion of the additional payments are used to provide supplemental benefits and better financial protection for MA enrollees to cover plans' administrative expenses.

Per a Milliman 2020 study, we know that MA has a high proportion of racial and ethnic minorities than fee-for-service. MA enrollees are more likely to be Black and Hispanics. MA enrollees are disproportionately lower income and will enroll in Medicaid. MedPAC has also performed several analyses that the rate of diabetes is a much higher prevalence among lower-income and ethnic minorities, possibly 50 to 100 percent higher.

For me, has the industry lost money last year, per a PwC report that I circulated to MedPAC staff, I believe this is helpful for an uninformed reader, as any draconian MA cuts, as inferred by the 20 percent payment differential, would fall on the backs of disproportionately

lower-income, racial, and ethnic minorities.

That's all I have for Round 1.

MR. MASI: And thank you very much for surfacing this, Kenny, and we appreciate the feedback. And in a couple of places we have tried to be clear about the enhanced financial protections and the value that you talk about, like on Slide 10 where Stuart talked through the reduced cost sharing, the reduced premiums, and the additional non-Medicare-covered benefits that plans offer and the importance of that. And we can take another look at the chapter to make sure that those data points are reflected.

MR. KAN: Thanks, Paul.

MR. MASI: Andy, I think you wanted to get in here, too.

DR. JOHNSON: I think page 31 of the mailing materials has a statement to that effect, Kenny. So if there's something specific we can add to that, I think that would be helpful.

MR. KAN: [Inaudible.]

MR. MASI: Thanks.

MS. KELLEY: Brian.

DR. MILLER: Thank you. A couple of quick questions. One, do you know what the -- I was nerding out, reading rate notices, I admit, last night -- do you know what the R-squared for the CMS 2024 HCC risk adjustment model is compared to the 2020 model?

DR. JOHNSON: It varies by segment for V28 between about 11 percentage points and 19 percentage points of the claims variation, which is, I think, for each segment a little bit higher than the 2020 model.

DR. MILLER: Thank you. In 2016, the Obama administration Department of Justice Antitrust Division sued to block the Aetna-Humana merger, successfully, which was very exciting for those of us who follow antitrust merger cases. Do you know, or are you aware, of how the winning DOJ team defined the geographic market for Medicare Advantage when defining market share in addressing consolidation and competition concerns?

DR. JOHNSON: I don't think we're aware of how the DOJ characterized that.

DR. MILLER: So the DOJ defined, and they won the case and the judge agreed and blocked this large plan merger, that Medicare Advantage's best market concentration

and consolidation concerns are best measured at the county level, and our work does not reflect that, so I think we should probably update that to be technically correct.

Two other quick questions. You had mentioned, Luis, that benes who seek less care would likely -- I'm sorry, that benes who seek more care would likely elect fee-for-service instead of MA, due to comprehensive Medigap, a lack of network restrictions and utilization review. My question is, do you think that end-stage renal disease benes seek more or less care than other beneficiaries?

MR. SERNA: So that's a different population, and they are paid on a separate rate basis, and they have a separate model. But it is true that they would have a separate set of incentives, and they may even expect to hit the maximum out-of-pocket. So that definitely is a separate population.

DR. MILLER: So you think that they will seek more or less care than other beneficiaries? Less care or more care? It was unclear from your answer.

MR. MASI: I think this is something -- good question -- I think this is something we haven't been able

to do the analysis of yet, but no question this is important.

DR. MILLER: Yeah, this is -- the ESRD population versus other populations.

DR. CASALINO: If I may interject, the question should be less care or more care compared to their risk scores.

MR. MASI: That's correct.

DR. CASALINO: [Inaudible.]

DR. MILLER: No. Larry, I would like to ask my question, if you don't mind.

DR. CASALINO: Go right ahead.

DR. MILLER: Do you think that they seek more or less care than other beneficiary populations in Medicare?

MR. SERNA: So as we stated, this is relative to the risk score. I was trying to say they have a separate risk model. So for the ESRD population --

DR. MILLER: Right, but I'm not asking a risk question. I'm asking a utilization question. Do you think that ESRD benes use more or less --

MR. SERNA: The slide is in the context of favorable selection, and favorable selection is relevant to

risk scores.

DR. MILLER: But that's not my question.

MR. SERNA: So even for ESRD beneficiaries --

DR. CHERNEW: Let me just jump in. I'm going to try and answer for what I think the chapter is trying to say, and then we can go. I think there is a range of people that join MA. Some of them, ESRD people, for example, whose prevalence in MA has risen, seek more care than other people. So there are a lot of people in MA that seek more care than general, and that's a fine point.

The reason why we're having this sort of back-and-forth is because there's a sense in which that point that you're making is going to then step into a selection, is going to stem to a selection point. And the part that gets confounded when you take the general point that MA enrollees may be sicker or seek more care, whatever it is you think, that may be true on average, but that's not related to the selection point, which is about the residual. And I think what Luis is trying to answer is if you look at -- I can't remember what slide it is, 26 or 27, or some version of that -- those that have chronic conditions and may seek more care, ESRD people certainly

seek more care. There's no doubt that that part is true. But within that population, of people with ESRD, the MA people seek less care than other ESRD people.

DR. MILLER: That wasn't my question, Mike, but we'll move on to my next and final question.

Are you all aware of the 2024 Wakely report, certified by actuaries, about the value of Medicare Advantage compared with fee-for-service?

DR. JOHNSON: We've read a number of those reports. I think I might have to look back. I don't remember exactly what the details of that analysis are.

DR. MILLER: I think an important point from this, which we should probably include inside the report, is it states that the maximum out-of-pocket would increase fee-for-service spending by 2.8 percent, which actually could suggest that there might be negative selection into MA. Thank you.

DR. JOHNSON: I think one way to understand that analysis is that without the out-of-pocket limit in MA, selection would be even higher, but because it is there, that might have some dampening effects as to the level of selection that we measure in the report.

And, Brian, to your first point, on pages 86 and 87 on Figure 12-6 -- or Table 12-6, you'll see some county-level concentration results. So if you have specific suggestions for updating that analysis, that would be helpful.

DR. MILLER: The specific suggestion is that we should analyze market share at the county level and then do it by perhaps the share of counties that have a consolidation concern, like the HHI cutoffs that DOJ and FTC use. Measuring plan Medicare Advantage market share at the national level is not accurate.

MR. SERNA: That's exactly what we do. That's the table that Andy is referring to.

DR. MILLER: Right. But there's another table in there which goes by payer and suggests the national market share.

DR. CHERNEW: Gina has an on-this-point.

MS. UPCHURCH: Yep. You mentioned that hospice is carved out. If somebody is in an MA plan and they have to go into hospice, the A and B benefits related to the hospice, but they stay in the Medicare Advantage plan. So we don't have any sense of do we decrease what we pay those

Medicare Advantage plans? Is there already built into the formula?

MR. SERNA: Correct. So the --

MS. UPCHURCH: Okay.

MR. SERNA: -- capitated payment is reduced for an MA plan.

MS. UPCHURCH: Okay. Thank you.

And I just want to say, if I could, that per member per month of $211, that would be $2,532 per year that traditional Medicare people are paying, you know, additionally to support all these extra benefits that are coming to people in MA plans. And you do have to worry about the equity that's going on there.

And I know this wasn't about this, this chapter wasn't, and I really just want to echo the "wow" with all the work that you've done for these two documents that we reviewed.

But I do think there needs to be meaningful competition between traditional Medicare and Medicare Advantage plans. So we need to stabilize and standardize the Medicare Advantage plans so that the insurers give us their best options and that people have a way -- just

common people have a way of choosing between fewer options that are more meaningful and different so that they can, you know, get the things that work best for them and that are meaningful bids and they're not just such a plethora that people get lost and don't make standard easy decisions.

So thank you for this work.

MS. KELLEY: Lynn.

MS. BARR: Good morning. I always learn a lot on these reports. I think we're all, you know, trying to get our heads around this. I really, really thank you for the work you do, particularly in an area that's kind of fraught with a little emotion. So this is really good stuff.

My Round 1 question is really kind of going off a little bit of what Gina is talking about. It's like a little more focus on -- what are the beneficiaries really thinking? You know, like if -- like, for example, if -- you know, so we're going to reduce their out-of-pocket drug costs in the Part D plans, and so maybe that will make MA less attractive because, you know -- so what is the -- is there, like, some really robust research that says these are like the top three reasons or, you know, that -- of why

MA -- why people pick MA? Right? And if we can get more granularity on that, maybe that will give us future policy options to address because I do agree with Gina's point is that, you know, they've got salespeople. We don't have salespeople, right? That's a big deal in most businesses.

You know, MA plans have brokers, and we don't have brokers for fee-for-service that, you know, that we pay significantly. Maybe they get a little bit for Medigap, but it's -- I mean, as a businessperson, you'd rather sell MA than anything else because that's going to be a lifetime revenue stream.

So what is the -- you know, if there was a driver that we could go at that would level the playing field, you know, given that we are paying for -- you know, taxpayer dollars, right, what would that -- you know, where would we put our taxpayer dollars to try to level the playing field, and what would that cost? You know, so there is -- you know, future analysis is obviously not for this time.

But, you know, we've given so much benefits to the MA population. I'm just wondering, you know, how do people value those benefits? And if we gave -- you know, if we gave them dental and -- you know, what percentage of

people would choose fee-of-service? Is there -- there's no -- I haven't seen any kind of research out there.

DR. JOHNSON: There are some surveys of beneficiaries about what they -- on what basis they're choosing between MA and fee-for-service. I think Brian just referenced one in the chat as well.

In general, beneficiaries do think about the cost of premiums and out-of-pocket spending, also whether or not their physicians are in network and whether or not their drugs are covered by the formula. But we can put some more specifics in the chapter.

MS. BARR: What was the first two again?

DR. JOHNSON: Financial-related implications, like whether or not the plant has a premium or the levels of out-of-pocket spending based on the cost sharing coverage by the plan.

MS. BARR: Okay. Thanks.

MS. KELLEY: Kenny, did you have something on this point?

MR. KAN: Thanks, Dana.

So on Lynn's point and also acknowledging Mike's point that the model doesn't account for benefit -- doesn't

adjust for plan generosity by understanding, right?

DR. CHERNEW: You mean the model of selection?

MR. KAN: Yeah.

DR. CHERNEW: So just to be clear, the model of selection should not, analytically should not. It doesn't -- like, even if we knew it, I would say it analytically should not account for benefit generosity. It would be wrong to account for benefit generosity in a measure of selection. It would be right to account for benefit generosity in a measure of value.

So the issue is if you buy a nicer car, for those of us that buy cars, than a less nice car, and the nicer car is more expensive. The car is more expensive, the fact that it's a better value is a separate issue. And you wouldn't say, oh, because it's better, it's cheaper. It’s not; it’s more expensive. But it could be a better value.

So the estimate of selection and coding and spending that we do appropriately, appropriately does not account for benefit.

A measure of value is different. I could not emphasize that enough. We understand that Medicare Advantage provides benefits to people that they care about.

A lot of them are the disadvantaged beneficiaries that you mentioned. I completely agree.

But if you're asking a fiscal question, what does it cost, you should not adjust that for the value. They are separate concepts.

MR. KAN: Okay. Can we at least have a short reference to your point, Mike, which I think is a really good one? Because the current estimates do not adjust for, you know, MAs or estimated MOOP, and this is something we can, you know, possibly analyze.

DR. CHERNEW: Again, we could argue. The estimates of selection should not adjust for MOOP. Estimates of value should adjust for MOOP.

MS. KELLEY: Amol?

DR. NAVATHE: Thanks, team, for this fantastic analysis. I really echo Lynn's comments about appreciating all the work that you all put in, and it's a massive amount of reading materials that you provided and is a reflection of just how seriously you all take this work. So I really, really appreciate it.

I just have what is hopefully a relatively straightforward question of understanding how, for common

people like me, we should interpret the value of the differential payment that's happening.

So as I understand from your presentation of reading materials, this differential payment is the $84 billion. So if that $84 billion were used instead in a hypothetical world to reduce Part B premiums for all Medicare beneficiaries, do we have a sense of what that magnitude would be, just, again, to help sort of somebody like me interpret what the magnitude is?

DR. JOHNSON: I don't think we have at the top of our heads the number of -- the total reduction on total Part B premiums payments.

I think what we do make reference to in the chapter is that about $13 billion of that $84 billion is funded through Part B premium, higher Part B premiums for all Medicare beneficiaries, but we can look more into the interplay there between higher payments and Part B premiums.

DR. NAVATHE: I see. Okay.

So if you can bear with me for a second. So if we took this $84 billion, accounted for the fact that there's about 62 million benes across both MA and fee-for-

service, I was just trying to do some back-of-the-envelope math. So that would be about $1,355 per year per bene? I'm just trying to do a straight division. And if we put that into it, then divided that by 12, that's about $113 per bene per month.

So I'm not asking for you to comment on this because this is my math, not yours. But I was trying to just understand, again, kind of how do we interpret this dollar number, $84 billion, because it's so big and sometimes there's billions and trillions and tens and hundreds, and it's just hard to know what that means.

So the way I'm interpreting it, again, not asking you to comment, is that if those dollars were put right back in to reduce Part B premiums for everybody, that it has a value in essence of -- or it's equivalent to $113 per month per bene. And so that's helping me at least interpret.

Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Thanks, Dana.

Really magnificent chapter. Really a great resource.

