MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, October 10, 2024
10:46 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:46 a.m.]

DR. CHERNEW: Hello, everybody. Thank you for your patience. This is the October MedPAC meeting. It is the first -- for us anyway, it's the first time we're all here in person, and I think we have a really interesting set of topics for this today and tomorrow.

And we're going to start with a topic that has been of great interest for a lot of us, and we're really just beginning of digging in, which is to explore a whole bunch of issues around Medicare beneficiaries that are in nursing homes, and for that, I'm going to turn the mic over to Eric to give us the presentation.

MR. ROLLINS: Thank you and good morning.

I'm going to start us off by talking about Medicare beneficiaries who live in nursing homes. I'd like to remind the audience that they can download these slides in the handout section on the right-hand side of the screen.

At our April meeting, Commissioners expressed interest in taking a closer look at beneficiaries living in nursing homes. As a group, these beneficiaries have

significant care needs and high medical costs, and there have been longstanding concerns about the quality of care they receive. Some observers have also expressed concern that efforts to develop new payment models that promote value-based care have not prioritized this population.

Our presentation today is the first installment of our work on this complex topic. I'll start by describing the long-stay nursing home population, provide an overview of the nursing home industry, and review some of the major challenges to improving care for these beneficiaries. After that, I'll outline the additional work that we are planning to present in the spring.

The material from these presentations will form the basis for an informational chapter in our June 2025 report and lay a foundation for potential work in the future.

Many beneficiaries have difficulty caring for themselves because of physical and/or cognitive impairments. These beneficiaries may receive various kinds of assistance, either in the home, in the community, or in a residential setting, to help manage these limitations. Perhaps the best-known form of residential care is the

nursing home, which provides services such as 24-hour medical and skilled nursing care, rehabilitation services, meals, and assistance with activities of daily living.

Nearly all nursing homes operate as both nursing facilities, where they provide custodial care for individuals with functional and/or cognitive impairments, and as skilled nursing facilities, where they provide short-term skilled care following a hospitalization.

Nursing home care can be quite expensive. The annual cost of custodial care in a semi-private room is $104,000. Medicare does not cover long-term nursing home care but does cover up to 100 days of short-term skilled care following a prior hospital stay of three days or more.

The long-stay nursing home population, which we defined as people who have been in a nursing home for more than 90 days, is relatively small, about 1.2 million beneficiaries in 2022. That's only about 1.7 percent of the overall Medicare population.

Long-stay residents differed from other beneficiaries in several respects, as shown on the left. As you'd expect, long-stay residents tended to be older, with a median age of 81, compared with 72 for other

beneficiaries, and about a quarter of long-stay residents were 90 or older. Long-stay residents were also more likely to be female, more likely to have Medicaid coverage, and more likely to live in rural areas.

Long-stay residents also had much higher mortality rates. In 2022, 25 percent died during the year, compared with 4 percent for other beneficiaries.

Long-stay residents also tended to have much higher medical costs, with an average risk score of 2.12 versus 1.01 for other beneficiaries. The risk score measures how a beneficiary's expected Part A and B spending compares with the overall average. So Medicare spending per capita for long-stay residents was, thus, more than twice as high as spending for other beneficiaries.

Finally, the median length of stay for long-stay residents was 27 months, or a little more than two years, although that varies considerably across beneficiaries.

This slide uses patient assessment data to compare the beneficiaries who received long-term custodial care with those who received short-term SNF care. We divided beneficiaries in nursing homes into three mutually exclusive groups: long-stay residents received only

custodial care, which are the bars on the left in each group of three; long-stay residents who received Medicare-covered SNF care, which are the middle bars; and short-stay residents who received Medicare-covered SNF care, which are the bars on the right.

When comparing these groups, keep in mind that some information gathered in patient assessments is used to adjust payments, which may give providers an incentive to record certain characteristics as worse than they are to boost payments.

For example, the Medicare payment system for SNF care adjusts payments for functional status. The beneficiaries who received only custodial care were more likely to have bowel incontinence and dementia, while the two groups who received SNF care were more likely to have medically complex conditions. Among the two groups of beneficiaries who received SNF care, long-stay residents tended to be in poorer health than short-stay residents.

We also looked at the level of cognition for the three groups and found that 34 percent of the long-stay residents receiving only custodial care had scores that indicated severe cognitive impairment, compared to just 17

percent of short-stay residents.

The last set of bars on the right shows the median motor score on a composite of 11 self-care and mobility items. The median motor score was the lowest for long-stay residents receiving only custodial care, slightly higher for long-stay residents who received SNF care, and highest for short-stay residents who received SNF care.

While we obviously tend to focus on Medicare, Medicaid plays a key role for long-stay residents. Unlike Medicare, Medicaid requires states to cover long-term nursing home care. Given the limited roles played by Medicare and other payers, Medicaid is the predominant payer for nursing home care.

Medicaid generally requires individuals to have both limited incomes and limited assets to qualify for coverage. However, every state has at least one eligibility pathway that allows individuals who have higher incomes and need nursing home care to qualify for coverage. Under these pathways, beneficiaries most often deplete their assets by spending them on nursing home care before they can qualify.

These qualify for a process known as "spending

down." Once beneficiaries get nursing home coverage, they must contribute nearly all of their income toward the cost of their care. Medicaid then covers the difference between the program's payment rate for nursing home care and the individual's contribution.

Due to the high cost of nursing home care, the share of residents with Medicaid coverage rises steadily as the length of stay increases. We used information from the minimum data set, which is a standardized assessment that nursing homes complete for all residents at regular intervals, to identify cohorts of beneficiaries who entered a nursing home in the same month. We then used monthly enrollment data to track how the share of beneficiaries with Medicaid in each cohort changed over time.

In this figure, beneficiaries entered the nursing home in month zero. As you can see, about a third of beneficiaries were already eligible for Medicaid when they entered the nursing home. After entry, the share with Medicaid rose rapidly, reaching about 60 percent after three months and nearly 80 percent after 12 months, indicating that many beneficiaries could only pay for a few months of care on their own.

The experiences of the three cohorts shown here follow similar trajectories, suggesting that this pattern has been fairly stable over time.

Turning back now to Medicare, long-stay residents can receive their Medicare benefits through fee-for-service or a managed care plan. This graphic shows how enrollment patterns for this population changed from 2012 to 2022. In 2022, 65 percent of long-stay residents were enrolled in fee-for-service and 35 percent were enrolled in a plan, usually an MA plan.

Long-stay residents are more likely than other beneficiaries to have fee-for-service, but as you can see, the share enrolled in fee-for-service has declined significantly over time.

Among those in plans, roughly equal shares were enrolled in three plan types: institutional special needs plans, or I-SNPs, which are specialized plans for beneficiaries who need the level of care provided in a nursing home; conventional MA plans, which are open to all beneficiaries; and either dual eligible special needs plans or Medicare and Medicaid plans, which are specialized plans for beneficiaries who have both Medicare and Medicaid.

Since 2012, the shares enrolled in I-SNPs and in either D-SNPs or MMPs each increased by about 7 percentage points, while the share enrolled in conventional plans increased by about 5 percentage points.

Finally, Medicare lets all nursing home residents change plans monthly, while other beneficiaries are largely limited to changing plans during the annual enrollment period. As discussed in your mailing materials, there is some shifting from conventional plans into I-SNPs and fee-for-service after beneficiaries enter a nursing home.

So now I'm getting ready to switch gears and talk about the nursing home industry, but before I do that, I wanted to mention that assisted living facilities, or ALFs, are also an important source of residential care for older beneficiaries. And there is some overlap between the nursing home and ALF populations.

ALFs focus on people who had been living independently but now need some support as their functioning declines. They provide housing and services like health-performing activities of daily living and housekeeping. They may coordinate medical services with health care providers but do not provide these services

themselves. The average annual cost of ALF care is $64,000, which is generally financed with personal or family funds. Medicare and Medicaid do not cover the housing component of ALF care but may cover some other services furnished to residents.

About 800,000 people live in ALFs. They're generally less impaired than nursing home residents, although the acuity of the ALF population has increased in recent years. Residents typically live in ALFs for about 22 months, with about 60 percent later moving to a nursing home. ALFs can, thus, serve as a bridge between living in the community and a nursing home.

Okay, Back to nursing homes. There are about 15,000 nursing homes in the country. The vast majority, 94 percent, participate in both Medicare and Medicaid, with the other 6 percent participating either just in Medicare or just in Medicaid.

Almost all nursing homes are freestanding, and almost three-quarters are in urban areas.

Just over 70 percent of nursing homes are for-profit, with another 21 percent that are non-profit, and 6 percent that are government-owned, such as a VA, county, or

state facility.

In terms of size, about half of facilities have less than 100 beds, and 12 percent have less than 50 beds.

In terms of payer mix, Medicaid is the largest payer for nursing homes, making up 63 percent of days. Fee-for-service Medicare accounts for only 10 percent of patient days, while private and other payers account for the remaining 27 percent of days. The share of days covered by Medicare is actually higher than 10 percent, because this private and other category includes days covered by MA plans. The private and other category also includes out-of-pocket spending and long-term care insurance.

Let me expand a bit on why private long-term care insurance plays a limited role in financing nursing home care. In 2020, 7.5 million people, including people under age 65, had some form of LTC insurance. The extent of this coverage varies widely but begins with the documented need for help with activities of daily living.

There are both supply and demand factors that limit the size of the long-term care insurance market. On the supply side, insurers have had difficulty projecting

costs, mortality, and morbidity, which may not play out until many years after a policy is sold. These miscalculations resulted in large increases in premiums that prompted many lower-risk policyholders to drop their coverage.

Adverse selection also complicated insurers' projections, as did moral hazard, particularly as consumer preferences shifted to policies that covered home-based care.

To manage moral hazard and adverse selection, insurers stopped selling policies to individuals with limited function or cognition or with certain diagnoses. On the demand side, many people prefer to self-insure if they can afford it, and some lower-income individuals may not be able to afford the premiums.

The presence of Medicaid coverage for long-term care also dampens the incentive to purchase a policy, and many beneficiaries wrongly believe that Medicare covers long-term care.

As I just mentioned, policies are simply not available for individuals who are older, sicker, or cognitively impaired.

Finally, premiums for women are about 60 percent higher than premiums for men, due to their longer life expectancy. So although women are more likely to benefit from a policy, they may also get priced out of the market.

Switching back to the nursing home industry, we also looked at differences between urban and rural nursing homes. As you can see on the left, rural nursing homes make up 27 percent of all facilities but smaller shares of days and revenues because they are both smaller and have lower occupancy rates.

Rural facilities have an average daily census of 59, compared with 85 for urban facilities, and an average occupancy rate of 70 percent, compared with 78 percent for urban facilities.

However, on average, rural nursing homes perform somewhat better financially than urban facilities based on their total margins, which consider all payers and lines of business. Rural nursing homes have lower payments per day than urban facilities, but those payments cover their costs, so their total margin is slightly positive.

In contrast, urban facilities have much higher costs per day and payments per day, but their higher

payments do not cover their costs, and their total margin is slightly negative.

However, as we discussed in your mailing materials, one recent study found that margins for nursing homes may be higher than they appear in cost reports because some nursing homes may make inflated payments to related corporate entities to obscure some of their profits.

There are a number of major challenges to improving care for beneficiaries in nursing homes. One shortcoming is that nursing homes have a financial incentive to hospitalize their long-stay residents so that they can qualify for higher skilled care payments, even if their clinical condition doesn't warrant a hospitalization.

Medicaid's payments for custodial care also tend to be low. For example, MACPAC found that in 2019, 81 percent of nursing homes had base payment amounts that were lower than their acuity adjusted costs. However, I should note that due to data limitations, MACPAC's analysis could not account for supplemental payments that about half of states make to nursing homes. These low payment rates affect facility staffing levels, staff turnover, and

quality of care. Racial and ethnic minority groups are particularly vulnerable because they are more likely to live in areas where nursing homes have lower staffing levels and lower quality.

Nursing home residents also have high rates of potentially avoidable hospitalizations. For example, one study found that 20 percent of hospitalizations for residents with advanced dementia and 43 percent of hospitalizations for residents with congestive heart failure were potentially avoidable.

CMS uses a mix of data sources and measures to assess quality of care in nursing homes, but the commission has raised two concerns about this quality reporting. First, many measures are based on patient assessment data that may not be accurate because they are also used to establish payments. Second, there are no measures for resident quality of life, resident satisfaction, and end-of-life care.

In 2021, the commission recommended that CMS finalize the development of patient experience measures and begin reporting them. Other efforts to improve care, such as state-run inspections and the nursing home compare

ratings, have had limited success.

In terms of next steps, we plan to come back to you in the spring with two presentations that examine Medicare's efforts to improve care for long-stay residents. The first presentation will look at managed care-based approaches. Here, we plan to focus on the impact of I-SNPs where relatively little research has been done. The second presentation will look at fee-for-service-based approaches, such as the SNF value-based purchasing program, ACOs, and a CMMI demonstration that focused on reducing avoidable hospitalizations among nursing home residents. This presentation will also examine efforts to improve care that aren't directly payment-related, such as the star ratings for nursing homes and inspections.

The material from today's presentation, plus the two in the spring, will lead to an informational chapter in our June 2025 report to Congress.

I would also like to note that we will monitor the new staffing standards for nursing homes as part of our regular work on payment adequacy for SNFs, which you'll see in December and January.

That brings us to the discussion. First, I'll be

happy to answer any questions about the material in this presentation. Second, we'd like to know if there are additional issues related to beneficiaries and nursing homes that you'd like us to explore during this meeting cycle. Finally, we'd like to hear about potential policy issues related to beneficiaries and nursing homes that you might be interested in exploring in the future.

That concludes the presentation, and I'll now turn it back to Mike.

DR. CHERNEW: Eric, thank you very much. That was chock-full of information.

We're going to start with our Round 1 set of questions, and just to remind everybody, Round 1 is for clarifying questions. We will then get on to Round 2 for substantive comments.

But, Cheryl, I think you are first in the Round 1 queue.

DR. DAMBERG: All right. Thank you. Great chapter. And this is really important work since this is the most vulnerable population.

I have two questions. One, in the chapter it notes a decline in the number of facilities, and I'm

curious as to whether we have some sense of there's some unmet demand in the market.

MR. ROLLINS: You mean unmet demand for nursing home care?

DR. DAMBERG: Yeah.

MR. ROLLINS: Carol can weigh in on that more in further presentations. My suspicion would be given occupancy rates that generally -- I mean, there could be certain areas that are exceptions, but at a high level probably not. I think the decline in nursing homes, to some extent, is part of a long-term cyclical trend, where we have fewer hospitalizations, fewer people going and needing skilled care. There's also sort of an ongoing shift in terms of people who used to be in nursing homes but now like home and community-based forms of long-term services and supports.

So I think those are factors that sort of over time are putting some downward pressure on the number of nursing homes.

DR. DAMBERG: Great. I think that context would be helpful in the chapter.

And then secondly, there was a note that for-

profit entities have lower occupancy rates, and I was kind of curious. Do you have any insights as to why that's the case?

MR. ROLLINS: Off the top of my head I do not, but we can get back to you on that.

MS. KELLEY: Tamara.

DR. KONETZKA: Eric, thank you so much. I really appreciate the department of the knowledge in this area that you and Carol have, and you're covering a lot of ground.

A couple of quick questions. On Table 2, I'll say more about that in my Round 2 comments, but I really like these three groups that you divided the nursing home population into. Do you have the N's for that, which I think should be added to the table. Because that's just interesting how those fall out.

MR. ROLLINS: We can add the N's. I don't have them off the top of my head.

DR. KONETZKA: A couple of other really minor questions. On page 5, it says, in the chapter, it's talking about one-third of nursing home residents at any given point in time being short stay. I feel like that

number must be wrong. Maybe one-third of admissions? But it's usually more like 15, or something. It just seems very high.

MR. ROLLINS: We can double-check that.

DR. KONETZKA: Yeah, just double-check that. And, you know, I'm going to leave the other. I have a few other minor things I think I'll just talk to you about separately, to save time and move on.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, Eric, for this great, great, informative chapter with a lot of facts, as Mike said. I have a couple of questions. I hope that they're relatively brief. The first one is, it's striking you mentioned in the long stay setting that there's kind of an incentive still to have the beneficiaries be hospitalized and then come back as short stay.

One of the things I was curious about is in the long-stay nursing home population, how does hospice use compare to those who are not in some sort of similar beneficiaries, if we could identify them.

MR. ROLLINS: You mean do decedents in nursing homes use hospice at higher rates than decedents in the

community?

DR. NAVATHE: Yes. Thank you for restating that better than I did.

MR. ROLLINS: I do not know the answer to your question, but I think that is probably a knowable question.

DR. NAVATHE: Okay. The second question I had is, so when beneficiaries or their families are using their own incomes or assets to pay for nursing home care, it seems like, as highlighted in the reading materials, there's a spend-down program for higher-income folks.

I was curious if there are multiple mechanisms here, and if so, how the rates would vary. So for example, if you're not part of a spend-down program how would the rates for long-stay nursing home care compare to those with Medicaid. And in the spend-down phase, if there's variation at the state level. The way that the reading materials make it sound is, in general, that the rates being paid are less than Medicaid, and then Medicaid kind of tops up. I was curious what the income requirements there are, if there is a time horizon. If you can give us a little bit more detail about how that works.

MR. ROLLINS: In terms of how the spend-down

process works?

DR. NAVATHE: Yeah. So I guess one question is related to the spend-down process. One question relates to outside the spend-down process, what the rates look like.

MR. ROLLINS: We can go back and check. You know, there's one figure in there that said the annual cost of nursing home care -- it was in this slide -- was $104,000. And that's based on a report from Genworth, which is the largest private long-term care insurer. So you can think of that as kind of like private pay rates.

The rates that Medicaid is going to pay for nursing home care are going to be lower than that. There's going to be a lot of variation across states, but sort of like very rough order of magnitude. It might be more in like the $70,000 to $80,000 range.

So before you're on Medicaid, to the extent there is the higher private pay rate, my intuition would be that that's the rate you're facing until you actually go onto Medicaid.

DR. NAVATHE: Thank you.

MS. KELLEY: Lynn.

MS. BARR: Great work, as always, Eric. Thank

you so much for helping us better understand what's going on here. I have five quick Round 1 questions.

You said that the death rate in 2022 was 25 percent, but that was a COVID year. What's a normal death rate in the skilled nursing, like in 2019?

MR. ROLLINS: With the exception of 2020, which was the onset of the pandemic, it was very consistently, and this was over about a 10-year period, it was consistently between 24 and 25 percent a year.

MS. BARR: Okay.

MR. ROLLINS: And in 2020 it jumped up to 33 percent.

MS. BARR: Got it. Thank you. Is there any pattern that you could see in the closure date? Of course, I'm interested in rural versus urban. Did you see anything, you know, for profit, not-for-profit? Did you see any kind of consistency?

MR. ROLLINS: I don't think we looked at it into that level of detail, but that is something we could look into certainly for future work.

MS. BARR: Thanks. I'm particularly concerned about rural because of their staffing issues with I'm not

able to get nurses, which I hear a lot about. And I'm wondering if that's starting to cause closures.

Are rural nursing homes -- I know, rural, rural, rural -- are rural nursing homes' margins affected by whether or not they're in an expansion state? So you say that they've got that higher margin, but they've also got less Medicaid, right, and you have less Medicaid support. So I was curious, is there any sort of, you know, kind of correlation of that to whether or not -- would the numbers be similar for the Medicaid expansion states versus the non-Medicaid expansion states?

MR. ROLLINS: The Medicaid expansion is affecting a population that, by definition, is not eligible for Medicare, so there's not going to be a direct link there between whether or not your Medicaid program has taken that expansion group versus not. There's not going to be a direct link between making that decision and what your nursing home population is going to look like.

MS. BARR: Great. An answer without homework. Good job. Can we get more of those?