I have two Round 1 questions. So on page 29 of Table 12-3, I think, it says that the plans project that 28 percent of rebate dollars will go to the non-Medicare supplemental benefits like dental, vision, and gym memberships. And then in a footnote, it states that 12 to 14 percent of that 28 percent will go to administrative costs and dollars. So does that mean -- is it correct to interpret this as that of the 28 percent of rebate dollars that go to these non-Medicare supplemental benefits, that half of that basically is going to administrative costs and profits, half of the 28 percent?

MR. SERNA: That's not right.

So it's that 12 percent of the total estimated dollar amount of the projection for these supplemental benefits.

DR. CASALINO: Wait. It's 12 -- it's 12 -- so the supplemental benefits --

MR. SERNA: It's 12 percent of the 28 percent --

DR. CASALINO: Twelve, yeah, yeah.

MR. SERNA: Not 12 percentage points.

DR. CASALINO: Oh, I see.

MR. SERNA: Yeah.

DR. CASALINO: So it's 12 percent of 28 percent. So if you wanted to know what administrative costs and profits were based on supplemental benefits, it's not 14 percent. It's 12 percent of 28 percent, would be more like 3 or 4 percent, right?

MR. SERNA: I believe so. I'm not -- I have to actually do the math.

DR. CASALINO: In fifth grade, I could have done that, but --

[Laughter.]

DR. CASALINO: That's Monsignor Carey, our teacher.

Okay. And my other question is, I actually haven't ever heard this addressed, and I don't have a clue what the answer is. So does it happen very often that a plan's projections for what it's going to cost to provide the Part A and Part B benefits, so the plan's bid basically -- does it often happen -- or projections of where the plan will spend money? Let me rephrase this. Does it often happen that where the plan's projected they're going to spend money, like 28 percent to these non-Medicare supplemental benefits -- does it often happen that those

are way off, and if it does, what happens then? Or does it just not happen very much?

MR. HAMMOND: So I don't think we've looked specifically at what the variation is across plans with regards to whether or not their bids are more or less accurate. But the bids do include plan estimates of what line of service they spend their dollars on. So hospital, physician, skilled nursing, they break that out.

We've done cursory looks at whether or not those projections seem to be relatively accurate, and we haven't noticed a large divergence between what they predict and what they end up spending on.

DR. CASALINO: You have or have not?

MR. HAMMOND: We have not --

DR. CASALINO: Not.

MR. HAMMOND: -- seen a large divergence, at least across the entire program, but we haven't dug into the variation for specific plans.

DR. CASALINO: Thanks.

MS. KELLEY: Stacie.

DR. DUSETZINA: Great. Thank you.

This is fantastic work. I really appreciated all

the efforts you put in, especially to compare it to the existing literature.

I have two questions that came up as I was going through. One is about you mentioned that three-quarters of the special needs plan enrollment was into HMO plans, and I was just kind of trying to puzzle my way through that. Like, if you don't really have cost sharing because you have dual eligibility, why would you go into the most restrictive network type of plan? So I'm just curious. Is that related to more generous supplemental benefits or something else that you can measure?

MR. HAMMOND: So we have noticed this trend as well, and we're looking into it. One thing we've noticed is that some of it seems to be driven by just what plans are offered in SNPs. Most of the plans that are offered are HMOs, and so that I think is driving some of that pattern. But this is something we're looking into.

DR. DUSETZINA: Okay. Great.

And the other question I had was about the use for the favorable selection estimates when somebody is going from fee-for-service to MA. One of the things I worried about as an unmeasured component is access to

supplemental coverage and was just thinking about, like, what happens if your fee-for-service spending is lower, because you really can't afford care, because you don't have a supplement in fee-for-service, and how that might affect your estimates. I was just kind of trying to puzzle through, like, what that might do to the estimates that you've produced.

MR. SERNA: So your question is would a beneficiary potentially have more access to care and more use?

DR. DUSETZINA: Right. So, like, they have an artificially lower-than-what-they-need care in fee-for-service because they just can't afford the 20 percent co-insurance that would be their responsibility and that that kind of incensed them to switch to MA where they actually have more out-of-pocket protection. So, like, you're artificially lower than what they actually need in fee-for-service and then kind of appropriately getting what you need once you get into MA and can afford it.

So I was just trying to think through, like, how that might affect the estimates.

MR. SERNA: Yeah. So the estimates are limited

by the fee-for-service experience, and that limits things in both directions that could make selection higher or lower. For instance, also someone who is more likely to obtain their Medicaid eligibility on MA enrollment, that would then shift their coefficients relative to what they would have been in fee-for-service.

So those things, we can't account for. But I will say that given the limited amount of studies based on survey data, there does not appear to be more access for the low-income population when they are in MA. But that's definitely something that we'll keep an eye on.

MS. KELLEY: Greg.

MR. POULSEN: I'll postpone to Round 2. Thanks.

MS. KELLEY: All right. Paul.

DR. CASALE: Yeah. Great work. Again, thank you. Just a terrific chapter.

Just a question. With the coding intensity certainly being one of the -- you know, the data showing one of the drivers of the difference in payment, in the chapter, there was a mention around audits briefly or lack thereof. And I'm just curious about, is there either more information or thoughts about -- or are there any plans

that you are aware of in terms of increasing auditing to sort of under it? Because the numbers, at least that were mentioned, seem quite high in terms of not being supported in the chart and such.

DR. JOHNSON: So CMS did finalize some regulation around the RADV audits and made some plans for giving plans a heads-up of what the plan is for those audits and the methods to be used. They then released this new guidance document just a few months ago about how they're going to target the audit-eligible beneficiaries within the contracts that are selected for an audit. So we don't have a lot of new information. That has been something we've been, you know, waiting for, for a while. But I think we're now just sort of tracking what the next steps are in this sort of a new phase of CMS ramping up their RADV audit plans.

MS. KELLEY: Okay. I think that's all I have for Round 1, unless I've missed anyone.

[No response.]

MS. KELLEY: All right. Then we can --

DR. CHERNEW: Kenny.

MS. KELLEY: -- move to Round 2, and Kenny is

first. Yes.

MR. KAN: Thanks, Dana.

I have three questions. Question one. As this is a status chapter, I believe it is very important to discuss the financial health of MA plans, similar to how we analyze our payment updates.

There is a 2024 analysis performed by PwC, a leading accounting firm which I've shared with MedPAC. PwC analyzed the audited statutory financials of the MA industry through third quarter of 2024, and the firm's conclusion was that the industry lost money last year.

In addition, per PwC, the report suggests additional headwinds in 2025, bigger losses. Why? CMS gave MA plans a normalized zero rate increase in 2025 while medical inflation was running at 6 percent per CMS's most recent advance notice, which was released one or two weeks ago.

Many MA HMOs are upside-down in having to deal with a negative spread. It is definitely not in robust financial health, as page 84 of the detailed chapter suggests. Can we please revise the chapter to indicate the actual financial reality of MA plans in future slide decks

and the detailed chapter as suggested by a top accounting firm? Question one.

DR. JOHNSON: We can look into more information about the financials in a given year, but I think the appropriate context, too, is to recognize that plans have been bidding below, further and further below the benchmarks for a long time, and have substantial rebates, especially on the average that are continuing to increase. So to the extent that plans are making money or losing money in a given year, it does reflect sort of expectations of the plans and how they bid and are competing and whether or not they are, you know, having an expectation that plays out with the reality of what utilization and their spending is, too.

MR. KAN: Thank you.

Question two. As an actuary, I care deeply about the predictive accuracy and actuarial soundness of mathematical and statistical models. There is a 2011 CMS report which analyzes how various risk adjustment models such as AAPCC compare in terms of its predictive ability and actual soundness.

As a refresher, the AAPCC is the foundational

framework underlying the DECI method, which was used by MedPAC to evaluate the reasonableness of our coding intensity approach. Per the report for CMS -- and hence, CMS disregarded it -- the AAPCC methodology only has a 1 percent -- 1 percent predictive accuracy ability. The actual number is 0.8 percent and as such was ignored by CMS. There's a higher probability of Washington Commanders beating the Detroit Lions this weekend than 1 percent.

Given this low 1 percent predictive accuracy ability, I'm very confused. Please help a simple actuary like me understand two things. Number one, are you aware of the 2011 study? If you are aware, why would MedPAC rely on an inaccurate and cite an inaccurate 1 percent framework to evaluate our coding intensity model given that CMS disregarded this?

DR. JOHNSON: Thanks, Kenny.

That study has been updated in 2018, '21, and '24 as well and does show the same results for a low R-squared for the AAPCC model.

The DECI method and the method that we use to estimate coding intensity doesn't rely on the predictive accuracy of the AAPCC risk scores. It uses the same set of

demographics -- age, sex, Medicaid eligibility, institutional status -- as a way of controlling for differences in the enrollment shares among those populations between MA and fee-for-service. But it doesn't really rely on that R-square, the predictive accuracy of spending for the method. So that isn't -- although the AAPCC method is a concern if it were to be employed as a risk adjustment model, it is not really an effect on our method of estimating coding intensity.

DR. CHERNEW: I'll just say two things just to clarify. The predictive accuracy is an individual-level thing. What we're doing is a population-level thing. And so the R-squareds of individual-level things are often very low, but that doesn't mean they're bad predictors at a population level. That's a little bit besides the point in some ways.

I think the broader point -- and I appreciate what you did in the presentation -- is we had a completely different method that we used that had a whole set of different concerns, all of which were valid. It turned out that gave the exact same estimate as the DECI method. And then we were worried, well, there's a bunch of other

critiques of what was happening, because this is a complicated thing.

So then we went to the academic literature. There was a ton of people that did a gazillion different things. It just makes the academic conferences stunningly dull. But the point is they also come up with the similar numbers.

So the direct answer to your question is the predictive accuracy -- and I think you said this, Andy, so I think I'm just going to repeat for those at home. The predictive accuracy of AAPCC at an individual level is admittedly poor, which is why it is not used for risk adjustment. But that doesn't mean that the core information at a population level is not useful.

MR. KAN: Thanks, Mike.

I could be wrong, but I re-read a paper last night, and I believe that 1 percent -- or 0.8 percent to be exact is actually on a group level. But it would be helpful if we can include a section in the technical appendix on that.

Thank you.

And then question three, moving on. On page 4,

in my Round 1 question earlier, you know, I mentioned social determinants of health and impact on health status. And MedPAC's done a lot of good work on this. As we all know, MA has a disproportionately higher population of lower income, ethnic and racial minorities. Hispanics, Blacks, and Native Americans have a 50 to 100 percent greater burden of diabetes with complications and lower mortality than whites.

Hence, it should be no surprise that would be a likely higher prevalence of diabetes with chronic complications, which adds a higher-value HCC score, versus diabetes without complications. I believe this is justified, given the higher prevalence, and this is also further corroborated by the rich body of literature.

So help me understand. How did we normalize for social determinants of health? If we did normalize for this, did we back test for predictive accuracy? If we didn't, I suggest that MedPAC consider incorporating social determinants of health data into its future estimation of coding intensity and favorable selection. Otherwise, we're comparing an apple to an orange.

Thank you.

MS. KELLEY: Greg.

MR. POULSEN: Thanks.

You know, many thanks to you all -- Andy, Luis, and Stuart -- for this good stuff. It's very detailed. It's very well researched.

I've seen this analysis evolve over the last three years that I've been here, and I'm really grateful for this great work, and I think it's gotten better and better, so thanks.

You know, Amol, I'm going to take a brief -- what's going to sound like a sidelight, but it really does relate. It's 90 seconds, so you can put that in.

[Laughter.]

MR. POULSEN: More than 60 years ago, I lived in Pearl Harbor. I was the son of a naval aviator, and that location impacted some of my thoughts in terms of history there. On December 5, 1941, the Japanese consulate in Honolulu sent messages providing an accurate description of the location of ships in Pearl Harbor, as well as aircraft at Hickam, Wheeler Airfields, as well as updates on other defensive positions. This information was gathered by about two dozen people, and 100 percent of those people

were of Japanese ancestry.

Now, we all are aware that some of the folks viewed the people of Japanese ancestry as a threat, and many Japanese Americans were interned along the West Coast of the United States. However, in Hawaii, where the risks were certainly the greatest, the population broadly and naval intelligence and the FBI specifically concluded that the vast majority of Japanese Americans were loyal to the U.S., and that there was no broad internment in the Hawaiian Islands.

Indeed, in Hawaii, young Japanese Americans enthusiastically volunteered for military service. These volunteers formed the 100th Infantry Battalion and the 442nd Regimental Combat Unit. These two groups were the most decorated units in the entire U.S. military and received more Purple Hearts than any other on a per capita basis.

Okay. End of digression, but it really does have a point.

In the chapter on page 5, there's a seminal statement that reads, first, "Reforms are needed to reduce the level of payments to MA plans." That's a deeply

troubling statement to me if we don't follow up with the sentence that comes right after it, which I think is very clarifying and helpful, which says, "100 percent of the" -- I'm sorry. Taken by itself, that would be like saying 100 percent of the espionage in Honolulu was conducted by people of Japanese ancestry, a true statement, but one that could be acted upon unwisely.

The following sentence in the chapter, however, provides the appropriate context. It reads, "Relatively higher levels of payment stem largely from coding intensity and favorable selection." This is the equivalent of stating the vast majority of Japanese Americans are loyal to the United States.