Why does Medicaid eligibility rise before they're admitted? Your graph actually shows this increase of

Medicaid eligibility in the two to three months before they're admitted into the nursing home. What's happening there?

MR. ROLLINS: We noticed that, as well, and I don't have a good explanation for sort of why it does start to tick up a little bit in the months before they go into a nursing home.

MS. BARR: And that brings me to my final question. The concern I have is this is related to people gaming the system and hiding assets, which I think probably a lot of people are aware of, maybe even know somebody, anybody here know somebody that's hidden assets for Medicaid? I do. You know, and quite proud of it.

So I'm wondering, do we have any sort of sense of what's happening there in terms of people spending down so that they can qualify or are hiding assets?

MR. ROLLINS: I am not aware of any studies that sort of specifically quantify that. It seems like that would be a very difficult question to answer. Medicaid has a lot of restrictions in place about sort of transferring assets for just this sort of thing. But as you are probably aware, there is a whole branch of legal practice

that is Medicaid estate planning. It is an incredibly complex area. It varies by state.

MS. BARR: Interesting. All right. Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you. Really strong work here. I had a question about the payer mix, just for clarification. So 10 percent of the patients in SNFs, it was mentioned, are Medicare fee-for-service. The Medicare Advantage were bundled in a different category, private and other. So I was wondering what the percentage of Medicare Advantage patients are, that are in SNFs, according to this data.

MR. ROLLINS: Well, that's the problem we have with the cost reports is they don't break it out. But, you know, just very rough order of magnitude, if 10 percent of your days are people who are in Medicaid fee-for-service and roughly half of Medicare beneficiaries are in fee-for-service versus MA, instead of 10 it's a little bit closer to 20 percent. My guess would be it's a little less than that because we hear fairly consistently that MA plans are focused on sort of reducing the length of that sort of SNF coverage in their plans.

So I wouldn't necessarily just take that 10 and double it to 20 to account for the half of Medicare people that are in MA, but I think maybe somewhere in the 15 to 20 percent range, off the top of my head, is plausible.

DR. CHERRY: Okay. Thank you.

MS. KELLEY: Gina.

MS. UPCHURCH: Thank you so much, to you and Carol, for this chapter and this work. I think it's really important work, not only because it's how many people live their lives when they're Medicare beneficiaries, but because of the transitions going in and out of community-based settings to skilled nursing, and potentially back to community-based settings, in and out of hospital, skilled nursing.

So one question I have is, are transitional care codes -- and I don't do CPT coding, so excuse me -- I know they cover it going in and out of the hospital. What about going in and out of skilled nursing? Can somebody bill transitional care codes for that?

MR. ROLLINS: That I do not know.

MS. UPCHURCH: Okay. It would be good for us to know that.

The three midnights rule, to be able to restart the Medicare aid billing when somebody goes for a rehab in a skilled nursing facility, is that rule there to prevent abuse in and out of skilled nursing, or why do we come up with three midnights versus two midnights? Because I know a lot of Medicare Advantage plans waive that three midnight rule because, you know, they just do. Do we know why that three midnight rule, is it mainly to focus on not having people come in and out of skilled nursing facilities to sort of game the system?

MR. ROLLINS: I confess I don't know. I believe the three-day requirement has been in place since 1965, so the logic for it would be far in the past. I can't answer that part of it, that the average length of stay when the three-day rule was around 13 or 14 days. So three days was thought of as a reasonable requirement.

MS. UPCHURCH: Okay.

MR. ROLLINS: But you are correct that the vast majority of MA plans do not use this requirement.

MS. UPCHURCH: They don't use it, and I think that's telling. So we need to look into that and figure out why they are waiving it. Okay.

MR. POULSEN: Could I jump in on that one? At least I know some of the plans that I'm involved with don't because they have additional oversight that isn't there available for fee-for-service Medicare. So they're using an alternative mechanism to define need.

MS. UPCHURCH: The benefit. Okay, right.

Then on page 24, we talk about the CLASS Act, and I was a huge fan of the CLASS Act. And I believe it was a voluntary thing. So I guess my question would be do we know if anybody has looked at mandatory and whether it could be matched by employer, just like we do Social Security and Medicare. Has that been looked at as a potential, and is that something we could refer to in this chapter?

MR. ROLLINS: I'm sure at various points there have been proposals to create a sort of mandatory long-term care program. For example, they are starting one in Washington State. There's a state-run one in Washington that's getting stood up. We could do a little digging on that.

MS. UPCHURCH: Yeah. I think it would be important to know that because it just makes perfect sense

to me for employers to be paying for some of this moving forward.

And my last Round 1 question is, you mention, on page 30, that there's volume-based purchasing program but it did not decrease readmissions. I'm not sure what a skilled nursing facility value-based purchasing program is. What does that mean?

MR. ROLLINS: It's a quality incentive program.

MS. UPCHURCH: What would be some examples? Sorry.

MR. ROLLINS: For example, to encourage reductions in readmission rates.

MS. UPCHURCH: So they could do things within the skilled nursing, whatever they can do, just to decrease admissions. But how is that to do with value-based purchasing?

MR. ROLLINS: That's just the term they call it.

MS. UPCHURCH: Okay. All right.

DR. CHERNEW: If I understand it correctly, basically it's a program that nursing homes could be in, and they would get a reward, a bonus, if they could manage the readmissions from the --

MS. UPCHURCH: Okay. I thought it meant they were purchasing something to get a discount.

DR. CHERNEW: No. Value-based purchasing is just the language that is used for all the payment models that incent providers to do whatever it is they want to do.

MS. UPCHURCH: I gotcha.

DR. CHERNEW: In this case it's designed -- if I understand it correctly, the homes would choose to participate, and if they met certain goals, including admissions to hospitals, they would get some reward.

MS. UPCHURCH: That makes good sense.

DR. CHERNEW: Is that basically right?

MS. UPCHURCH: Thanks. That's great. Thanks.

MS. KELLEY: Wayne.

DR. RILEY: Eric, great work by you and Carol. Just a clarification question on Slide 10. You mentioned that the annual cost of assisted living is $64,000. That strikes me as a little low because I think a few moments ago you mentioned nursing home care was $104,000, roughly, on average. And I guess maybe I had the misunderstanding that assisted living was more expensive than nursing home. Could you tease that out for us?

MR. ROLLINS: So nursing home care is more intensive than assisted living, so it is going to be more expensive than ALF care.

DR. RILEY: Okay. And the 64, obviously there's regional differences embedded in that. So any color commentary around the regional differences?

MR. ROLLINS: I don't know what the regional differences are. One thing about the ALF care, and I think we do touch on this in the mailing materials, is there's sort of a base rate that you might pay when you're in an assisted living facility, but if you need additional services, there will be additional charges.

DR. RILEY: The add-ons, right.

MS. KELLEY: Okay. I think that's all I had for Round 1. So unless anyone wants to correct me, we'll move to Round 2, Mike. All right. Stacie.

DR. DUSETZINA: This was a really informative and very depressing chapter. I will say that some of my comments are going to be based a little bit about having a crash course with this in my personal life, trying to help my mom navigate through these services at her end-of-life care. So I have a few bits of information I'd love to see

for just informing people about how this works or doesn't.

One is around the long-term care insurance space, and you do a really great job of describing that. But I wondered about the extent of coverage, even for people who have it. I think there is a misconception that if you have it you're okay. But talking with other experts in this area it sounds like the coverage is really not that great, even if you've checked all of the boxes of having that in place. And we know that there's a lot of discrimination in that market, so people can't access coverage at all.

Around the issue of spend-down, I also was really interested in states' abilities to go after the home and assets after a person has died, when there has been nursing home care. And I think having some context around that would be also important, because it's not clear to me how variable that is by state, but I know there have been some news reports of state Medicaid programs going after people after their loved ones have passed away in that situation.

There are a couple of things around the access to nursing home care that I'm very interested in. I know you said occupancy rates look okay, but I wonder how variable is that, like the ratings of the nursing homes, if you're

looking at a higher-rated nursing home how likely is it that you can get a bed.

And I'd potentially love to see a workstream around even something like a Secret Shopper study of can you get in and what are the requirements. I would say, personally -- and I hate to throw anecdotes out there -- my family attempted to try for like four or five places for my mother, and were waitlisted at all of them. And some of them even had a requirement of documenting literally hundreds of thousands of dollars of liquid assets that did not include a home in order to even be put on a wait list.

So I think there is kind of a lot contextually around can you even get a bed and a room that I would like to know more about.

And then on the quality measurement side, that seemed incredibly important to know what's going on with beneficiaries and their quality experiences in nursing homes. And it's complicated, I think, by the high level of dementia in residents. So I think that maybe some thinking about how do we get good reports from the people in nursing homes themselves, or can you engage caregivers or family members to also help support that quality reporting effort.

This is incredibly important work, and I think, as you note in the chapter, a lot of people have no idea the extent to which this isn't covered, and it's helpful to highlight the ways that it isn't covered right now.

MS. KELLEY: Tamara.

DR. KONETZKA: Okay. So as I mentioned in my Round 1 comments, I really like Table 2 and this grouping of residents into three different groups. Because I think over and over, I like to say that this isn't really a dichotomy, you know, short-stay Medicare residents and long-stay Medicaid residents or private pay residents. These are often the same people and they are cycling through.

So I think dividing it into sort of long-stayers who go to the hospital and come back, and the SNF stay or not, into separating those out from the people who really cycle through and go back to the community is very useful.

I think my only suggestion to push that a little bit more is I'd love to see those groups broken down a little bit more by dual status and MA status.

The spend-down analysis, I really love that that's included and that you did this analysis. It's

something that everybody knows happens, and it's talked about all the time, and it's really hard to find data on that. So I think that this is really good information because it just sort of affirms what everybody knows, that most people who go into nursing home spend down very quickly given the cost of it, and that Medicare is therefore such a dominant player.