Recognizing this distinction is critical, and the team paints this effectively, And I'd really like, if we could, turn to slide 18, which I think is very, very helpful on this point.

Thanks.

Consider the differences between the provider-sponsored health plans, most of whom are on the left-hand side of this slide -- Kenny referenced this a little bit -- and the large commercial plans, and you can see where they

fall. They're in blue. And I believe that the Medicare program and its beneficiaries are very well served by many of these groups, but particularly some of those that are in the provider-sponsored group and other smaller plans. And it would be a shame to do harm to those plans.

They don't tend to deny claims or place onerous preauthorization commitments upon the population, and since the providers are incentivized to be cost-effective, they don't need to provide these kind of effects.

And just in the last month or so, we've seen the tragic results of how some people think about health insurance these days. It's very different than it was a while ago and largely built on those kind of activities that I think are not reinforcing of good quality care.

It's no wonder, then, that Thomas Tsai and some of his colleagues at the Harvard School of Public Health found much higher levels of satisfaction at provider-sponsored plans. Pay attention to these numbers: 4.41 on a 5-point scale for provider-sponsored plans versus 3.78 for others. That's an enormous difference when you're looking at big populations, almost a stunning difference.

Similarly, the research firm of Faegre Drinker

found that provider-sponsored plans had higher scores on quality metrics on five times as many metrics as did the general plan population.

So being on the left side of the graph that we see, however, on the risk adjustment graph, most of these plans are, indeed, losing money, even though some of the big ones are not. And I think you guys have the data. So I think that reflects what you're seeing as well, simply because the risk adjustment is the primary mechanism for -- and the preferred selection is the primary mechanism by which Medicare Advantage plans gain a differential financial benefit.

So, back to my point. If we fix the risk adjustment mechanism as the way of reducing overpayment, we will be effective. V28 has made some improvements. I think you all pointed that out in the data that we see in the chapter. Additional improvements are meant to be made. If we can truly reflect the differential between the risk factors and not -- the true differences in risk as opposed to creating machinery that identifies or even creates risk differentials, then I think that we have a chance to have a level playing field where Medicare beneficiaries will see

the real benefits that I think many of us perceive as being the goal and opportunity for Medicare Advantage.

So, again, thanks so much to you guys for some really good work.

MS. KELLEY: Scott?

DR. SARRAN: Yeah. I also want to start by commending the work. This is really rigorous, well-done work, and I think we all owe it a lot of respect.

A few people have already introduced the concept of a playing field and value creation. I think that's an important framing set of concepts.

The way I think about the MA program writ large is that we want the program to be one in which plans succeed depending on either beneficiaries and/or taxpayers winning, right? Beneficiaries win by improved access, improved clinical outcomes, reduced out-of-pocket costs, and/or new incremental benefits not offered under traditional Medicare, right? We all agree those are the beneficiary wins.

Taxpayers win either via decreased spend, as best as can be compared -- and you guys have done an excellent job of comparing that to traditional Medicare -- or

potentially private sector demonstrating an innovative way of efficiently -- underlining efficiently -- delivering on incremental new benefits not offered under traditional Medicare.

With that in mind and realizing I'm going to run the risk of blowing my average talk time, I've got nine concerns that have been elucidated in the report and other publications, et cetera, that are problems with, I think, the current MA program not -- and I want to -- side to Greg -- not a negative reflection on excellent work done by many plans, many employees of plans, and particularly recognizing the wonderful work done by many provider-sponsored or provider-integrated plans.

All right, nine concerns. First -- and you guys mentioned this -- there's painfully little evidence of improved quality in the MA program writ large compared to traditional Medicare. You elucidated the problems with stars. There's a variety of literature out there over the last many years that compares a variety of quality outcomes in MA versus traditional Medicare. They're all fraught with imperfections.

But the few that have shown some improvements in

quality strike me as the analogy to pharma bringing a drug to market based not on hitting their primary endpoint out of the park but by having 10 secondary endpoints and hitting on one or two of them, meaning the evidence isn't great.

Number two, there's a huge amount of evidence. So in contrast to the trivial amount of evidence around improved quality writ large in the MA program, there's a huge amount of evidence, and you guys did such a great job of this, to the point that we should put to bed any objections of overpayment versus fee-for-service Medicare. I mean, huge amount of evidence.

Number three. And you guys pretty much teased this out. By any reasonable standards, the MA program is an inefficient taxpayer-funded vehicle for either reducing beneficiaries' out-of-pocket costs or supplying new supplemental benefits. Yes, there is value, no question about it, to MA plans offering beneficiaries, particularly as others have pointed out, low-income beneficiaries, a better out-of-pocket proposition. And yes, there is value. Beneficiaries recognize this, and that's a big part of why they sign up for MA in the supplemental benefits. The

question is whether that is an efficient use of taxpayer money to fund those improvements in out-of-pocket costs and/or supplemental benefits via this program. That's the question. It's not whether there is some value; it's whether the value offsets the cost to taxpayers and is done efficiently.

Four, code capture. And you guys, again, I think you have elucidated this really well. Code capture is worse than a zero-sum game. I mean, it really -- it creates a huge amount of net-zero administrative spend. It's an arms race, and it saps energy, time, and dollars out of the system. And it does not -- it is not paired -- by and large, it is not paired to how care changes for beneficiaries who have major risks for adverse clinical outcomes.

Five. And you guys have put to bed this issue. There is favorable selection in MA. All the logic in the world suggests that, and you guys have rigorously proved that.

Six. Prior authorizations as widely implemented in many, not necessarily all, but many MA plans, are at best -- at best, burdensome to both beneficiaries and

providers and are a not-insignificant contributor to widespread provider burnout, which is a major issue for us that we have discussed and will continue to discuss in other bodies of work. Prior authorization, as practiced by many MA plans, adds a significant -- a significant amount of administrative costs to the delivery system. And others have pointed this out in other discussions in bodies of work. It's not insignificant, and there is at least anecdotal evidence that at times prior authorizations impact beneficiary access to needed care.

Okay. Number seven. The MA program, again, writ large, notwithstanding Greg's well-made points about the wonderful work that many plans do -- the MA program, writ large, has had demonstrable adverse impacts on the delivery system. Right? As I discussed, inarguable that the administrative costs related to prior auths, et cetera, and the provider burnout related to that, that is not insignificant. And we've had pretty good discussions in other sessions around the negative impacts of the MA program on skilled nursing facility industry in terms of their -- at least at times -- and there's been a lot of discussion about this recently -- fairly arbitrary

reductions in utilization of SNF and other post-acute care, as well as decreasing rates via essentially market clout to skilled nursing facility. And that's in large part why that industry is in trouble now. And we've had discussion in other sessions -- Lynn particularly has helped us with this -- about MA's negative impact on many rural providers.

Number eight, the increasing vertical integration of very large players essentially makes true transparency impossible, not just difficult, but right now impossible. Maybe we can move it from impossible to difficult. And transparency is required, I think we'd all agree, in order to do adequate oversight and to better align goals, again, between taxpayers and beneficiaries and plans.

The last one is kind of a pet peeve of mine. I'll acknowledge that -- is that there are two populations that I'm particularly passionate about that have been essentially left behind and poorly served by traditional Medicare. And I'm disappointed that the MA program has not, by and large, done anything to address the needs of those populations, those two being, as we've discussed this recently, beneficiaries living long-term in nursing facilities and beneficiaries suffering with severe mental

illness.

And I'll end by just saying I'm disappointed that opportunities to really create triple-aim wins for populations that are so poorly served within a fragmented fee-for-service system have not been taken up by the MA program, with very few exceptions.

So thanks again, guys, for really excellent work.

MS. KELLEY: Brian.

DR. MILLER: Thank you for this work. I just wanted to start off by saying that my focus is as an independent thinker focused on helping find the right answer, or in many cases if there isn't a right answer, a better answer.

Ironically, I'm one of the people who has always thought that MA plans are overpaid. I also think our model is wrong, and these both can be true.

In many markets, I've seen, in my limited time on the Commission, that we change our models. For example, this year we suggested that SNF margins went up 5 absolute percentage points, and last year we suggested that MA overpayments increased by 18 absolute percentage points. These sorts of wild swings year to year unfortunately can

undermine our analytic credibility.

I know that actuaries at Milliman and Wakely are putting their own reputations and careers on the line certifying their work around MA. While we may not necessarily agree with what they do, our analysis is incomplete unless we address and cite their publicly available work.

I'd say my concerns about our model in this space come from my experience as an FDA product reviewer, who had to review pharma company data and ensure accuracy, precision, and integrity, recognizing that doing so is important for patients and physicians across the country.

In doing so you look at internal validity of data models, external validity, and then the last and important one is common sense. In the case of drugs it's does it fit with pathophysiology and pharmacology, and obviously for insurance the question is different.

So my concerns about the current MedPAC model, which is still new, remain fundamentally unaddressed. One is the favorable selection concern. My colleague, Kenny, mentioned that more poor or minority beneficiaries are enrolled in MA. Those are two demographic features which

are well-associated with poor health status, greater health care utilization. There is a plethora of research that suggests that that is the case.

I also mentioned the ESRD population, where 21st Century CURES represents a natural experiment, where benes could then access and elect to enroll in MA, and they chose to, with ESRD market share in MA rising from 27 to 52.3 percent as compared to 54 percent of the general Medicare population, suggesting a favorable selection of 1.7 percent. And colleagues may say is that spending. I do not know of any cheap ESRD benes in this position.

I also worry that the MedPAC model of favorable selection fails at external validity. The Biden administration has done an excellent job of cracking down on plan marketing practices over the past four years. I have not always agreed with everything that they have done, but they have tried to do a very good job and I believe have succeeded.

My question unanswered in this setting is, in this setting of increased marketing and advertising regulation, what do we propose is the real-world operational business mechanism by which plans are

harvesting, if we believe this is true, healthier, lower-cost beneficiaries. Policy has to be executed in the real world, not just in a model or a book chapter.

I also worry that the MedPAC model of coding intensity, not just favorable selection, fails at internal validity. There is clinically appropriate coding intensity. There is borderline or abusive coding, which is gray, although I'd be inclined to call it borderline and abusive. And then there's clear fraud. I think we need to measure these buckets rather than say that they need to be measured, and then not measure them. And that's an analytical challenge that I'm confident that the staff can surmount.

The MedPAC model of coding intensity also fails at external validity. My colleague mentioned the 2011 CMS report about the AAPCC model, which underlines the DECI model, which is what MedPAC now uses, which accounts for 1 percent of spending. I think that's objectively a terrible number, and we can all agree on that.

The coding intensity methodology also fails the common-sense test. We included EGWPs or employer group waiver plans in our analysis. A change that's not valid is

that plan option is not available to the general public. And then we've also failed to value differences in benefit design, which drives selection.

My mentor in payment policy, Gail Wilensky, was a wonderful friend who passed away last summer, and I emailed with her basically every day for a decade. She encouraged me to have fun, be a critical thinker, buy a convertible. Great lady. We'd take turns buying each other croissants and coffee.

We talked a lot about the continued debate on MA versus fee-for-service, and she actually said it best once, many years ago, and said that she couldn't believe that we're still debating this. She said, "Do a chart review, use technology, stop wasting our time on a technical problem that has an operational solution." And as usual, a lady who is in her late 70s and unfortunately passed away last summer at 81, was correct.

And so I think we do need to be pragmatic. I think in this vein we should be thinking about automation and AI diagnosis of coding in fee-for-service and MA to ensure accuracy across programs. If we believe there are real differences, and there probably are, our

recommendation should be to Congress to fund a chart audit.

So I think instead of modeling, we should make recommendations to clearly identify scope and solve the problem. We should be pragmatic and not political, and we need to stop modeling and start getting this real work done.

I'd also encourage my colleagues to think more holistically about the MA and fee-for-service programs, because problems that are in MA or fee-for-service are not separate. If we have a problem in MA, we also probably have a problem in fee-for-service, and vice versa. My colleague, Kenny Kan, and I, along with former Commissioners Craig Samitt and Brian DeBusk, four very different people, very different backgrounds, very different industries, last year wrote a Health Affairs blog entitled, "The Need for Holistic Policy Thinking in Medicare" about these issues, so that we can all work together to solve problems across programs. I would encourage you all to read it, and I'd encourage us all to be pragmatic and work on solving problems. Thank you.

MS. KELLEY: Lynn.

MS. BARR: Thank you. Wow. There's a lot of

comments there to comment on. I don't even know if I'd get to my own comments. But a big plus-one on Scott's comments. I really do appreciate those. You know, Greg also had a really great comments.

Related to the provider plans, I really question -- and look, first of all, I want to say that the provider-based health plans that I've worked with, the MA plans that I've worked in my career, were outstanding. Every one of them. And they definitely had a very different bend, and their focus -- you know, coding was in there, but it was really hard to get them to do it, right, and they really rejected the idea that that was clinically significant, and they preferred to do more work related to managing the population and innovating.

But they're small, right. And so a lot of their failures are from scale. And I think that when we think about provider-based health plans, they are inherently small, in most cases. Many of them like 5,000 lives. They shouldn't be taking full risk on 5,000 lives. So any data we see of them having really bad results, they can have really great results the next year because their numbers are way too small.

So I just think as policymakers we need to provide an MA-type vehicle for provider-based health plans that work without scale, and I think we're doing some of that with some of our ACO work, and creating more ACO-type opportunities where they can move into value-based payments. And when I talk to these organizations, why are you doing this, it isn't, well, Deloitte said we could make 20 percent, although Deloitte probably tells them that -- no offense to Deloitte. But they are there because they see the future of population health, and they want to be part of that future, and they feel like they have to do this to learn, and to lead.