I also echo the comments others have made about I appreciate the inclusion of the review of private long-term care insurance in the chapter. Your review really captured some of the challenges with this market. I think it's often tempting for policymakers, or really anybody interested in long-term care to think about expanding the private long-term care insurance market as like the great solution, right. It's like you're just going to get people to be more aware of this and buy private insurance policies, that seems like a great insurance product. It should be, you know. There's a non-trivial chance we're going to run into these costs, and it's very expensive. So why wouldn't we insure against it?

But as you describe in your chapter, I think there are just some structural difficulties with that

market that make it very hard for insurers to offer a good product and stay afloat, and then consumers, on the other hand, see those policies as not very good value. And so it's this kind of niche market, where you have to be a really risk-averse person and not be rich enough to just sort of pay for it out of pocket, but be really risk averse and sort of, you know, middle income, where you want to preserve your assets.

So I just think after decades of trying to expand this market, through various policy levers, that we sort of have to acknowledge that it's going to remain this little niche market.

I think that it could certainly play a role in the future, you know, in some kind of public-private partnership. I just think it won't be a big solution in a private-only mode. I don't have suggestions to really expand that. I just love that it's in the chapter.

A note on hiding profits through related party transactions. You know, there is always this debate of, you know, yeah, Medicaid rates are low. We use Medicare profits to sort of subsidize Medicaid rates. But, you know, really the overall profit margins are pretty low.

And, you know, there is, I think, a strong argument that we just don't really know what those profits are, and that's all true.

But the point I want to make is that can be true, and we can still be underfunding long-term care, in general, when we look across Medicare, Medicaid especially, and at their total margins. These things can both be true, that we need more transparency in where the flow of public funds is going, and probably overall we're still not funding the long-term care side enough to get the kind of quality that we all expect.

Okay. Turning to your next steps that outlined, I'm very excited about drilling down into the I-SNPs. To me, given all the sort of perverse incentives around rehospitalizing people, to bring them back through a Medicare SNF stay and gain more profit for the facility that way, I feel like the I-SNPs are like the most exciting, promising model out there to try to address some of those adverse incentives.

So I think there's so little we know about SNPs. It's still not that many people, but it's a promising model. And so like anything we do, even just

descriptively, about who is in SNPs, which facility starts SNPs, we know a little bit about that from recent research. And then also what their hospitalization rates and ER rates are when people are in SNPs.

And I would take a broad view of this in that you can compare people in SNPs to not in SNPs in the same facilities, but then also just look at the facility-wide statistics around facilities that have SNPs or don't have SNPs, or have more people enrolled in SNPs versus less. We know that sort of large, for-profit facilities with a lot of Medicaid are more likely to have SNPs. So to me that's a really sort of interesting fact to follow up on. You know, it's these sort of lower-quality places that seem to be gravitating towards this model, so there's a lot to investigate there.

And I think also just some of these practices around the I-SNPs, sort of not having to adhere to that three-day hospital stay and providing post-acute care. So whatever we can glean about how those practices have played out and what they do to try to sort of reduce low-value hospitalizations would be really interesting.

And then finally about the I-SNPs. You know, in

the end it's still a Medicare program. It's a Medicare Advantage plan, and it doesn't necessarily incorporate Medicaid. And, you know, maybe at an individual level that's not so important in the nursing homes, Medicaid covering their long-term care, and the things we're talking about are all Medicare. But it may be at the facility level. So I'd love to see the I-SNP analyses look at how do I-SNPs play out in states with higher or lower Medicaid rates or facilities that are really dependent on Medicaid versus not so dependent on Medicaid. Does their Medicaid dependence sort of affect the success of these SNP models, or whether they adopt them at all.

I feel like your second area of research, beyond the I-SNPs, there's sort of a lot in there, a lot of different directions in terms of investigating and monitoring SNF quality. To me, also to echo what a few other people said, probably the most important thing, if we want to focus that, is to sort of monitor supply and access to nursing home care, by quality levels, especially in light of the staffing rule being implemented. I think there are some big concerns that sort of the exit from the market, and nursing homes just going out of business or

being sold to private equity, et cetera, all might sort of increase as this staffing rule gets implemented. So I think we really want to monitor that, while monitoring the staffing ratios directly and seeing how those react to the new regulations.

Again, great work. Thank you so much.

MS. KELLEY: Scott.

DR. SARRAN: Yeah. First, let me pile on in a positive way by thanking you for doing -- you and Carol for doing an excellent job of setting the table for an important body of work that I'm very excited about.

Four brief comments as we further dive into this space and begin to lay out potential solutions, recognizing we're not at that point yet.

So the first is anything we can do, I think, in the narrative to highlight how stagnant we are in this space in terms of improving quality. There may not be a lot of literature on that, but there may be some in terms of there being -- again, I keep coming back to that word "stagnant." There's not been much improvement in underlying core quality measures in this population, and that's really different than in many other settings; for

example, hospitals, where we have done, as everyone knows, a lot of wonderful work in this country about improving quality of care.

Second point, as we, again, start to frame out towards solutions, the challenges -- and you've developed that pretty well -- one of the thoughts that I'd add to the challenges is that the major challenge, in my mind, to dramatically improving the care in the short term, meaning, let's say, next several years, is the lack of appropriate accountability for improving care.

It's October. So it's baseball time of year, So it's the outfielders all watching the -- you know, well-intentioned outfielders watching the ball drop between them, right? So we have nursing facilities who are partially accountable, but typically in a very punitive regulatory fashion by an overlapping mix of state and federal agencies that has been well proven not to improve quality in a meaningful way and, in fact, just sort of freezes bad behaviors in place sometimes.

There's limited role for physicians in really driving the care in nursing facilities. It's a very different setting than most physician's practice in terms

of office, hospitals, ambulatory surgery, et cetera, where physicians are -- if not the driver, they're a significant part of the team that drives day-to-day and minute-to-minute care.

MA plans, and as we develop potential solutions, we'll want to dive, of course, deeply into why they've not been, by and large, a significant driver of improvement, at least to date.

And hospice, Amol, thanks for teeing that up, because I think they are another player in this space.

But, again, all these outfielders, no one player has the responsibility of catching the ball of quality and moving it forward.

Third comment is I'd tee up as a thought that we do some qualitative interviews or focus groups along the lines of why haven't we been able to improve quality. What are the impediments? And I know you've done some discussions with some I-SNP leaders.

A couple other groups that you might do some, whether it's a small number of qualitative interviews or a formal focus group, one would be nursing facility medical directors. And the question, again, there is, what do you

people think are the impediments to dramatically improving quality?

And there is -- as you probably know, there's an association, PALTC, Post-Acute Long-Term Care Medical Association, who can speak for and could get you some names of people who are really thought leaders in that space.

Another potential focus group or people to talk to would be directors of nursing in long-term care facilities, again, asking the question: What do you think it would take to dramatically improve quality?

And the last comment I make, as we begin to dive deeply into MA plans, I-SNPs, potentially even D-SNPs, and what could be done better by those plans in terms of being a major player in improving quality, let's make sure we highlight the current Stars measures that apply to all MA plans, with some discussion about how, by and large, those measures, or at least many of those measures, are really inappropriate for these populations in this setting. So let's at least get that out there, and you could get a comment from PALTC or other -- American Geriatric Society or so forth to speak to that. But I think we want to capture that early on in the discussions about potentially

a greater role for -- whether it's broad-based MA or I-SNPs, et cetera.

So, again, thanks, Eric. Really excited that we're going down this road.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks, Dana.

Again, Eric, thanks for such a great chapter. Really informative.

I really appreciated that you spotlighted the issue of racial segregation in terms of where different subgroups end up, and I think it's important to continue to highlight those disparities and the fact that those disparities have grown, and that some of our most vulnerable of the vulnerable are ending up in low-quality, low-staffed facilities.

I also appreciated the focus on where we're lacking measures, be it patient experience with care, end-of-life care, and other quality-of-life measures.

But one other measure that sort of came to mind as I was thinking about this is I don't know to what extent there is switching going on between different nursing homes. So I know sort of anecdotally from some of my

friends that they have transferred their parents, and I don't really think we know how often that's going on and what the reasons are for it, you know, whether that's something that patients could provide some insights about in terms of some of the underlying quality issues that they experienced.

And I also don't know whether, to the spend-down analysis, you know, is there any evidence that as people transition on to dual status, are nursing homes kind of forcing them out in some way? So I think that would be really helpful to spotlight.

I personally would like to see more transparency in terms of the payments that states are making to nursing homes as well as these third-party transactions. Not sure if we can make any headwind in that space.

And then, lastly, I do support the future direction of the work that you laid out, particularly the drill-down to I-SNPs.

MS. KELLEY: Lynn.

MS. BARR: Thank you again, Eric and Carol, wherever you are.

So a couple brief questions. You mentioned the

third-party transactions and the profitability of nursing homes, and it occurs to me that you're less likely to have those third-party transactions -- I'm sorry -- related-party transactions in a rural setting because they're less likely to be, you know, corporately owned. And I was just wondering if there's some way you can account for that or assess that through ownership that might help inform, you know, the, quote/unquote, "higher profit margin", which you know is pretty small anyway.

And then the second comment I have is around quality, and so can you -- you know, the quality measures we have for SNFs today, we've got Star ratings. I mean, it's pretty thin, and the Star ratings are very flat, you know, things like that.

But I do recall several years ago looking at scopes of work out of the QIOs, and there was a big discussion about the quality in the rural nursing homes being significantly worse than the rest of the country, and that they were putting significant resources from the QIOs to specifically on rural. They prioritized -- like, I think it was more than half of the funding to go to these rural nursing homes because they were so far behind. So if

you can help us flesh that out.

And then I guess, you know, the QIO budget, does that come out of Medicare? I mean, I don't know who pays for the -- I think it is -- it is a Medicare cost, and it's somewhere in the -- or used to be somewhere in the range of about a billion dollars a year. And so I'd like to know what we're getting for our money, and, you know, what is the work that the -- you know, what is the work that the QIOs are doing on quality? Because you're talking about several other quality things that you're going to be looking at in the fuller report. What are the QIOs doing? How much are they spending? And what is their performance? You know, because they have very, very specific things. So we should be able to get a lot of data from the QIOs about what they've been doing in both rural and urban and what they have identified as -- I think it was two-star-below nursing homes and what their success has been.