So I think we should really take provider-based health plans and put them in a totally separate analysis, and look at them differently, because I don't think they're the same. And it will help solve a lot of the issues that we see.

Kenny, your comments about MA being in trouble, the thing about insurance, as we all know, is you've got to be able to take this, right. So you're going to win, you're going to lose, because you can't predict. And in 2020, I think the health plans did really well, based on

their '21 bids, right? They had wild profits nobody clawed back. We didn't take it back because nobody went to the hospital, right.

So there is skill in bidding. It's not our responsibility. It's their responsibility. I mean, what has been said in the literature is that the MA plans are the most profitable insurance plans in this country. And so we see that in the literature. So that should be a red flag to us, that Medicare, they're making more money off Medicare than they are off commercial insurance, and yet our providers are getting paid a fraction of commercial. How does this make sense to anybody? I mean, we're taking money away from the providers and it's going to the MA plans.

So something's not right, and does necessarily need to be fixed.

Your comments, Kenny, about SDOH and diabetes with major complications, I can tell you that in a lot of my rural communities that were 90 percent white, reasonable economic conditions, they under-coded diabetes. Nobody ever put diabetes with major complications. It's the lowest-hanging fruit in coding. So I don't think your

assumptions really track with the reality, which is, boy, there is low-hanging fruit with diabetics. We can get more money off of all of them by coding them, because almost all of them have a complication. So we just target that -- I mean, coders, not us, but we target that as a population.

I basically disagree with everything Brian said. Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: Thank you. First, I also want to commend the work. I really like how you were able to provide all the detail when we possibly want in the appendix and then also combine that with pretty straightforward, intuitive explanations in the chapter. So thank you for balancing those.

One area where I think we could do even a little bit more, and at the risk of belaboring this point, is that I think for people who haven't spent a year and a half reading that appendix and various versions, for people who aren't researchers and are not inclined to that, I think it does seem counterintuitive that as MA enrolls more duals, for example, and more people with various conditions, you know, that favorable selection still exists or would

actually increase. And I think once you read the methodology it becomes very clear. In the chapter it's talked about as the prediction error. Mike mentioned the word "residual." I'm not sure those words are intuitive to everybody.

And so I think clearly, it's very important that we think about these things as conditional. So even though MA plans are enrolling more and more duals who are generally sicker, that doesn't mean that they don't have favorable selection. That just means that we control for being dual in their risk score. And so conditional on being dual, there's still a range of people's propensity to spend, right, whether that's through the health conditions or preferences.

And, in fact, what your data shows, which I found really interesting and consistent with other things in the literature, was that as people get sicker, that area, that range of variability actually increases.

And so I think it would be great to add to the chapter just an example like that, to make sure people understand what we mean by sort of the conditional prediction, because for some people it may be

counterintuitive that as MA enrolls sicker people, they still have favorable selection.

So a couple of other big-picture comments. One, people have touched on this a little bit, and this is not to discount Greg's comments about the heterogeneity. I think that's really important to consider. But this $84 billion we're talking about, or some large sum of money that is basically taxpayer- and premium-funded, fee-for-service premium-funded subsidization of these extra benefits in MA, I think it's really important for us, moving forward -- and we don't do this, generally, I think, across these different sessions and different decisions we're talking about.

But I think it's really important to keep in mind the opportunity costs. We know that beneficiaries value things like a gym membership, and that may be why they sign up for MA. But the fact that some beneficiaries value a gym membership doesn't mean that that's a better use of that money than fixing rural copayments or addressing physician payments. There are a lot of opportunity costs to these, and I think we just have to keep in mind that there's this big opportunity cost when we think about

potential solutions to this problem.

Building off of that, as well, there were a few other things in the chapter that I really want to express support for, things we can't really do now, but I think that we should keep pushing for. One is to keep pushing for the data so that we can assess the value of those extra benefits. And on the one hand, for things I was just mentioning, like what is really the value of a gym membership in terms of paying taxpayer and premium beneficiary money on it.

But also things like dental care. The research on the value of dental care, even though people sort of assume it's important, the research, causally, is just really poor. And if we can sort of push these data and find out exactly what we're getting for providing dental care, I think that would be great for the Medicare program and also just great, in general, to know that in a big-picture sense.

And then I guess the other thing I really want to emphasize is that we've had this discussion before. I think we really need to keep thinking about ways to reduce our reliance on the fee-for-service population to estimate

these benchmarks. This hasn't come up now. I think there is broad support for that. I think that's something we should keep pushing and including in terms of kind of solving this long run as the MA population grows. Thanks.

MS. KELLEY: Stacie.

DR. DUSETZINA: It's really nice to be following Tamara there because I agree with everything she just said, so I will say endorse.

You know, in addition, I think there are a few major issues for me. I'll keep it very brief. But the first is that the issue of overpayments means that the plans use rebates to make the benefits artificially inexpensive for people when they're choosing plans. So thinking about the buydown of the Part D plan so a fewer-dollar premium. That often, I think, is the way that people get into their benefits in the first place is shopping and trying to get their drug coverage. And when you look at the differences between MA and fee-for-service, and you're trying to understand those options, it's almost a no-brainer that if you don't know what you're giving up you're going to pick MA, because it's such a good deal.

Anecdotally, I had a colleague whose mom I was

helping shop, who was like suspicious. She thought it was a trick that she could get a plan for zero dollar. She was already an MA enrolled. But that's what it is these days.

So I think that's important for thinking about who's picking MA and why we've seen such huge uptick.

I think the issue that Tamara brought up about the opportunity costs for spending on supplemental benefits and how much of our funds are going into supplemental benefits is important. And it made me think that in one of the chapters we have on the supplemental benefits workstream there was a lovely table about what types of benefits are being offered -- acupuncture, et cetera, cash cards.

It might be helpful to have something like that in there, so that people really have a concrete understanding when you talk about supplemental benefits that these are the things we're talking about and the distribution across plans, so people are just a little bit aware of that when reading this chapter.

You know, I think reading the chapter, it's clear to me that the bonus programs and the issues of the overpayments are very important. To Greg's point, the

distribution does matter. But even on that graphic that you show, it's like 15 percent of enrollees on the left side of the graph, 85 percent on the right. So clearly there is a large amount of payment that's going on here that may be better used in other ways.

I also wanted to just say that there have been a lot of comments about enrollment in MA by Black and Hispanic beneficiaries. And I think that's great if it's a choice that is being made because this is the best plan for you and this is what you like, versus you can't afford the other option. And I worry that for a lot of people, affording to be in the fee-for-service program is impossible, when you start to think about the need for purchasing Medigap or even the additional premiums for the Part D plan.

So I think it is important to say it's great that we have a lot of people who are in MA, and hopefully they are well supported by those plans, but it might not be as much of an active choice as a forced choice because of affordability.

But incredible chapter, great work, and I really appreciate all of your efforts.

MS. KELLEY: Cheryl.

DR. DAMBERG: Just briefly. Thank you for all this great work. This is a vast space, obviously a lot to chew on.

You know, my comments largely echo some that have already been made. So I'll try to keep this brief, as I know we're running out of time.

But as this program continues to grow, I think we need to continue to monitor what's happening in this sector and to recommend changes to correct for incentives in the program that are distorting behavior, such as upcoding.

And, you know, there are a lot of public dollars in play here, and we need more transparency on a number of fronts to understand the value that this program is delivering.

I share the concerns raised by others about the overpayments, whether it's through coding intensity or favorable selection. It exists, and taxpayers are overpaying in this place, in this sector.

And the coding intensity, you know, following on Stacie's comment about the distribution, you know, it's creating this very uneven playing field across the plans in

terms of these payment differentials. And, you know, it's affecting the profitability of those organizations, and it's potentially driving out competition on the left-hand side of that distribution.

I secondly have concerns about the consolidation happening in the marketplace, particularly between insurers and providers and their ability to capture more of the premium dollar through that mechanism. We clearly need more data and publicly available data on ownership and affiliation arrangements to really understand what the implications are related to that space.

In terms of the rebates, I've really struggled with this space. So I understand, you know, these supplemental benefits potentially offer value and particularly to vulnerable subgroups of the population. But I'm concerned about the growth in the size of these rebates, and it really has come at the expense of taxpayers and beneficiaries and fee-for-service and the fact that we have a very uneven set of choices out there for beneficiaries when they choose between traditional Medicare and Medicare Advantage.

And I think underlying sort of this rebate issue

is the star ratings program, and I know the Commission has thought a lot about this. But I think, you know, from the perspective of Congress and CMS, I think this area requires a rethink. I do think it's distorting behavior by virtue of the fact that it's new money when the quality bonus payments are paid out rather than operating in a budget-neutral manner, and it is affecting the size of these rebates.

And per some of the other comments raised, you know, the question is, are these dollars being spent in the best place to maximize value for all Medicare beneficiaries, not just the subset that are in Medicare Advantage?

And lastly, I just want to note and to comment on Kenny's comment about the financial health. You know, as I look across the information contained in this chapter and just broader knowledge of this market, it seems like the health of this industry is very robust financially. Clearly, there are some plans that are not doing as well as others, and as Lynn pointed out, there's ups and downs year to year in terms of profitability. But we see high gross profits. We still see a lot of market entry and continued

expansion. So that suggests to me that this sector is very strong in terms of its financial health.

MS. KELLEY: Okay. I have comments from Robert and Betty that I will read.

Robert says this is a fantastic report. There's so much to talk about, but he'll limit his comments to beneficiary access to care.

As we know, the Commission has supported the inclusion of private plans alongside Medicare Advantage. The reasons cited are largely due to efficiency of care through payments models that are risk adjusted and based on a predetermined rate.

Robert does have concerns that private plan offerings may create two tiers of care in which those who can purchase private pay plans are afforded greater access to health care services that suits their specific needs. At some point, it would be ideal to study if there are inequities associated with private plan offerings that are designed to supplement Medicare Advantage.

In addition, the fact that the three largest MAOs enroll 57 percent of Medicare Advantage beneficiaries is somewhat concerning, especially in the context of an

unpopular preauthorization process. This type of consolidation may have an unfavorable impact on access to care, particularly in socially vulnerable communities. Although we do conduct population-level surveys and annual focus groups, they do have limitations.

Robert would like to see more robust access indicators so that we can better understand the extent of any inequities and their major drivers.

And he thanks the staff again for an excellent report.

Betty says this is fabulous work, and she particularly appreciates the inclusion of the technical appendix. The presentation opened with the Commission's support of MA as an avenue for beneficiaries' choice. Choice requires knowing what you are getting and what you are giving up. This remains very difficult for policymakers and beneficiaries. She thanks the staff for these important steps in that direction for policymakers.

Betty adds that Gina's and other's comments on meaningful competition with greater transparency for beneficiary decision-making both within MA and traditional Medicare and between are spot-on and important areas for

our ongoing workstreams.

And I have Larry next.

DR. CASALINO: Thanks, Dana.

So some of what I'm about to say may sound critical of Medicare Advantage, and I just want to make it clear that, in fact, I'm not critical at all of the concept of Medicare Advantage and the benefits it could provide and that I believe some Medicare Advantage plans do provide, as Greg and Linda pointed out.

And we haven't even talked about the original promise of Medicare Advantage, and what made it seem so attractive to me and to many other people is that, by the use of capitated payments, it would be possible for money to -- for providers, really, to think about what's the best way that we can use the money we have to improve the care of our population of patients instead of focusing on what services will fee-for-service Medicare pay for it. That's almost been forgotten about.

So I'm very supportive of the concept of Medicare Advantage, but that's not the way it's working out in general, right?

So I'm simply critical of paying Medicare

Advantage plans far more, about $84 billion in 2025, than Medicare could pay for the same beneficiaries if they were in traditional Medicare.

Now, as a policy analyst and someone concerned about the future of Medicare and of the federal budget, I find this very troublesome. We're, in effect, forcing Medicare beneficiaries in traditional Medicare to subsidize benefits for beneficiaries in Medicare Advantage. This makes it even more expensive to be in traditional Medicare and I think will lead possibly to a death spiral, really, for the traditional Medicare program.

I think Tamara is right to refer to this as opportunity costs, but I think the report, I think, would be better than it is, even, if it just, in very clear terms, made it clear that traditional Medicare beneficiaries do subsidize Medicare Advantage beneficiaries and all these, you know, vaunted supplemental benefits.

So, beyond this, I have several things to say briefly. Luckily, I have fewer than Scott's nine, which I thought were very worthwhile and succinctly said. I'll try to focus on things that haven't been said. I'm also using my New Jersey background to talk faster than I should,

probably.

[Laughter.]

DR. CASALINO: So luckily, my wife's probably not listening. She's shown very little interest in this.

So I think one thing that has been mentioned that I think is critical is that it's very difficult and really, for most people in 46 states, practically speaking, impossible to switch to traditional Medicare once you've chosen Medicare Advantage. I don't think that many beneficiaries understand that. I don't think many physicians understand that. I doubt that many members of Congress understand it.

I mean, I was in full-time practice for 20 years. I've studied Medicare for another 20. I recently enrolled in Medicare, and I didn't know until -- I think it was Gina talking some meetings ago about the fact that when you choose, in all the four states, you choose Medicare Advantage, that's it. You're not getting out of that. It's a lifetime decision, which you may regret for various reasons in the future. So I think that that's so important.

I think it doesn't need to be stated in any kind

of value-based way, but I think it should be clear, because I think that would be a service. People do not know this.

Okay. Second point. On page 31, the report refers to the -- quote, "the continuing trend of higher levels of payment throughout the history of Medicare's payment policy for managed care." That's a very kind of anodyne way of saying that in every year that the program has existed, Medicare Advantage has paid more for beneficiaries than it would have paid for the same beneficiaries in traditional Medicare. We do say this on page 33, but it's really kind of buried there. And just the way the report is structured, it would be better if it were said on page 31, I think.

Okay. The other thing that I think is a big omission in the report -- and I don't mean to be critical, because I think it's a great chapter -- the role of brokers and agents, which I also didn't understand and which Gina enlightened me about during a meeting a few times ago. A lot of beneficiaries use brokers and agents, over 30 percent at least, to choose their plan, and brokers and agents have incredibly strong incentive, financial incentives, to put people into a Medicare Advantage plan

rather than traditional Medicare and, in fact, to put people in some Medicare Advantage plans rather than others, because plans pay these agents and brokers, and they give them enrollment targets and bonuses for -- even within the same plan, you may get a bonus for enrolling someone in United Plan A rather than United Plan B, because United wants them in A rather than B.

And we're not talking about small amounts of money here. I mean, last year, it could be up to $626 per beneficiary enrolled by an agent or broker in a Medicare Advantage plan in the first year and $313 every year after that, that the person remains in that plan or a similar one. So the financial incentive -- you'd have to be a saint to put people into traditional Medicare. In traditional Medicare, you get paid at most half of what you would get paid for enrolling in Medicare Advantage if you put someone into traditional Medicare in a Medigap plan. I think that's important. It's important to the growth of Medicare, which is very robust, but this is one of the reasons it's so robust. I think this combined with the fact that once you're in Medicare Advantage, it's hard to get out.

Okay. It is true that -- I think it's a good point that's been made that when we talk about 20 percent payment -- I'll just use the word "overpayment" for shorthand. It is true that that shouldn't be -- as Kenny said, I think, that that shouldn't be taken to be profit, right? But it does bring in more enrollees, and that is profitable, right?

As Lynn said, Medicare Advantage historically has been much more profitable for insurers than commercial insurance for non-Medicare beneficiaries. I won't go into that more, so just leave it at that.

It is true, as Lynn and Greg were pointing out, that smaller plans and provider-sponsored plans may not be doing as well financially, and I think that this would be something we might want to think some more about. So I'll leave it at that.

During the Round 1, you guys clarified the difference, the 12 to 14 percent of the 28 percent of, quote/unquote, "profits at administrative cost," and I didn't understand that it was not -- the 12 points not yet. So I think making that more clear would be good, and I think getting that out of the footnotes and into the text

would be good, because it's kind of an important point. People understand and would be interested in, you know, what's administrative cost, what's profits.

And this is also a problem in table 12.3, where there actually isn't a category for administrative costs and profits. It's not deliberately hidden, I'm sure, but functionally, it's included just under the category of non-Medicare-covered benefits and not even mentioned in the footnote to that table.

So I think more clarity in the table and the text about what we're talking about with administrative costs and profits, I think, would be useful.

And that's it. Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you, guys, for this great work.

So I have a few points that I wanted to make, just upon reflection. I think this has been a great Commissioner dialogue and set of comments. I mean, it's a lot to digest. I think a couple of points I wanted to make.

So I think it's very clear that MA provides a lot

of value in terms of its innovation, its ability to provide premium reductions across Part B, across Part D. I think there's some value, some benefits to patients in the actual integration between the medical and the pharmacy benefit and administration of those at times. I think there's a whole bunch of different things that we could point out there.

The fee-for-service program, on the other hand, certainly innovates at a slower pace, right? It kind of innovates at the pace of legislation effectively, and so I think that's kind of important context in some sense to bear in mind.

And so I think there's clear value in the MA program. That seems quite consistently clear across many Commissioner comments, maybe not all of them.

I think simultaneously, I think it is -- many Commissioners have also made the comment that it's very hard to understand, however, how to quantify what that value is, and that obviously is in the context of higher payment. So if there's higher payment, what are we, what are beneficiaries, what are taxpayers getting for that value? I think we don't have the data to be able to make

that assessment, and that is the assessment, I think, in some sense, that is the most important assessment to understand.

The fact that there is higher payment, I think, is well supported. It's well supported by your work. I think Andy referenced the long-term bidding profile and the trajectories. We showed some data on supplemental benefits and how they're kind of continuing to go up. So I think that the general notion that there is financial health in the sector is well supported by the data as well.

I think Greg and others have made -- Lynn and others have made really important points, however, that MA is not a monolithic institution. There's a lot of variability. Again, you showed some data on that point, and that variation is really important because I do agree with some other points made that, you know, we don't want to take a policy approach that treats the MA program as if it is a monolithic institution. And so that complicates, I think, a lot of the policy strategies that one might take.

And I think it's indisputable that beneficiaries are voting with their feet, that they're moving more and more into MA. I think the benefit generosity of the MOOP,

the maximum out-of-pocket, the innovation in the supplemental benefits, dental vision, et cetera, clearly have value to beneficiaries. Again, the problem, of course, is that taxpayers are also paying more for that. So how do we reconcile that?

I think Larry's point about kind of supporting this notion of choice, you know, I think beneficiaries made this point as well. It is important to realize and for us to convey that very clearly -- we have done this in prior work as well -- that when you join MA, that you do exhaust that guaranteed ability in most -- the vast majority of states -- I think all but four states, if I remember correctly -- to then re-enter with a guaranteed enrollment into Medigap, into supplemental Medicaid -- supplemental Medicare. That's important.

And I think in general, there is this lack of symmetry between the MA and fee-for-service that we have pointed out in terms of the quality program, in terms of other dimensions. Sometimes there's more -- oftentimes there's more generosity in the MA side. There's obviously differences between MA and fee-for-service in a number of different ways.

Last point I wanted to make is that, that being said, I think from an analytic perspective, the work that you all have done is fantastic. I think it's comprehensive. I think there -- this is complicated. I think it's easy to get sideways on a bunch of these different points.

Terminology like "favorable selection," I think can be confusing, and so I just -- I wanted to just point out that I think that the notion that there is favorable selection in MA is not at all at odds with the trends that we see that there are high-risk populations who are disproportionately joining MA, whether that's racial/ethnic minorities, whether -- as you pointed out, whether that's based on HCC score or other dimensions. Those two things are not at all at odds. And I think that's really important, and we obviously can try to do a better job of stating that.

Similarly, I think there are differences in the incentives you all pointed out to code in fee-for-service and MA. And there could be -- as Brian points out, there could be different types of coding differentials, some that may be at a very extreme fraudulent, could be on the other

extreme, there could be conditions that aren't coded in fee-for-service that otherwise do belong from a diagnosis perspective to a patient.

But the assessment that you all are making is not a value judgment on whether that code should or should not have been there. The judgment we're making is, one, about how the payment system functions, and the payment system functions with this underlying assumption that the coding patterns are similar. So when the coding patterns are differential, that creates this asymmetry in payment, this differential payment that's happening on the MA side. So I think it's just really important to reiterate that there's not a value judgment here on what's happening on who's right on the coding piece. It's just simply an empirical fact that there's a difference, and that is the basis for a lot of the calculations that you all are doing.

So thank you so much for all your work, and this is fantastic. I really thought the Commissioner dialogue also was really informative. I learned a lot, and I will stop here because I know we're over time. Thank you.

MS. KELLEY: Paul.

DR. CASALE: I'll be very brief. Thank you.

Thank you again. Great work.

I just want to make a comment and agree with many of the comments that have been made on the coding intensity issue, which Scott brought up and Amol just brought up. I think, as Scott said, it's not clear that it provides any meaningful improvement in quality. And as, again, Scott said, if addressed appropriately may actually go a long way to addressing these differential in payments. So I think whether it's through more robust auditing, whether the version 28 model will actually impact that, I guess we'll see. Or as in the MSSP program, you're limited in how much your risk score will improve, no matter how many codes you put in. I think there's lots of options, but I think more attention to that as a way to address the differential payments, I think, is important.

And similarly, for the quality bonus payment, again, people made the comment about meaningful measures and really moving towards more meaningful measures in that program.

Thank you.

MS. KELLEY: believe that's the end of the queue, Mike.

DR. CHERNEW: So, again, I'll say again, wow. The first time was about the quality of the work. The second time was about the quality of the discussion. So I really do appreciate everybody's views. There's obviously differences of opinion around the table. I think that's probably a good thing in the grand scheme of the world.

I will just say three things before we take a very quick break and then come back to do critical access hospital chapter.

So thing number one, the concepts of the cost of Medicare Advantage relative to traditional Medicare is different than the concepts of the value of Medicare Advantage relative to traditional Medicare. And I hope we have tried -- I pray that we have conveyed that well in the chapter, and, you know, I can tell you some of it's a Rorschach test. People's views determine how well they think we've reflected them. But since I get complaints on all sides, we will continue to try and do better.

Second point, there is heterogeneity across plans. I think, Greg, you've raised this a lot. I could not agree more. We have charts on this. There's heterogeneity in coding, which you mentioned. There's

heterogeneity in value. There's heterogeneity in a range of things. This is a challenge in general because we are trying to provide a status report on the MA chapter. So we want to provide some aggregate sort of sense of the program, but we certainly want to acknowledge, per your point, that there is heterogeneity. And that heterogeneity needs to be taken into account in terms of policy and a whole range of other things. I could not agree more, and hopefully, that is prominent enough. But I say it now so those at home understand that we really recognize that.

Third point, I said this. Tamara said it. Tamara said it better. But the analytic -- if you look at slide 28, you don't have to put it up. But if you did, I wouldn't complain. If you did, I wouldn't complain about slide --

[Laughter.]

DR. CHERNEW: I'm sorry. About slide 28. You don't have to. I'm not complaining. It's wonderful work.

But selection is -- I'm going to use the word. I understand, Tamara, it is not the right word. I'm sorry. "Residual." And so it turns out, if you have very low predicted spending, it's virtually impossible to have

selection because you can't select on somebody whose predicted spending is really low. There's just not a lot of room there. If you really -- high predicted spending, if you're really sick, if you're predicted to be really high spending, there's a lot more room to have selection.

And so I will say about this chart, the shorter the bar -- the shorter the bar, the more selection there is, if you will, because the selection percentage is lower, which is our measure. And so we have really, really taken this to heart to try and do this analytically, and so because this is so important in the overall debate to understand what we're measuring -- surprisingly, it's on the screen now -- I just wanted to emphasize that we really understand the selection work and the relationship between the residual part and the predicted part.

So I'm going to leave it there because I've been trying to get everyone to speak less, and that should go for me too. I have a lot of things I'd like to say. I won't. We're going to take a very quick five-minute break because there's a really, really important issue about how critical access hospitals are treated in terms of beneficiary cost sharing, and that is particularly

important because while this is a status chapter, that we're going to be planning to get to a vote on. So we have to make sure that there's enough time to have a discussion for things for where we hope to get to a vote.

So let's take a very quick -- and I mean that. I don't know. I don't have a lot of show business experience. "A tight five," is that what they said?

MR. MASI: Good show.

[Recess.]

DR. CHERNEW: So welcome back, everybody. There has been a lot of concern about a range of things about care delivered in rural areas and access to beneficiaries and the care for beneficiaries in rural areas and paying supervisors in rural areas. And there is, I think, one particular topic that we've been concerned about, and Lynn, you'll get some credit for how this all came about. But in any case, and that's beneficiary cost sharing for critical access hospitals.

So we're going to go through an analysis of that, we'll get a draft recommendation, and we'll see how the discussion goes. But Jeff, you're going to start.

DR. STENSLAND: So as you may remember, in our

September meeting, we discussed outpatient cost sharing at Critical Access and we are going to revisit that topic today. In addition, to provide you will a more complete picture of cost sharing in rural areas, we also present some new information on charge-based coinsurance at rural health clinics. In future meetings we will follow up on other rural issues such as the effect of expanding MA enrollment in rural areas.

To recap where we are on critical access hospital cost sharing, recall that we discussed cost sharing in the spring of 2024 and again in September of 2024. Given the Commission's strong interest in moving away from charge-based coinsurance, today we will present the Chair's draft recommendation to change CAH coinsurance. Depending on your interest, Commissioner interest, we may come back for a vote on changing critical access hospital coinsurance in the spring, and that without objection, work will culminate in a chapter in our June 2025 report to Congress.

And now for our roadmap. We start the presentation with a theoretical overview of three types of special payments to rural providers. Then we will focus the rest of the presentation on one type of rural payment

model, namely cost-based payments, where beneficiaries pay charge-based coinsurance. We first discuss critical access hospital coinsurance. Then we present the Chair's draft recommendation. And to give you a fuller perspective, Brian will then talk about rural health clinic cost sharing. But given that this is the first time you have seen this rural health clinic work, the Chair does not have a draft recommendation on rural health clinic cost sharing at this point.

So I think rural special payments can be categorized into three groups. The first is add-on payments to PPS rates. Examples of this are low-volume hospitals and sole community hospitals. We have talked about these programs at length in past reports.