Thank you very much.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks again for work on this chapter.

I just want to build off a comment that Cheryl

just made about the disparities, racial disparities, but also just income or even rural/urban disparities, because I know in a lot of CCRCs, continuing care retirement communities, that have SNFs, you know, often those folks can afford sitters to be with them also in a skilled nursing facility or out, you know, assisted living.

So you think about it. The person working in a non -- a place where people have money, you have more work, and it's harder to do, but we punish them because of their quality ratings. So, to me, it's sort of this idea of workforce. There needs to be more workforce support for financially strapped skilled nursing facilities, because there are all sorts of benefits that come from having people with money staying with you. So I just feel like we need to think about that.

On page 15, we talk about there are a lot of people on Medicare Advantage plans, and they switch plans. My question is, who is switching these folks' plans? I'm with the SHIP program. We don't help people with skilled nursing facilities. Pharmacists, they hire pharmacists to do medication drug regimen reviews. Who is the person that's going in? A lot of these folks have POAs. Is that

who the -- who is working -- who's the insurance company working with these folks to be switching their plans? I'm concerned about conflict of interest with that. Who's moving these folks around the plans?

You can call it anecdotal if you want, but when you hear it over and over, at some point, it becomes a theme and a sort of standard of care, which is -- and there's something in this chapter that's incorrect, and it needs a little editing.

On that page 15, Medicare -- people with low-income subsidy on Medicare Advantage plans could switch every month. This coming year, that's changing. They can only switch during the first three months when there's a Medicare Advantage plan open-enrollment period. But after that, for the rest of the year, they can only go back to fee-for-service and a Part D plan. They can't switch to different Medicare Advantage plans, and that's because -- I think, because, like my cousin, you get a call from this person saying, hey, I've got this plan, and you can get more of a cash benefit if you switch to my plan. Okay, sure. Even though he has a POA and it's not him. He said, okay, fine. And so they switched his plan. So now they

only allow this in 2025, Medicare Advantage plans, that people that have low-income subsidy cannot switch every month. It's a quarterly -- excuse me. Every quarter, they can't switch. It's a monthly opportunity, though, to get back to traditional Medicare, and if you're dually eligible, that's fine, but if you're not, you may have underwriting for a supplement. So that rule just changed for 2025. So I just want to put that out there, and I do worry.

MR. ROLLINS: Gina, I will note that doesn't apply to people in nursing homes.

MS. UPCHURCH: You don't think it applies to people in nursing homes?

MR. ROLLINS: It's written into law. They have continuous open enrollment.

MS. UPCHURCH: Wonderful. Okay, thank you. So who's switching them in these nursing homes? Who's making the insurance choices?

MR. ROLLINS: When we come back to you in March, we will go into the rules around marketing and how that takes place in the nursing home context.

MS. UPCHURCH: Okay, great. So let me clarify on

that part. So people that are in the community that are in MA-PDs, they cannot now switch every quarter or every month. It's just people -- they can, but they have to go back to traditional Medicare. That's a new rule for 2025. It's a new special enrollment period that just got started. So thank you for sharing that. That's helpful.

And the last two things that I would say is I do hope that we can point out this idea of people that are -- you know, I get invited to many steakhouse dinners to talk about hiding my assets for the five-year lookback with Medicaid and skilled nursing. So I do hope we can put that in there, because it's just a huge problem in what people are doing.

I don't know if every state's different, but in North Carolina there's a five-year look-back in shifting your assets over. So I think we at least have to mention that.

And then, lastly, just a plus-one on just the quality of care and the beneficiary experience in skilled nursing facility and looking into that as much as we can.

Thanks again.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you. I really like this chapter a lot.

I'll make just two comments, one regarding quality metrics for skilled nursing facilities. I do wonder after looking at the chapter, whether we're overthinking it a little bit, because Medicaid has a substantial interest in the SNFs. A lot of the bed days are actually occupied by Medicaid.

But if we look at just short-stay patients that are Medicare only, maybe that's an incremental step in getting some sort of control over the quality measures, because if we look at a smaller population like Medicare-only short-stay, maybe the first 90 to 100 days, then we can look at effectively are they reducing ED visits, are they reducing readmissions, are they keeping infection rates low, and even starting to introduce the concepts of patient and family-centered care through survey tools and things like that, so maybe just starting off incrementally small and then creating scale may be the way to do it.

The other comment I have -- and I found this kind of really fascinating -- was the comments around assisted living facilities. And though intuitively I probably knew

this, but seeing the statistic actually kind of resonated with me, which is the fact that, you know, 60 percent of people in assisted living facilities eventually do progress to a skilled nursing facility. And, of course, Medicare doesn't really have a direct role in assisted living facilities except for Part B and maybe some other services.

But I do wonder whether -- and this would have to be studied -- if there are opportunities to change the benefit program such that we can keep patients in assisted living facilities longer or even prevent them from regressing to a skilled nursing facility, because even based on your own data, it's $40,000 more per year to have somebody in a skilled nursing facility than an assisted living facility. And is it a missed opportunity for Medicare not to be more directly involved in assisted living facilities for the purpose of having those patients be able to manage in place for a longer period of time?

So I was rather kind of fascinated with that concept. So it may be something that could be, you know, fleshed out. I could speculate as maybe where the opportunities are, but it should really be data-driven.

Otherwise great report, and thank you.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you so much for this great work. Really important, and maybe I'll start by piling on to that comment and the one earlier about the cost of assisted living.

My experience in my region of the country is assisted living is expensive and more expensive than some nursing homes. So this might need to be disaggregated by region.

I really wanted to commend us for taking this on because it really disproportionately impacts women, and as such, it should be a concern to all of us.

This division we've had about long-term care primarily being a Medicaid issue financially and proportionally, in my view, is a reflection of this artificial artifact of 65 and above needs occasional short-term skilled, and then there's this other group that needs longer-term services. And I don't know if we can take on the word "custodial care," to get rid of it. This is not a criticism of this work. It is the term that's used, but it seems so derogatory to me. It always has, because it also implies a janitor or a warden. And so at least in the role

that I'm in, you know, skilled nursing care, good; better, payer; custodial, bad. You don't want to be there. You don't want to work there. "Skilled" is better. So if we could kind of help change the language around that because what we say is what we can see.

I wanted to pile on to Tamara's comment about long-term care insurance. I know we have been pushing. We're talking about that as a nation. I don't see how that can be a solution because insurance works best for relatively rare conditions or relatively rare situations like house fires, and you need enough well to carry the sick, and I don't see how, as we move with aging baby boomers with everything that's going to be happening, how that can really be a solution.

I wanted to double down on the comments about quality and also appreciate Scott's comment about talking to directors of nursing facilities. I expect that they would tell you that they need stable-enough staff, strong-enough staff. They need to be able to recruit people who are retained.

And the Clemens article mentioned that the data is quite clear on our ends but more fluctuating with the

others, but that there's been -- it was in the reference -- relatively few that really looked at staffing mix and skill mix and aligning it to the conditions. And that's, I think, really important because these are not monolithic situations.

And, again, we often think about the low-wage workers. They were not low-skilled workers. They're not low-skilled workers. They're low-wage workers. And I'd like to challenge any of us to think about doing these jobs in an understaffed situation with people who are confused. They're afraid. They have cognitive disorders. You know, we could have to work there; we might have to live there. So this really needs to be a national priority.

In terms of solutions, I don't have those, you might guess. I am very disturbed about incentives that financially prioritize people going in --or it gives a financial incentive for people to go in the hospital and then come back out, giving financial boost to both the nursing home and the hospital.

Obviously, the value-based purchasing wasn't enough to change that behavior, but anything that can better align the incentives of these organizations and the

best interests of the people who live there, I think, should be high priority, because we can't rely on altruism to address what economics has to do.

So thank you for taking on this really important work, and I look forward to what happens next.

MS. KELLEY: Brian.

DR. MILLER: First of all, I'd like to thank the Chair for elevating this issue and my fellow Commissioner Scott for making us all aware of this population, because this population is often forgotten in health policy discussions. As clinicians, you know, as a clinician, my fellow clinicians, we see this population, but it's often forgotten here in Washington.

I think that the staff have done an amazing job of beginning to describe this population and their care options. This is not something that, again, you can find a lot of literature on in the Medicare population that's organized in one concise location, so I really appreciate that.

I also think that we should be careful to respect our role as addressing Medicare payment policy and not tread on our sibling MACPAC's toes in Medicaid policy.

It's important, and they serve -- Medicaid serves as a long-term care insurer for many in this population, but we should be cautious to recognize what our lane is.

In looking at the chapter, I thought it was interesting that only 5 percent of facilities are owned by private equity firms and that most skilled nursing facilities are actually small businesses or regional enterprises. There's a lot of potential for innovation with small businesses and regional enterprises.

And one thing that we should think about, you know, collectively as a group is to make sure that we don't use Medicare program policy to inadvertently drive consolidation and raise costs and lower quality, which is something that has happened with physician practices and the Medicare program policy over the past 20 years.

I agree with my colleague Betty's comments about language, and if we're worried about language, we could think about describing as short-stay and long-stay or short-stay and, you know, those who live in the facilities if we're worried about terminology.

In looking at those two populations, I think there's a couple things we need to realize, and the first

is that running a skilled nursing facility is not easy. You have lots of regulatory requirements. You have staff. You have limited funding. You have capital infrastructure that you have to run.

There are medical needs on top of being a hotel, right, because you're functionally running a hotel and a care facility and a rehab facility all in one. And so in looking at those populations, looking at those who are long-stay or who reside in these facilities, I think that while home- and community-based services are important, it's important for us to actually recognize, as Scott has taught me, that this is not a population that can frequently leave independently, even with maximal support at home. These are folks with high levels of advanced dementia. They have difficulty going to the bathroom by themselves. They can't. They're often incontinent. This is a population that has difficulty with not only independent activities of daily living but activities of daily living. So not only can they not go grocery shopping, this is a population that can't put on a sweater in the morning. So this is a vulnerable population that needs highly customized and personalized care.