The second is fixed payments plus a PPS rate, which is how Medicare pays rural emergency hospitals. The Commission discussed the rural emergency hospital model in our March 2024 report to the Congress, and we will continue to report on the program annually.

The third type is cost-based payments. We talked about critical access hospital program and are going to review that again today. Critical access hospitals are

paid 101 percent of costs prior to the adjustment for the sequester. The new information today will be on rural health clinics and how cost sharing works in that program. The rural health clinic program payments are limited to 80 percent of costs, but coinsurance from the beneficiary is not limited, as Brian will explain.

The charge-based coinsurance is the focus of today's discussion.

As we discuss in more detail in your mailing materials, critical access hospital status can dramatically increases payments rates for outpatient services and post-acute care services at these small hospitals. These higher payment rates are often critical for keeping these hospital financially viable. However, much of the additional payments for outpatient services at critical access hospitals are funded by higher beneficiary coinsurance, which is set at 20 percent of charges.

Prior to the sequester, Medicare payments to critical access hospitals are set at 100 percent of costs minus coinsurance. What is important to note that coinsurance is set equal to 20 percent of charges, and charges are list prices which are often far higher than

hospital costs, meaning 20 percent of charges can be a large portion of the total payment to the critical access hospital.

In addition, charges can vary widely from hospital to hospital, meaning the share of the payments paid by the hospital can vary widely from hospital to the next and even across services within a hospital. For comparison, PPS hospitals' cost sharing is 20 percent of the administratively set payment amount, and this tends to be far lower than charge-based coinsurance and is also more consistent across providers.

To examine coinsurance, we looked at 2022 claims, and at that point there was about $3.3 billion of coinsurance billed to beneficiaries and their supplemental insurers for outpatient services at critical access hospitals. Program payments were about $3.2 billion, and total payments for the services that required coinsurance were about $6.5 billion. What this means is about half of the fee-for-service outpatient payments to the critical access hospitals were coinsurance.

There were 1.9 million beneficiaries using these services and they or their supplemental insurers paid an

average of $1,750 in coinsurance over the course of 2022. For about 84 percent of rural beneficiaries they have supplemental insurance that would pay that coinsurance. But about 16 percent of rural fee-for-service beneficiaries do not have supplemental insurance, and they would be billed 20 percent of charges directly.

On average, coinsurance was equal to 52 percent of the payment amount, but in about 4 percent of hospitals, those with the highest mark-ups, the full cost of the claim was billed as coinsurance. The program did not pay anything. This occurred for about 1 million services in 2022.

In the next slide we are going to illustrate how the coinsurance is all driven by charges.

Now look at this slide, and even for hospitals with identical costs, as we've laid out in this example, coinsurance can vary substantially from one hospital to the next, depending on the hospital's markups.

In the first column we show that if a hospital's service cost $600 to provide, and that hospital charged $1,000 for that service, its coinsurance would be $200, or 20 percent of charges. In contrast, look at the last

column. This is a high markup hospital, where the CAH charged 400 percent of costs, or $2,000 for the same service. In that case, coinsurance would be $480, or 20 percent of that much higher charge.

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

Another difference between critical access hospitals and traditional hospital coinsurance is the existence of a cap on coinsurance at traditional hospitals. In 2025, the cap is $1,676 per procedure, which is the amount of the inpatient deductible.

The idea is that a beneficiary should not pay more in coinsurance for a single outpatient procedure than they would for an inpatient stay. Without a cap on this outpatient coinsurance, a beneficiary without supplemental insurance would have an incentive to have a joint replacement done in the inpatient setting just to avoid the high level of outpatient coinsurance.

Let's walk through the comparison of OPPS and critical access hospital coinsurance. Let's start with the PPS hospital in the first column. Assume the joint

replacement surgery costs $13,000 at this hospital, and it charged a list price of $26,000. The outpatient payment rate is prospectively set at $12,867 in 2025, for a wage index of 1. This is the third row. The coinsurance that the beneficiary is billed is going to be the smaller of either the cap or 20 percent of the payment rate. In this case, the cap is lower and the coinsurance would be $1,676, in that first column.

In contrast, look at the second column. This is the critical access hospital case. The critical access hospital has the same costs and the same charges as the PPS hospital. However, the coinsurance at the critical access hospital is set at 20 percent of charges and this has no cap. Twenty percent of the $26,000 of charges is $5,200, as we see in the second column.

The point of this example is to show that the coinsurance difference between a PPS hospital with a cap and coinsurance at a critical access hospital without a cap can be substantial.

I also want to note that this issue of coinsurance being greater than the cap has been growing over time, and is expected to grow in the future, as more

expensive surgeries and more expensive drugs, Part B drugs, are provided on an outpatient basis at critical access hospitals.

In September, we discussed the policy option of setting coinsurance equal to 20 percent of the payment rate at critical access hospitals. The key assumption in the model is that program payments will increase to offset any reduction in beneficiary coinsurance. The implication is that payments to critical access hospitals will not change, even though beneficiary cost sharing declines.

Because coinsurance is equal to 20 percent of the payment, that means that any increase in the payment due to cost-based payments will be borne 80 percent by the Medicare program, and its taxpayers that fund it, and 20 percent by those using the critical access hospitals or the supplemental insurance of those using the hospitals.

Now I will walk through what the implications of the policy would have been in 2022 for costs to the program if coinsurance had been based on the payment rate.

We examined 2022 claims and compared what coinsurance would have been if it was set at 20 percent of the estimated payment for the service as opposed to

charges. We found that beneficiary coinsurance would have been about $2.1 billion lower. This is about a 60 percent reduction in coinsurance, on average. This would lower coinsurance for beneficiaries that do not have supplemental insurance and reduce inequities of coinsurance across critical access hospitals.

The total cost of shifting a larger share of critical access hospital payments to the program, along with the effect on fee-for-service and MA together, would have been about $3.2 billion. And that $3.2 billion in extra spending would have been funded about 75 percent from the program and its taxpayers and about 25 percent by the beneficiaries, who would pay higher Part B premiums, because 25 percent of the costs of all the Part B spending is funded through Part B premiums.

So that leads us to the Chair's draft recommendation, which reads:

The Congress should set coinsurance for outpatient services at critical access hospitals equal to 20 percent of the payment amount for services that require cost sharing, and place a cap on critical access hospital outpatient coinsurance equal to the inpatient deductible.

The implication for spending is that program spending will increase relative to current law. We won't get this final spending estimate until the Congressional Budget Office makes an estimate if we decide to go forward.

With respect to beneficiary and provider implications, the recommendation would reduce cost-sharing liability for beneficiaries who use critical access hospitals, reduce Medigap premiums for beneficiaries in states with critical access hospitals, increase Part B premiums for all beneficiaries, and have no material effect on critical access hospitals' revenues or willingness and ability to treat Medicare beneficiaries.

Now I'll turn it over to Brian, who will pivot a bit and talk about charge-based coinsurance at rural health clinics.

MR. O'DONNELL: Before we get into charge-based beneficiary coinsurance at RHCs, I'll first review some basic RHC background.

In 2022, about 4,800 RHCs billed fee-for-service Medicare. Of these, about two-thirds were provider-based, meaning they were owned and operated by a hospital, and the remaining third were independent, freestanding facilities.

In 2022, RHCs treated about 2.3 million fee-for-service Medicare beneficiaries and furnished 9.5 million visits to those beneficiaries. Fee-for-service payments to RHCs totaled about $1.9 billion.

RHCs must initially be located in a nonurbanized area that qualifies as a HPSA, MUA, or governor-designated shortage area. RHC services are generally outpatient visits, such as E&M office visits, furnished by clinicians. Fee-for-service Medicare pays RHCs an all-inclusive rate per visit, which is calculated by dividing total costs by the total number of visits.

Over time, Congress added per-visit payment limits to different types of RHCs, which means that the Medicare program payments are based on the AIR up to a payment limit per visit.

As of 2021, all RHCs are subject to payment limits. Payment limits vary based on whether an RHC is independent or provider-based, and other factors which I'll review on the next slide.

Independent RHCs and non-specified provider-based RHCs are subject to the national statutory payment limit per visit.

As the table on the right-hand side of the screen shows, these payment limits are set to increase rapidly, growing by 120 percent from 2020 to 2028, and then by MEI thereafter.

The next group of RHCs, which accounts for about two-thirds of all RHC volume, are specified provider-based RHCs. These RHCs have only been subject to payment limits since 2021, and their payment limits are generally substantially higher than other RHCs. They are provider-based RHCs that are part of a hospital with fewer than 50 beds and were enrolled in Medicare as of December 31, 2020.

The payment limit per visit for these RHCs is the greater of the national statutory payment limit or their historical costs per visit, updated by MEI.

Now, switching back to the topic of coinsurance, beneficiary coinsurance at RHCs is equal to 20 percent of RHC charges. Beneficiary coinsurance is not capped based on AIRs or payment limits. Medicare's program payment is set to 80 percent of an RHC's AIR, subject to payment limits. Unlike at critical access hospitals, program payments do not change based on beneficiary coinsurance. Therefore, RHCs can increase total payments by increasing

charges.

As a point of comparison, for clinician services in other settings, beneficiary coinsurance is capped. For example, under the physician fee schedule and the FQHC payment system, beneficiary coinsurance is set to 20 percent of the lesser of the payment rate or charges.

This slide walks through an example of how higher RHC charges results in higher beneficiary coinsurance and total payments to RHCs. In the first two rows, you can see that these RHCs have the same rates -- $152 per visit -- and the Medicare program payment per visit does not change. However, as seen in the next row, RHC number two has higher charges at $225 per visit, which increases beneficiary coinsurance from about $30 to $45 per visit.

Because program payments didn't change, you can see in the last row that RHC number two, the one with the higher charges, also realized higher total payments per visit.

This payment structure can lead to high and variable beneficiary coinsurance, which we evaluate on the next slide.

In 2022, we found that average beneficiary

coinsurance as a share of estimated AIRs per visit was 34 percent at independent RHCs, 38 percent at non-specified provider-based RHCs, and 17 percent at specified provider-based RHCs.

Also, as shown on the right-hand part of the slide, we also found that beneficiary coinsurance rates varied widely within types of RHCs. For example, looking at independent RHCs, at the 10th percentile, coinsurance was 20 percent. However, at the 90th percentile, coinsurance averaged 57 percent.

In another example, we identified about 100 RHCs owned by a private equity firm and found that the average coinsurance was about 60 percent at these RHCs due to high charges.

The key takeaway from this slide is that RHCs often have charges that are far above their AIRs, which increases beneficiary coinsurance and may create inequities across beneficiaries.

To provide Commissioners with context about the charge-based coinsurance at RHCs, we simulated the effect capping coinsurance at 20 percent of AIRs on two outcomes, beneficiary coinsurance, which I discuss on this slide, and

total fee-for-service payments to RHCs, which I discuss on the next slide.

In 2022, we estimate that capping beneficiary coinsurance would have reduced beneficiary liability by 43 percent at independent RHCs, 49 percent at non-specified provider-based RHCs, and 8 percent at specified provider-based RHCs.

In terms payments to RHCs, we estimate that capping beneficiary coinsurance would have reduced total fee-for-service payments to RHCs by 12.9 percent at independent RHCs, 15.8 percent at non-specified provider-based RHCs, and 1.4 percent at specified provider-based RHCs. The effects on specified provider-based RHCs was small because two thirds of these RHCs already set their charges at or below their AIRs, and many others set their charges just above 20 percent.

In addition, the effects on independent and non-specified provider-based RHCs are likely to be smaller in the future because of rapid growth in payment limits. For example, in 2028, we estimate that total fee-for-service payments to independent RHCs would fall by about 7 percent, which is small relative to the 120 percent increase in

payment limits occurring at the same time.

This brings us to the Commissioner discussion. We're happy to answer any question on the material and would like your reactions to the Chair's draft recommendation on CAH coinsurance.

And with that, we look forward to your comments, and I turn it back to Mike.

DR. CHERNEW: So thank you very much.

A few things. We're going to go through Round 1 and 2. When we get to Round 2, I do want to make sure that everybody says at least a nod or a nay, whatever -- I'm asking you to vote -- about their general reactions towards the draft recommendation, because the plan is to come back and have a vote. And so you may not have any comments on the chapter per se, but I care about your general -- just your general perceptions, even if it's 20 seconds, especially if it's 20 seconds.

Anyway, let's start the round, and as an aside, we are contemplating the rural health clinic work, which, you know, you can give thoughts about your enthusiasm. We're not planning a recommendation on that, so that's sort of on a different path.

Anyway, I think we're going to start with Round 1, and I think Kenny was the first in Round 1. Is that right, Dana? Oh, Lynn was the first. I'm surprised I didn't see that. Kenny was putting in Round 1 right when the last session was ending, but anyway, go ahead, Lynn.

MS. BARR: Let me turn on my microphone.

Okay. Thank you. Thank you. Oh, my God. This is a fabulous paper. Lots of great information, very, very easy to understand.

I do have a number of Round 1 questions, so I'm just going to run right through them.

Right in the beginning, we talk about how the CAH markup is the cause of these higher co-insurance. I think it's important to compare the CAH markup to the PPS markup because, you know -- and you mentioned this later in the chapter as well about how in micropolitan areas, you know, the more urban you get, the closer they get. That's because they're going up. They're pricing based on the market, on the local market, right? If they're isolated, they do less. But roughly, they're about 250 percent of charges. And I think the national average for PPS hostels is about 350 percent -- or of costs. I'm sorry. Of costs.

And so, yes, they mark it up, but people blame them, and it's like, oh, it's their fault because they mark it up. It's like, no, actually, they mark it up a lot less. And you do mention that commercial insurance uses those rates to determine payments. So it's important they can't just bottom them out at, you know, below their costs or at their costs. So anyway, wanted to make sure that that was all clear.

And page 7 -- so I'm just -- this is all out of the report, right? So at page 7, you mentioned that rural fee-for-service beneficiaries bypass their local hospital, instead choosing to receive non-emergent service at a larger and more urban hospital. And that Knudson paper, which is something that I object to strenuously that was published by CMS, those non-emergent conditions are the top 20 DRGs people drive by for, you know, like strokes, GI bleeds, and heart attacks.

So I'd like to ask the physicians in the room, would you prefer to go to a local hospital that doesn't have a surgeon, doesn't have TPA, et cetera, for a stroke? And that's considered, you know, people are bypassing, and they're saying it's because of quality. And I just think

that's ridiculous.

DR. STENSLAND: I would just say that when we looked at bypass in our rural thing, I think you were here for that. But the things that we saw a lot of bypass for that they did were things like congestive heart failure, pneumonia, UTI. Those were kind of things that we saw a lot of bypass in our analysis of the inpatient admissions when they didn't go to their closest hospital, and they went to somewhere else, meaning the closest hospital, things that they did commonly. We'll try to come back with more data on that.

MS. BARR: Yeah. That wasn't -- that was not -- none of that was included in the paper that you quoted. They didn't mention any of those conditions. So anyway, I just hate that.

Okay. Page 11, approximate costs, and this goes to my question I raised in the -- so we say it's 101 percent of costs. But I just want people to understand it's allowable costs, and there are a lot of legitimate costs of providing care that are not allowed. And so, it's not 101 percent of costs.

And then the rural sector has been uniquely

affected by sequestration, right? So now it's 99 percent of costs, and that's permanent, where other people that were affected by sequestration in subsequent budget cycles were able to actually raise their budgets appropriately to cover their costs. So this is an unfair tax on cost-based reimbursed facilities under Medicare, where they're being disproportionately charged for sequestration.

Page 14. What is the range of charges on page 14 in that graph? Could you -- and could you include the $400 charge in the table? Because what I really worry about is when we're talking about coinsurance, you know, and it's a $400 physician visit, it's $80 out-of-pocket, you know, if you're paying just 20 percent of that, right? And that's almost the cost of going -- of paying for yourself to go see a fee-for-service physician. So the amount of coinsurance is becoming -- like you say, we're paying for everything or almost the entire service that would cost the same.

Page 21. Can you compare RHC coinsurance costs and total charges to fee-for-service on that table? And then we can always talk more about that. I'm just going to give you -- you know, if you want to come back, we can talk

more.

On page 25. On page 25, it says despite the claim, denials, and delays -- or site visits suggest that net rates, MA plans pay CAHs -- even after denials are still generally higher than traditional PPS rates for outpatient care. I feel like that statement is misleading. We could -- you know, we could talk about that a little bit more, but I'm not -- I want to -- I feel that that's a misleading statement, that it's not consistent, that it's not consistent with the experience of what we're seeing with denials in rural papers that are being published. And so I just want to -- want to come -- maybe we can talk about that.

DR. STENSLAND: We can talk about that.

MS. BARR: We can talk about that. All right.

On page 28, Table 4, are those real markups? Can we use real median markups by percentile? It seems like it was an illustrative example because they were all rounded numbers, and could you just give us the real markups by percentile?

DR. STENSLAND: That is approximately the markups by percentile.

MS. BARR: Okay.

DR. STENSLAND: So it's not like within the tenth of a percentile, but that's approximately it.

MS. BARR: Okay. Great. Then maybe you just mention that, because they're rounded numbers, they look like they were made up. Not that you guys would ever make up a number, ever, but other people might think you did.

On page -- okay. Page 17 and 18, great insight into RHCs, private equity at a 60 percent premium. I think when you do your later analysis of markups, I think maybe carving those out or -- and is it -- a little bit more about that and also making sure that, you know, when you're down at the bottom of the paper and you're looking at markups of different sectors, how much is the independent -- the independent sector is much higher than I would have expected, but they're the ones that are getting all the penetration from private equity, right? It's not the provider base. It's all the -- so what was that -- what was that number before private equity started doing it?

And I'm seeing tons of -- I mean, I get lots of calls on these private equity acquisitions of these independent RHCs. It's a whole new industry right now. So

I think we need to really pay a lot of attention to it and try to improve on it.

MR. O'DONNELL: Yeah. And I should say, there has been more entry since 2022. In the 2022 data, even if you extracted the kind of PE-owned RHCs, the markups would still be high at independent RHCs, but that is in 2022. Going forward, it could be a different story.

MS. BARR: Yeah. The problem with that is 2022 didn't have the updated RHC rates, right?

MR. O'DONNELL: It was just two years into the big, long hike of rates, so just beginning.

MS. BARR: Okay. Yeah. So part of it is like -- I mean, what did they use to get paid? Independent RHCs? It was $80, $90 a visit. I mean, it was so little, that if they didn't charge more for co-insurers, they couldn't stay in business. And so I think there might be a shift on that -- it's because we were underpaying them so egregiously -- where they were having to charge the beneficiaries more. And I'm curious as how that changes as their rates go up, but it does take time for the rates to go up to the point.

And I'm almost done. On page 30, the Med Supp rate was a lot lower than we had anticipated, right? It

was 84, 86 percent, you know, where the national average is in the 90s, and I was surprised by that. And I was curious if you had any more information on that.

And it doesn't mention under-insurance in terms of employer plans, right? So can you also provide more context there about employer plans? And I don't know to what level we have the data of employer plans not paying for the excess co-insurance, but I know that that was true in my rural community. So I don't know how many of them were true.

Page 31, there's a typo. It says, like, $380 supplemental. I'm sure you guys would have caught that.

Page 34 -- yes.

DR. CHERNEW: Make sure they're questions.

MS. BARR: They are questions. They are questions.

So in page 34, the Medicare costs go up by $2 billion, and the MA part, right? So we're going to have to increase the payments to MA. But the question is, isn't MA -- so Medicare is going to have to pay more because the beneficiaries are going to pay less, right? And so if we had 100 percent of Medicare, that $2 billion would just be

on us, right? And so we're saying, well, we're giving MA more money, but it's just because they have half the beneficiaries, right? And it's going to cost them more money. So it's not a gift, and I just want to make it really clear, you know, that we're not -- this is not a -- you know, a problematic.

That's Round 2. I'm sorry. Okay. But I have nothing on Round 2.

Thirty-six. Page 36. I got two more. Co-insurance grew at a rate of 7 percent per year. Expect that to continue. Can we see a graph of outpatient revenues over time? Did that grow at 7 percent, you know, as well?

And then shouldn't the denominator in that be rural fee-for-service, not 33 million patients in that calculation? And that's, again, on page 36. So, like, I'm not quite sure, and again, we can talk about this more, and so -- in the interest of time.

And on page 37, please list employers in the table.

And that's it. Thank you. Sorry. It was a lot.

MS. KELLEY: Kenny.

MR. KAN: Great chapter. I support the Chair's draft recommendation, and I just love what -- Lynn's average speaking time.

MS. KELLEY: Greg.

MR. POULSEN: I actually had a really quick question, and before that, I will say I support the Chair's recommendation as well. So we'll get that out of the way, and we don't need to come back.

But it was simply the question on slide 13 where we said that we don't anticipate an impact on hospital finance, and I just wondered. I realize a lot of this is Med Supp. So there's probably not a big impact in terms of bad debt. But in terms of collection for Med Supp, that isn't always universally easy either.

So, you know, it seems to me there may be a minor benefit to the hospitals on this move. Do you see it the same way, or is that -- am I seeing it incorrectly?

DR. STENSLAND: Yeah, we didn't look at the -- like, somehow Med Supp being unable to be collected. That's not in there.

What is in there is two offsetting factors. The one factor is when we reduce the amount that the

beneficiary is liable for or their supplemental insurers, there's going to be less bad debt, because in some cases, you know, the hospital bills people, and they don't pay it. And when they don't pay it, then the Medicare program comes in and pays 65 percent of it, but that's still not a whole amount. So they're benefitting from that, and that's the plus for the rural community hospital.

And then the -- but the minus for the hospital, which kind of gets to what Lynn said, is the sequester, they get a 2 percent reduction on the program payments. They don't get that 2 percent reduction on the beneficiary co-insurance. So then the co-insurance, the amount that they're actually entitled to get, is a little bit less because now it shifts to the program, and they're getting 98 cents on the dollar rather than 100 cents on the dollar. But of course, they're more likely to actually collect because the program pays their bills, and sometimes the beneficiary doesn't pay the bills. And those things roughly offset. So that's how we get to zero.

MS. KELLEY: That's all I have for Round 1, Mike. Can I go to Round 2?

DR. CHERNEW: Please go to Round 2.

MS. KELLEY: Okay.

DR. CHERNEW: And for those of you in Round 2 or who are not in Round 2, I am going to want to make sure that everyone gets this recorded on their view of this. So yes, go ahead.

MS. KELLEY: I'm going to start with a comment from Gina.

Gina supports making the cost sharing for those using critical access hospitals more equitable by limiting beneficiaries' cost sharing in traditional Medicare to the usual Medicare allowable amount. Her concern is that this may in turn increase the rebate amounts paid to MA plans in these rural communities, potentially driving more people to MA plans, which may negatively impact these rural hospitals and providers. Is there a way to limit the rebates paid MA plans in these rural communities so as to make traditional Medicare and MA plans more equitable?

She also supports trying to make beneficiary cost sharing in rural health centers more equitable.

And now I will go to Stacie.

DR. DUSETZINA: Great. Thank you so much.

I feel like this topic is one of those where it

feels like when you learn about it, you're like I cannot believe this is allowed to be happening to beneficiaries, and so I will say I just enthusiastically support the work and the recommendation.

MS. KELLEY: Cheryl.

DR. DAMBERG: I also support this recommendation, both the setting the co-insurance based on the payment amount as well as the cap.

I do think that this is an issue of equity in terms of beneficiaries across the spectrum in terms of where they live and what types of facilities they have access to.

MS. KELLEY: Lynn, I have you next for Round 2. Do you -- but I thought you said you were done. I'm not sure.

DR. CHERNEW: No. Lynn, you should actually go with your comments. Everyone is being brief. So there's more time to -- take your time. There's more time than I feared. I just want to make sure that everyone has a fair time to say, because I don't know how much they're all going to want to say in advance.

MS. BARR: Very little to say other than I am

incredibly grateful to the work that you've done. And, Jeff, you know, you spent your whole career, you know, really supporting rural, the rural sector, and we've been so lucky to have you. And this is incredible work, and I'm so grateful that this horrible injustice might actually be cured, thanks to this Commission and your work and your diligence on this.

So I strongly support the recommendation. I think we have more work to do around RHCs, but I was very -- I learned. I didn't know that, you know. So we're always learning stuff from your work, and I really look forward to the final report. Thank you.

MS. KELLEY: Scott.

DR. SARRAN: Excellent work. I think particularly the slides that you put together that illustrate specific scenarios are wonderful because they really drive, I think, the take-home, and I support the direction we're going in.

MS. KELLEY: Tamara.

DR. KONETZKA: I also strongly support the draft recommendation, both parts of it, paying at a percentage of payments and also the cap. To me, this just falls into the

category of an inherent unfairness that was probably not intended in the first place and that just needs to be fixed, so somewhat of a no-brainer.

And thank you to Lynn for making us all aware of this issue.

MS. KELLEY: Josh.

DR. LIAO: Thank you for this work. I think a lot of the conversations helped me to understand all the broader issues around rural that are yet to be done and yet to be discussed, but I think this -- among that is for policy symmetry and equity reasons that others have mentioned, obviously need to do. I support the draft recommendation.

MS. KELLEY: I have a quick comment from Robert. He supports the Chair's recommendation. He does have some concerns about the increase in program spending without offsets.

Next, I have Paul.

DR. CASALE: I also want to my thanks for the great work. I learned quite a bit -- a lot, actually. And I just want to say that I support the Chair's draft recommendation.

MS. KELLEY: I also have a comment from Betty. She enthusiastically supports the work and the recommendation, and agrees that this is an important step toward a more just system.

And I think that's all I have for Round 2 in my queue.

DR. CHERNEW: A few people, Larry.

DR. CASALINO: I support the recommendation, and I agree with Scott's point that the examples are very helpful. I mean, the text is also very clear, but the examples make it easy for people who otherwise don't know anything about it.

DR. CHERNEW: And Kenny, I think you said something in Round 1. Yeah, right. Brian.

DR. MILLER: I just had a question of whether we should target the policy a bit more. I was digging around online and I found this great paper about CAH margins, by Chris Whaley at Brown, Ge Bai at Hopkins, and Marilyn Barlett. And it showed that margins for system-affiliated CAHs were pretty high, and non-system-affiliated CAHS or independent CAHs was much lower.

So I'm wondering if we should target this

recommendation more related to independent CAHs so that we don't inadvertently drive consolidation, or bring in another hospital designation like Medicare-dependent hospitals, all-community hospital, something like that, to help make it more targeted.

DR. CHERNEW: Amol.

DR. NAVATHE: I support the draft recommendation.