This is very hard. It's hard for fee-for-service Medicare. It's hard for Medicare Advantage plans. As Scott has educated me, this is an opportunity for institutional special needs plans, or I-SNPs, where they can lead and improve quality. So I think, you know, hopefully in this work we see some time and effort spent on thinking about how network construction is done, how quality ratings are done, how Star ratings, marketing, advertising, and all these other sort of meat-and-potatoes regulatory policy issues that are in Medicare fee-for-service and Medicare Advantage, how they probably need to be different for I-SNPs to permit that customized and personalized care and that sort of supercharging of staff at skilled nursing facilities to help care for these vulnerable individuals who cannot put on a sweater, cannot self-toilet, and frequently cannot feed themselves.

And these are, as we saw from the statistics, you know, about one in four will pass away during their stay in an average year, and the average age is a decade older than short-stay beneficiaries. So this is a very challenging population.

I think for the short-stay Medicare beneficiary

population, we need to think differently. So things like the rigid staffing ratio and other regulations basically look at the current care model and encase it in concrete, and if we're unhappy with the current care model and we recognize that care is often inadequate, it's not necessarily the fault of the facilities or the beneficiaries. We need to think differently, and we need to think about performance-based regulation and value-based, right? Like, we want to pay for outcomes. We want to reward quality and innovation, be it a change in the staffing model, be it a change in technology.

So I think that what we want to do for that population is think about how we create dynamic systems to support Medicare beneficiaries and the small businesses that are supporting them in creating personalized and scaled care delivery systems in skilled nursing.

Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, four very quick points.

As Brian was just -- "hinting at" would be too weak a term. Medicaid-dependent nursing homes are pretty awful places to be. They're awful places to go into as a

physician to take care of patients, and they're awful for the patients and the families. Can't really exaggerate that, and it speaks poorly of us as a country that we're willing to just kind of throw elderly people into these situations, which many of us may wind up in someday.

Second point is we talk, as we often do and as other people often do, about racial and ethnic minority groups and, for example, more likely to get care in low-staffing, lower-quality nursing homes, and that's great. I think to the extent we can do so; we should also talk about income disparities and whether poor people -- where they wind up. And, actually, any MedPAC work, I would always do racial, ethnic, and income disparities to the extent we can. I think that's so important.

I think the fact that we haven't -- not MedPAC, but the country hasn't done enough of that over the years, one of the reasons we're so divided right now.

Third point is that there could be -- by the way, Eric, I thought it was a fabulous chapter -- and, Carol, wherever you are -- and such an important topic. But the third point, which maybe could be discussed in some way in the chapter, is we shouldn't have a mental model that

families make a free choice of where they want a person to go when they're discharged from the hospital.

A lot of the hospitals are getting paid by DRGs. Generally speaking, there's a lot of pressure to get the patient out, and so it's not like the family can investigate for a week or two and try to figure out where to send their grandmother. There's a lot of pressure to get them out now. And then you may not be able to get them into, as Stacie was mentioning, the nursing home of your choice anyway.

So I think that's actually -- functionally, practically, I think that's a really important part of what goes on, and some maybe further exploration of that would be useful.

And the last point is I think you had a nice couple of paragraphs in there about REITs and private equity. I would just say maybe a little bit, a few cents of explanation of how REITs actually work and why buying property, buying nursing homes, buying the real estate is a pretty attractive proposition and the potential. There is some data, I think, now on the effects of that. So I would just like us to kind of stay on top of that. But for

this immediate chapter, a little bit more explanation about REITs and the findings in relation to REITs, I think, would be good.

MS. KELLEY: Greg.

MR. POULSEN: I'll make this really quick because I know we're really short on time.

I guess the most important thing I could say is -- I think a lot of the key points I was going to make were just made by Brian and Larry, so I agree with what they said.

I do think that it's worth reiterating what a great job this chapter was. I think it was fabulously done and got a lot of really good information.

On the two-tiered base that a number of people have mentioned, that a lot of us have mentioned, we did a quick analysis a few years ago, and in the Mountain West where we were, we looked at nursing homes that we could use as recipients for our care for people leaving our hospitals, and what we found is that among what we viewed as the top quartile in quality, 70 percent of them didn't accept Medicaid at all. So they just were non-starters for people who didn't have resources to jump in, and that ended

up being a significant component of the transfers that we saw between facilities. People would stay in one of the good facilities until they ran out of resources, and then they'd have to transfer.

A bunch of other good points were made, but in the interest of time, I will leave it at that.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks. I just wanted to echo my fellow Commissioners' comments. This was really great work and certainly a very important population for us to dive into. I'm going to try to make four relatively discrete points.

First one is -- I think a couple of Commissioners have kind of mentioned and touched on the elements of wanting a little bit more detail perhaps on geographic variation here. I think that the markets certainly vary. I think we've done some work here to kind of describe rural versus urban, for example, but I think there's a lot more texture to that, so I think understanding a little bit more about how market structure varies and therefore what that means for beneficiaries in terms of access, as well as how that interacts with workforce issues.

I think we know, coming out of the pandemic, that there has been really dramatic changes to the workforce, and it's particularly impacted this industry. So I think it would be remiss for us not to acknowledge that and look a little bit further into that piece.

The second point I wanted to make is we do point out that our next steps include MA, I think appropriately, with a heavy focus on I-SNPs. We also put the data out there that I-SNPs are a quite small share of the overall population. So I just wanted to simply plug for making sure that we're also examining the conventional plans comprehensively, particularly with respect to the flexibility that they may have around providing some additional supplemental benefits that overlap with the LTSS type of space that relate to this general population, especially that they may end up migrating into nursing homes, as well as the PACE model, which is trying to keep people out of institutionalized settings and in the home.

The third piece there is to try and see if there's -- I know this is not an area where there's a tremendous amount of literature or evidence per se, but I think understanding if there are sort of alternative

models, if you will, of aging, aging in place, aging outside of institutions, delaying institutionalization, I think that would be helpful for us to understand. Especially, I think, Brian, Betty, others have kind of pointed out it'd be great for us to understand what the care model is that we're seeking, in a sense, and I think better informing us, in fact, about what those different models and components might be would be helpful for us as we think about -- you know, very down-the-line thinking about policy.

And then a couple of plus-ones, I think, a couple of folks have mentioned. I just wanted to plus-one on additional information or sort of driving toward greater information on bene experience, and then Larry's point about trying to stratify, understand by income disparities, I think very important.

Thank you.

MS. KELLEY: Paul C.

DR. CASALE: Thank you. Adding my thanks, Eric, great chapter to Carol.

Just a couple of one -- a few plus-ones, one on quality. I won't add to that, what's already been stated.

And a plus-one on the assisted living facility costs, which I think is underestimated. I mean, at least in our region, my region, beneficiaries have to put down hundreds of thousands of dollars or show that they have hundreds of thousands of dollars even to get on the list. So I think that $64,000 is a bit underestimated.

The other comment I wanted to make was if this data includes beneficiaries admitted to long-term acute care or hospital facilities, I know it's a small group, but they are very -- and in particular, the variation geographically around access to LTCHs, I think if that data is available, I think it would be of interest.

Thank you.

MS. KELLEY: Tamara, did you have a last word?

DR. KONETZKA: The issue of quality measures has come up a few times. So I just had one comment about that, and that is I think it's important to remember that in the nursing home sector, relative to basically any other sector we study, there is no dearth of quality measures, right? And so, if you look at what's in Nursing Home Compare already, there are all the inspection results from annual inspections of nursing homes.

There is daily -- we have daily staffing ratios in nursing homes as a structural measure of quality, you know, by staffing type, and you can follow staff over time, et cetera.

And in the clinical quality measures, the outcomes measures, we have a sort of somewhat evolving set of measures, and there are specific measures for short-stay residents of nursing homes and for long-stay, and these are a combination of claims-based measures that are not as gameable and MDS-based measures, you know, which give us some information we would never get from claims but, you know, maybe are subject to a little bit more gaming.

And so, yeah, are there problems with the quality measures? For sure, just like quality measurement in any health care sector. But there are already, yeah, a lot of ways we can measure quality in nursing homes. So it's not necessarily that we need new measures.

The big glaring gaps that I think are worth emphasizing are patient experience measures, resident experience measures, right? That has been on the agenda for a long time and isn't there.

And then the other gap is probably end-of-life

care measures, right?

And so, to the extent that we look at nursing home quality, it's not that we need new measures other than those two areas. We could drill down a little bit more than we have in the past on measures that are specifically for short-stay versus long-stay and, you know, some of the different components of nursing home care, compare not just the overall Star ratings. Thanks.

DR. CHERNEW: Okay. There was a lot of passion around the table. There's a lot of issues here. I think that's good.

So let me just for those at home and, again, for us here to sort of reiterate sort of where we are. We are at the very beginning of a whole body of work to try and understand what's happening to this population. And so we have not yet put on the table or even particularly contemplated specific policy things.

These are, as you point out -- it's complicated because a lot of this care is not funded by Medicare, and we are the MedPAC. That being said, these people are overwhelmingly Medicare beneficiaries, and we care about all Medicare beneficiaries and the experiences they have.

And more to the point, there are actually many policy things that are Medicare policies that relate to a lot of these folks. The I-SNPS is the obvious one, and we will do a lot more work on I-SNPS. But, also, I think someone mentioned that if you want to discharge someone from a hospital, you need a place for them to go. So it affects hospitals we care about.

There's a range of what other MA plans are doing, and how those decisions are being made all influence these populations. And as has been noted, this is a somewhat unique population that doesn't get as much attention as perhaps it should.

So I appreciate all the comments. There's really a wealth of stuff for us to dig through, but I do think that we are going to continue to try and understand how this subset of Medicare beneficiaries can be better served within the realms of the Medicare program. That's what we intend to do.

But right now, what we're going to do is go to lunch. So before we do, let me say to those at home, thank you for joining us. Please, please let us know your thoughts. You can reach us at MeetingComments@medpac.gov

or on the website. We do want to hear from those who have been listening remotely. And, again, this is a topic in an area and a set of populations that we are going to spend a fair bit of time on, including later today or tomorrow, to continue to think about what's happening to people that have some of these needs.

So, anyway, Eric, thank you. Carol, if you're listening, watching, or just thinking about us, thank you.

And we will be back after lunch, and that is going to be at 1:15. We will talk about our focus group work. So anyway, thanks again. We are now adjourned.

[Whereupon, at 12:13 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION

[1:19 p.m.]

DR. CHERNEW: Hello, everybody. Welcome back for our afternoon session.

One thing that may not be clear to folks about MedPAC is we do a lot of really big data work, and it underlies a lot of the things that we do. But it is not the only thing that we do. We try to do some survey work, and we actually get out into the field and talk to people in a whole range of ways. And this comes up in a bunch of places. We often refer to it, but we haven't really spent time thinking about how all of that focus group process works.

So given the general interest in that we are now going to have a session on it, and I think Ledia is going to start. So take it away.

MS. TABOR: Great. Thanks. Good afternoon. 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.

Each year the Commission conducts focus groups with beneficiaries and clinicians in different locations to

hear firsthand experiences with the Medicare program. Today, Katelyn and I will summarize the findings from this year's focus groups. We present the findings together today, but where relevant they will also be woven into materials discussed this analytic cycle and included in the March and June reports to the Congress.

Before we start, we would like to acknowledge the contractor team from NORC at the University of Chicago, in particular Rebecca Catterson, Lauren Issacs, and Alex Figueroa, for all of their work on this project.

First, I will provide some background on why we do focus groups and our methods. Then Katelyn will summarize findings about choosing coverage, access to care, and experiences with MA. Then I'll discuss focus group findings around telehealth, organization of care, and prescription drugs. Then we look forward to your discussion of the findings and suggestions for potential future topics.

Understanding the experiences and perspectives of Medicare beneficiaries and providers is central to MedPAC's work. A benefit of the focus group approach is that it allows us to ask questions with answers that cannot easily

be put into numbers, for example, the "how" and "why" of experiences. The findings provide narratives and real-life examples that are useful as the Commission discusses issues affecting the Medicare program.

Even with these benefits, we want to note that due to the nature of focus group research, our sample size was limited, so findings cannot be generalized to the communities we studied or to the nation as a whole.

In May and June of this year, we conducted a total of 24 focus groups. Twenty-one of the groups were held in-person with participants residing in or around Philadelphia, Phoenix, and Dallas. Each year we select three cities in different regions of the country.

In each of the locations, NORC moderated discussions with different groups of participants. We held groups with Medicare beneficiaries 65 years or older and separate groups with dual eligible beneficiaries. New for this year, we held separate groups with beneficiaries enrolled in traditional Medicare and those enrolled in Medicare Advantage for both the Medicare-only and dual eligible beneficiaries groups.

We also spoke with clinicians that regularly see

Medicare patients in an outpatient setting, including separate groups of primary care physicians, specialists, and nurse practitioners and physician assistants.

Because of the Commission's continued interest in access to care for rural beneficiaries, we also conducted virtual focus groups with beneficiaries residing in rural areas throughout the country.

A core set of research questions and topics of interest, informed by MedPAC's analytic agenda, guided the development of discussion guides for all focus groups. Topics discussed in beneficiary groups included the process of choosing coverage, access to primary care and specialty care, telehealth, and prescription drugs. Topics discussed in clinician groups include acceptance of new patients and insurance, roles of NPs and PAs, telehealth, changing organization of medical care, working with MA plans, quality reporting, ACOs, and prescription drugs.

I'll turn it over to Katelyn.

DR. SMALLEY: Thanks, Ledia. We begin our conversations with beneficiaries by asking them how they choose between Medicare coverage options.

The process of enrolling in Medicare for the

first time was viewed by participants as an important life event, and many were able to vividly recall details of the process. Overall however, participants described being confused about their options, and some beneficiaries reported being overwhelmed by the range of choices, first regarding the decision between fee-for-service and MA, and second, among supplemental options for fee-for-service beneficiaries, or among MA organizations and plan types for those choosing to enroll in MA.

Clinicians agreed, with one primary care provider saying: "It's too many products, too many specific products and too many general products, and it's constantly changing. The rules are changing constantly. It's almost like it's designed to confuse people."

Because of the perceived importance of this decision, beneficiaries sought information from multiple sources. Many reported working with brokers to select an MA plan or supplemental Medigap coverage. Some described being contacted directly by MA plan representatives. Very few participants were familiar with state health insurance program or SHIP counselors, although a few knew of the service by their state-specific name. One participant

reported using SHIP to help decide on their Medicare coverage.

Opinions varied on the utility of the Medicare & You handbook and the Medicare.gov plan finder. While the handbook was described as comprehensive, many participants found it too long to be useful. One participant was very impressed by the functionality of the medicare.gov website, but few described relying on it when making their coverage choices.

Many beneficiaries discussed seeking advice from friends and family when making decisions. They sought guidance about coverage options directly, but also referrals to brokers.

Beneficiaries in our focus groups, regardless of their ultimate coverage decisions, had similar priorities for their coverage. Beneficiaries prized maintaining existing relationships with clinicians, and this reason was cited in favor of choosing both fee-for-service and MA plans.

Similarly, MA and fee-for-service beneficiaries considered prescription drug costs and formularies when choosing coverage.

For beneficiaries that chose fee-for-service coverage, access to a wide provider network was top of mind. Some beneficiaries noted requiring clinicians in specific specialties that were unavailable in MA networks, or specific individual clinicians that they had relationships with. They also had a perception that MA networks would be "narrow" and would limit their options. Some beneficiaries discussed wanting to avoid the possibility that their network would change unexpectedly.

On the other hand, MA enrollees were attracted by lower monthly premiums, compared to fee-for-service and Medigap. They also appreciated low prescription drug costs, and limits on other out-of-pocket costs. Some described how MA seemed to be a simpler, more streamlined option than fee-for-service, with the integration of traditional parts A, B, and D into a single plan. Access to non-Medicare covered services through supplemental benefits were influential for some beneficiaries.

MA enrollees generally valued access to supplemental benefits, but reported differing views on how they factored into their plan choices. Many saw these benefits as, to paraphrase one beneficiary, a nice feature,

but not a decision-maker. On the other hand, many dual eligible beneficiaries selected their plan based on dental and vision coverage.

Over-the-counter cards were frequently mentioned, and beneficiaries reported using them in a variety of ways, including paying utility bills and buying groceries. Other popular benefits included incentives for preventive health and wellbeing, like gym memberships. Stuart and Pamina will discuss the use of MA supplemental benefits in more detail this afternoon.

Overall, beneficiaries in both fee-for-service and MA were satisfied with their coverage, with most rating their experience as excellent or good.

One beneficiary noted that they were expecting their employer's insurance to be superior to Medicare, but found that not to be the case. Others, like the dual eligible beneficiary quoted on this slide, described how both the doctors and prescription drugs they needed were covered.

A minority of our participants reported ever having switched coverage. Those who switched from fee-for-service to MA mentioned seeking lower premiums, and those

switching from one MA plan to another discussed ensuring that their providers remained in-network, and lowering their prescription drug costs.

Some MA enrollees were aware that they could have difficulties obtaining Medigap coverage if they wanted to switch back to fee-for-service in the future, but noted that they were currently satisfied with their coverage.

Next, we asked both beneficiaries and clinicians about their perspectives on access to care for Medicare beneficiaries.

Consistent with the findings of our annual beneficiary survey, beneficiaries in our focus groups reported relatively good access to care. Nearly all beneficiaries reported having a regular source of primary care, with a mix of NPs, PAs, and physicians as their primary care provider. Most beneficiaries responded that they could access primary care when they needed it, and some also made use of urgent care in cases when they needed to be seen more quickly.

In general, beneficiaries reported longer wait times for specialty care than primary care, with wait times of several months in some cases. Many beneficiaries

reported that wait times as a new patient tended to be much longer than as an established patient. We have added new questions to the survey this year to better understand beneficiaries' experiences with wait times. These results will be presented at the December meeting.

Clinicians corroborated these findings, reporting better availability for established patients than new patients. However, several also mentioned that new patients who had acute issues, were coming from the emergency department, were newly discharged from the hospital, or were referred by another clinician were also prioritized.

Several clinicians reported patients can often schedule an earlier appointment with an NP or PA in the practice instead of a physician. Many beneficiaries noted they were happy to do so in order to be seen earlier.

A few clinicians said that a patient's wait time can be affected by the practice's scheduling processes. For instance, if scheduling is handled by someone who is able to triage patients, this can ensure that people are seen within an appropriate timeframe.

Beneficiaries in rural areas reported that they

sometimes had to travel long distances to access care at major medical facilities. They reported being comfortable accessing care close to home at, for example, a rural health clinic, for minor health care needs. Participants were satisfied with their ability to access this care, with one noting that "if it's something urgent, they will work very hard to get you in that day."

On the other hand, rural beneficiaries reported wanting to travel further for more serious or complex care. For instance, one noted that they would probably go to their local emergency room with symptoms of a heart attack, but would expect to be transferred to the medical center in the closest major city. Others discussed traveling to major population centers for routine care from specialists. Most of our participants seemed to accept long travel times as a tradeoff of living in a rural area.

As Ledia mentioned earlier, for the first time this year, we hosted separate focus groups for fee-for-service and MA beneficiaries. In the next section, we will report on beneficiaries' and clinicians' experiences with the MA program.

Generally, MA enrollees were satisfied with their

coverage, at similar rates to fee-for-service beneficiaries. As mentioned earlier, they frequently mentioned supplemental benefits when describing satisfaction.

The few participants who had switched plans did so to access preferred doctors or to lower prescription drug costs.

Clinicians discussed the overall increasing prevalence of MA, but several noted that they "treat all Medicares the same."

Most of our participants were not involved in MA contracting decisions, but perceived that those decisions were driven by financial considerations.

One issue that came up repeatedly among MA beneficiaries was difficulties with provider networks. Beneficiaries reported that their plans' provider directories were frequently out of date. Some described being sent to clinicians who they later realized were not in network. Others reported that their clinicians always verified coverage when they made referrals.