DR. CHERNEW: And Greg, I think you said something. I don't know if we have anything from Wayne. And if I got it right, that would be everybody. If I forgot you, I am so, so, so sorry.

So there's one other thing that I thought there was going to be a lot of conversation on. Oh.

DR. CASALINO: No, I did, but I was just going to say, if we have time --

DR. CHERNEW: Well, we do have time because it turns out that, well, I'll explain what I was hoping you would talk about, which no one did.

DR. CASALINO: I would be in interested if there were more comments from people more knowledgeable about this year, about what Brian just said. I'd like to hear it.

MR. POULSEN: I've seen those closely, and Lynn might as well. That may be a relevant issue, but it doesn't seem relevant to this discussion because it doesn't impact hospitals positively or negatively in terms of this. That was the point of my question to Jeff. So thanks.

DR. CHERNEW: I think our core issue here is a little bit more beneficiary protection stuff. I think there's also some implementation issues. But I think we will have a conversation about Brian's point and decide where we go, about how we might change it. There is an operational issue, which is if we change the recommendation, which we certainly could do, it's going to push us to a new draft recommendation, a new discussion, and a new cycle. That's just what's going to happen.

That might be the right thing to do. If people felt strongly, that absolutely might be the right thing to do. But I'm saying that's the process issue that's going to matter, because we have to have a draft recommendation discussion. We could think about how to do it now, but we haven't done the analysis to understand that. So we've been motivated by the beneficiary cost-sharing protection portion of it.

But maybe Brian wants to say something. Go ahead.

DR. MILLER: I was going to say, I mean, it's hard to run a CAH, especially in a rural area, so I understand why it's something -- and merging systems on particular matters. We don't want to inadvertently put the accelerator on consolidation.

But in general, you know, holding beneficiaries harmless I think is important. Because I'm generally supportive, but think that we should do that additional analysis and see if additional targeting is needed.

DR. CHERNEW: Yeah. So again, that's a reasonable point I guess I'd ask to the group. If we do additional analysis, that's going to take an additional amount of time, and then we're going to have to send out a chapter that has the additional analysis, and then we'll have to decide what to do.

So again, I'm happy to do it if that's what the consensus is, but that's just the process of how it would play out. But I appreciate the point, and we will consider that, and then we'll ultimately decide what to do.

Lynn, you want to say something.

MS. BARR: Yeah, like you say, this about the beneficiary. The effects on the hospitals are neutral. There is no impact on consolidation. I mean, the hospitals are whole. The beneficiaries are the ones that are suffering. They're suffering whether they're being charged at a system hospital or a non-system hospital. It's already an equity issue. We're already discriminating against them. I don't want to say we're going to discriminate against half of them because the other half are in systems. It doesn't make any equitable --

DR. CHERNEW: So we will ponder that. I think I get a sense of where you are -- not you. I mean collectively you.

As someone wrote in the chat, we really understand your passion. I'm not sure how you couldn't understand your passion.

So I'll just say, honestly, what I was also interested in hearing about, and I thought there would be some discussion, we've done a great work on rural health centers, and the rural health center issues are similar but they're not the same. And so we have a decision to make about what we think about what we do with rural health

centers.

It is easy to take from this discussion. I think it would be wrong, by the way, but one could take from this discussion, there's just not a lot of enthusiasm around rural health centers because no one actually really mentioned it. I actually don't think that's true.

So I just wanted to raise it explicitly so at least someone can say something, because there are always resources. Lynn.

MS. BARR: It's my paper. I've been waiting for four years for this paper. You know, I think that the RHC data was very illuminative, and I'm very concerned about the new RHC payments and the huge escalation of the all-inclusive rate, and how that will drive beneficiaries out of the community. But I think the solution there is to bring that co-pay down to a more normal rate as opposed to 20 percent of charges is still going to be $80. They're still not going to get care, right, for a $400 visit. And they're likely to not get care as opposed to going somewhere else.

So I think that the suggestion of just reducing it to the AIR rate would still prevent beneficiaries from

getting local primary care. So I think we need to get a lot more discussion about RHCs in department.

DR. CHERNEW: I appreciate that, and again, just for everyone else to understand, we are at the beginning of the RHC stuff. We don't have a draft recommendation. I'm not sure what to do. There's a lot of considerations. The sort of on-the-table question is, how much resources we spend to kind of continue to do that type of work to get there and where they fit into the overall system.

So, not surprisingly, I understand, and by the way, just to be super clear, I share. It wouldn't be in the chapter if I didn't share that part of enthusiasm, with a staff who really brought it to my attention, and I think they did a terrific job.

But I'm just looking around. Go ahead.

DR. DUSETZINA: Yeah. I'll reiterate that I think this recommendation that focuses on beneficiary coinsurance cost sharing is really important to emphasize, the support, regardless of how we get there. So if feels like this is step one. This should not be happening to beneficiaries.

DR. CHERNEW: This is just critical access

hospitals. This is a different version of a beneficiary problem.

DR. DUSETZINA: Right. But kind of going back to the broader comment that Brian raised but also comments that others have raised around MA and what happens there, there are a lot of nuts and bolts behind how do we do this, how do we fill in that gap. But I think that this is clearly egregious behavior to charge beneficiaries based on charges. And so I think that the emphasis of this should be fixed, and then we'll get to the how do we do it in a way that feels like the right way to do it is part two, right?

DR. CHERNEW: Well, I just want to be clear. We're going to have a vote, based on what everybody said, on literally how to do it for critical access hospitals. We have not explored the how to do it for rural health centers, because the programs are separate, so the how-to-dos are separate.

And so the question is the extent to which we pursue the how-to-do-it on the rural health center part versus we say, you know, we've addressed it in the critical access hospital part, let's move on to a whole slew of

other questions that the hospital team and others can look at. That's kind of what's on the table.

Did you want to add anything to that, Paul?

DR. DUSETZINA: I guess both seem important, the rural clinics and the critical access hospitals. Both seem very important. It feels like we have gotten to a farther, more mature place with critical access hospitals in the way we've been framing this and the recommendations.

But I think that to the degree that these are similar issues for beneficiaries and how burdensome it is for them to obtain care in their communities, I think that they both need to be addressed.

DR. CHERNEW: Yeah. Paul --

DR. DUSETZINA: But not at the same time.

DR. CHERNEW: I want to say a few things. We are in the Round 3, because you were so disciplined in Round 2, surprisingly so. And I truly understand -- I don't want to drag it out, and want to make sure people have time to talk, really, but I think we do want that set of direction. So Paul is going to ask a clarifying question, but you can actually use the queue if you want to say something. Or you can just say what you think.

But I'm just trying to express that the issue on the table is, there's an egregious issue that everyone mentioned, in critical access hospitals. We have a proposal, which most people supported, about how to address that issue. There is a similar but not the same issue in rural health centers. It takes a number of sessions like this to do the analysis, go with a policy option, have the draft recommendation, and do a vote. So there's a cost to everything we do, and there's a timing for what we do.

So because this is sort of new, that's what we're trying to get. So Paul.

MR. MASI: It's very exciting to be in Round 3. Thank you for this discussion. I just had kind of a narrow clarifying question related to the critical access hospital conversation that you folks were having.

Just to make sure we're understanding where this is going, are there any Commissioners that are contemplating a path forward that would allow any critical access hospitals to continue charging coinsurance to beneficiaries based on charges? I think that's an important clarification.

DR. CHERNEW: For the transcript --

MR. MASI: For the transcript --

DR. CHERNEW: For the transcript there are a lot of noes there, and I'm going to watch the queue. But anyway, let's put that part, at least for now, to bed. Again, please reach out to me. In fact, I should say this to folks at home. You also can reach out at meetingcomments@medpac.gov. We want to hear from you, both about critical access hospitals and rural health clinics.

Larry, you wanted to say one thing.

DR. CASALINO: Yeah.

DR. CHERNEW: And so does Cheryl.

DR. CASALINO: Yeah, it always seems kind of crazy to base anything anywhere on charges. And this is not really an issue for Medicare, but I don't know the extent to which non-Medicare beneficiaries in rural areas who don't have insurance get hit by these charges, which would be impossible for most people to pay.

But my question was, it seems like we're pretty far along. I would probably underestimate the work involved, but it seems like we're pretty far along on RHCs. And in terms of Commissioner time, we don't necessarily have to schedule -- I mean, we do schedule some sessions

for shorter periods of time.

DR. CHERNEW: Oh yeah.

DR. CASALINO: Would it be a lot more work to come up with a recommendation on RHCs?

MS. BARR: I'd like to weigh in on this.

MR. O'DONNELL: I think it depends on how you want to fix it, and I think that's what Paul and Mike the Commissioners --

DR. CHERNEW: And that's exactly -- because of the way it affects hospitals differently, it's a more complicated tradeoff. If the analysis we have -- but working through the solution is a little more complicated. And Lynn is going to give us a solution that she thinks would work. I'm almost sure.

MS. BARR: Actually, I'm not. But I wanted to raise the awareness of the Commission that there was a major change on how they paid rural health clinics, and this is mentioned in the report. But it has increased the cost to the beneficiaries dramatically. And I think that we need to look at this issue of the coinsurance -- I think we need to look at that new program for RHCs, because like I say, at that point, $400 AIR became -- I mean, the rates

went up a lot. And yes, we're paying coinsurance on it, but also what is the impact of these high prices in your local clinic, and how is that affecting volume.

So we've got some time now, we've got some data, and maybe this is down the road a little bit. I think the difference being charged for a $400 AIR and a $450, you know, charge, is not really the problem. The problem is the $400 AIR, not the upcharge.

So I do think we need to understand the impact of these new policies and how it's affecting beneficiary.

DR. CHERNEW: And the how-to may involve more than just a coinsurance thing.

MS. BARR: It's bigger than that. That's my point.

DR. CHERNEW: Cheryl.

DR. DAMBERG: I would agree. I think we're pretty far down the path in this rural health care space in understanding some of the myriad issues that are in play. And I guess I would like to see us continue down this path. I think there are a lot of implications not only for what Medicare pays but also what beneficiaries pay, and some of these big differentials and equity issues.

So I would be supportive. Obviously, the MedPAC staff have to balance all the different resource issues that are in play. But it feels to me like we've already made a pretty deep investment, and I would say continue.

MS. BARR: Yeah, oh yeah.

DR. CHERNEW: So Lynn said we could work the CAHs, the critical access hospitals. CAHs just seems like a crow kind of thing.

But anyway, so yeah. Just so you know, that is the plan. And just looking around the room and hearing not a lot of strong dissent, we will then consider what the actual tradeoffs -- Brian.

DR. MILLER: Not dissent idea. So again, if we're agreed that we shouldn't harm beneficiaries, but we're also aware that remaining an independent hospital is extremely hard. I joke that in the DMV region, for example, locally, there is like one major independent hospital, just over the bridge.

And recognizing that this is even more challenging in rural areas, I guess since this is an issue of benefit design, which interacts with how benes choose where they go in the network, recognizing that the fee-for-

service network is very wide, should we consider actually providing additional support for independent critical access hospitals, and say if we have coinsurance that at 20 percent, for critical access hospitals in general, should we think about setting coinsurance at 10 or 15 percent for independent critical access hospitals, to encourage beneficiaries to continue to support independent hospitals by providing an even lower out-of-pocket expense for doing so.

DR. CHERNEW: So my personal view is it gets really tricky when we start managing program design around ownership issues, but that's a separate point. So I understand that, and I think there are also things you might think through with payment and a bunch of other stuff.

So my general view is -- and it is challenging, admittedly, because everything is connected, but we can't do everything all at once. So my general view is on the critical access hospital, CAH, role. We should try and solve the problem in front of us, and then when we go around and talk about other things we might do, add-on work we might do, additional analysis we might do, other things

we might do, thinking about how we might deal with both consolidation issues, either through a benefit design or a payment mechanism or any other thing, we can have that discussion and decide where that fits priority-wise.

But I'm just speaking for myself. I don't think waiting until we can get to all of that resolve to solve a problem that seems pretty pressing sounds particularly appealing to me. But again, others may differ. Amol, go ahead.

DR. NAVATHE: Just to translate that, I think, if I understand this correctly, Mike, what you're saying is that we can get to a vote on this cost sharing piece quickly, and we can still continue the work thereafter, on the other pieces.

DR. CHERNEW: Exactly.

DR. NAVATHE: Versus holding up the vote to do the other thing.

DR. CHERNEW: And so just to be clear, based on the stuff that we just heard, I will talk to Paul. We are going to go to a vote on the draft recommendation. You can vote however it is you want to vote, but we are going to go to a vote on the draft recommendation. And we will then

push --

DR. NAVATHE: And just to be clear, that vote is not today. It is a future vote.

DR. CHERNEW: It will be a future vote. But we are then going to continue work on rural, in general, rural health care clinics, in particular, and that work is going to be more holistic than just work on the cost sharing issue, because of the ramifications for how that plays out.

And I would just say, broadly, when we think about our agendas moving forward, there are a lot of complicated issues about how we support hospitals that need support and how that plays out with different program designations in rural areas. And so this is a general thing that we can continue to, and will continue to discuss.

But all of that said, I want to thank the staff. I want to thank the Commissioners. I will reiterate to those at home to please reach out to us at meetingcomments@medpac.gov. We really do want to hear from you.

And with that we are adjourned for January, and we will see you again in March. Thank you all so much.

[Whereupon, at 11:52 a.m., the meeting was adjourned.]