Some beneficiaries reported having care disrupted when their specialists left their plan's network.

On the other hand, several beneficiaries said that their plan networks were robust enough that they have never had a problem staying in network.

Prior authorization also came up in discussions with both enrollees and clinicians. MA enrollees reported experience with prior authorizations for procedures, medications, and referrals. Some reported that this resulted in delays or gaps in care. Some reported prior authorizations resulting in denial of care.

On the other hand, many clinicians found prior authorization processes to be burdensome. Some clinicians described the need to have dedicated administrative staff to manage paperwork associated with prior authorizations.

Most clinicians mentioned receiving communications from MA plans, but feelings were mixed about their utility. Some felt the guidance was generic and did not provide useful additional information. Others appreciated when plans flagged enrollees at high-risk of hospitalization or coordinated care across providers for enrollees with complex health needs.

Some clinicians noted that information on their patients' medication adherence was also helpful feedback

from plans. Several clinicians reported that some of their patients had received home visits from their MA plans, but they did not perceive these to be integrated into the care they are providing.

Clinicians made other observations about working with MA. There was a perception among some clinicians that MA plans prioritize coding to get higher reimbursement for their patients. A few clinicians expressed frustration that MA plans sometimes designate them as a patient's primary care provider, even if they have never seen that patient, in some cases affecting their quality scores.

Finally, a few participants were employed by provider organizations that terminated a contract with at least one MA plan. While they were not involved directly in the decision, they reported that contract terminations were difficult for their patients. We are planning to look at several of these as part of our MA workplan over the next several cycles.

With that, I will turn it back over to Ledia.

MS. TABOR: In response to the public health emergency declared in January 2020 caused by the COVID-19 pandemic, Medicare temporarily expanded coverage of

telehealth services to urban areas and to beneficiaries in their homes. Congress has continued this temporary expansion of telehealth until December 2024. We have continued to track telehealth policies and use to help inform policymakers.

We asked clinician and beneficiary focus group participants a series of questions about their telehealth experiences within the past six months. About a third of beneficiaries in our focus groups had a recent telehealth visit. A common reason for choosing telehealth was because they were able to get a virtual appointment faster than one in person.

Beneficiaries reported circumstances for which telehealth was more conducive, like a beneficiary quoted on this slides who was happier that they didn't have to go to the office since they weren't feeling that well.

Beneficiaries also cited cases when in-person care is preferred over telehealth, and spoke about the importance of building relationships with clinicians as well as the importance of physical exams.

Similar to beneficiaries, clinicians reported that the decision to hold a visit via telehealth versus in-

person is determined by patient choice. As described in the quote, some clinicians discussed that older patients preferred in-person visits.

Clinicians reported believing that they have reached a steady state regarding the proportion of telehealth they are providing compared to in-person care.

Clinicians acknowledged the value of telehealth to facilitate access to patients including those who experience transportation barriers or have limited mobility. Clinicians also noted that telehealth may not be feasible for patients with complicated health problems or comorbidities.

Switching topics, we asked clinicians about aspects of the organization and processes of their practices, including referrals, roles of NPs and PAs, practice acquisition, ACOs, and quality reporting.

First up, we asked clinicians about their experiences refer patients to specialists for further diagnosis and treatment. Clinicians who were affiliated with health systems reported that they most frequently refer within their own system, but most noted that there was no explicit requirement to do so.

Consistent with the longer wait times reported by beneficiaries that Katelyn spoke about, clinicians described facing significant challenges when referring their patients to specialty care. Most depended on specialists in their personal network or health system, but despite this, reported that some of their patients were not getting appointments in "reasonable" timeframes.

Physicians in our focus groups worked with NPs and PAs in their practices in a variety of roles within clinical practices, including NPs and PAs seeing all patients or NPs and PAs focusing on patients with acute illnesses.

Physicians reported that they provided various degrees of training for their NPs and PAs, with more extensive training process for those who joined right after graduation compared to those who work independently.

Most NPs and PAs had positive experiences and felt like valued members of their practice.

We asked clinicians about whether their practices had been approached to be acquired, and many reported that they had been approached. Acquisition requests were predominantly by a health system or private equity firms to

become part of a larger private network.

Physicians in physician-owned practices expressed negative feelings about the prospective of being acquired. Some believed that private equity firms were decreasing quality of care, under the belief that they are driven by profits and not patient care. Physicians also commented on the management structure of larger organizations, noting a tradeoff with reduced decision-making power when employed at larger organizations.

In each clinician groups, we asked if clinicians were familiar with an ACO and their general experiences if they were participating in an ACO. Clinicians' direct experiences with ACOs were limited. Almost all clinicians were familiar with ACOs, but fewer than half were participating.

Participating clinicians noted that ACOs have changed the way they work through additional monitoring and rules, but they saw few benefits for their patients and minimal financial rewards.

Regarding quality reporting, many clinicians felt that quality measures did little to improve patient care and led to unnecessary work. Some noted that quality

measures and the reimbursement they receive often do not reflect their patients' complexity.

A specialist commented, "We find that a lot of these metrics don't really adequately adjust for the complexity of the medical situation . . . those metrics for us are tied into a reimbursement, so we follow them. But it's very complex data to analyze and very hard to adjust to get for some of the complexities that some of these patients come with."

Switching to our final topic, we asked beneficiaries to rate their prescription drug coverage and spoke to them about the rationale behind their ratings, drug costs, pharmacy use, and ability to fill prescriptions. We also talked to clinicians about their experiences prescribing and use of electronic prior authorization.

During a pre-group survey, most beneficiaries rated their prescription drug coverage as good or excellent. Dual-eligible beneficiaries in particular rated their prescription drug coverage highly.

Beneficiaries generally reported being able to access their prescriptions when needed, but some had

experienced high out-of-pocket costs, delays or shortages. When this happened, beneficiaries were usually able to access the prescription at another pharmacy, pick it up within a few days, or have their provider write a different prescription. When the cost of a prescription through their prescription drug plan was too high, beneficiaries commonly reported using discount programs, such as GoodRx, shopping around at different pharmacies, or paying out of pocket to afford their prescriptions.

Many clinicians reported discussing the cost of prescriptions with their patients. They noted that prescription drug costs are a major concern for their patients.

Clinicians also reported that they or staff in their practices spent a large amount of time on prior authorizations for prescriptions. A majority of clinician reported they were using electronic prior authorizations for prescriptions, which was seem as simplifying the initiation of prior authorization and potentially shortening the approval timeline.

Some clinicians reported having access to formularies in their EHRs, but reported that the

information is often incomplete or inaccurate.

That brings us to your discussion. We can answer any questions, and then Commissioners can discuss their reactions to the findings as well as provide suggestions that we can consider for future focus group topics.

Thank you and I'll turn it over to Mike.

DR. CHERNEW: That was wonderful and really, really comprehensive, I think. I have to say, the vast majority of that resonates, at least with me, but we'll hear how it resonates with everyone else.

So we do have a queue, and if I have this right, Lynn is first in it. So, Lynn?

MS. BARR: Thank you, Ledia. Great work.

So I'm going to ask about rural. I know you're surprised. So I do appreciate the comment that rural patients are driving by for more complex care, and I think this is something that's good, right? I mean, I don't want people going with a stroke to go to their critical access hospital that doesn't have any TPA, right? And so I think that's good drive-by.

Did you ask about drive-by and price or any -- did you get other -- any other qualitative information

about why people were not using your local hospital?

MS. TABOR: We were listening for the price component based on the work that the Commission discussed last month, and that never came up as a reason of why they were driving by.

MS. BARR: Did quality come up?

MS. TABOR: It wasn't so much of a question of quality. It was more like they knew that their local critical access hospital may have limitations.

MS. BARR: Okay. I think this is important because there is a lot of rhetoric that I hear about, and that's Round 2. I'll save my comment for Round 2. I apologize.

MS. TABOR: Yeah. But to your earlier question, the cost sharing didn't ever come up, but we were listening for it.

MS. BARR: I was more concerned about the quality issue, honestly.

MS. TABOR: Okay, okay. Thanks.

MS. BARR: Thank you.

MS. KELLEY: Robert?

DR. CHERRY: Yeah. Thank you for putting this

together. Really, really nicely done.

Just a clarifying question. In terms of the in-person sites that were chosen -- you know, Dallas, Philadelphia, Phoenix -- it wasn't clear in the chapter how those sites were chosen. You know, if you think about 100 different metropolitan areas, there's probably some sort of selection process to narrow it down to the three, even if you're doing it on a rotating basis. And it's helpful to kind of understand that so that we don't overgeneralize and can put things into context.

Thank you.

MS. TABOR: I'll start off, and then Katelyn can add in.

Thank you for the question. So, yes, we do select cities on a number of factors. One is we kind of do need a big enough sample to pull from to be able to recruit for these groups. So we are picking metropolitan areas.

We also pick areas that are in different parts of the country, just to kind of get different regional perspective. We also picked where there are focus group facilities that have expertise in recruiting Medicare beneficiaries and physicians, since that is kind of a niche

within the marketing research community. And we also selected cities that had, like, more of an even share of MA and fee-for-service penetration to be able to equally kind of have the opportunity to pull for those people that we were interested in speaking with.

Katelyn, do you want to add something?

DR. SMALLEY: I guess the only other thing that we would add is that we try and mix it up, so not go back to a city that we've been to too recently. So, yeah, we are kind of trying to go for breadth, but recognizing that three cities is a limitation.

MS. KELLEY: Wayne.

DR. RILEY: Great work, both of you. Thank you so much.

Three quick questions. Do you have a -- I may have missed this in the chapter, but the breakdown between fee-for-service and MA beneficiaries that you spoke to, through the focus groups?

MS. TABOR: We strived for 50-50.

DR. RILEY: Okay.

MS. TABOR: But we ended up with -- for those enrolled in Medicare only, it was an N of 31 for fee-for-

service, and Medicare Advantage was 41, so a little more Medicare Advantage.

DR. RILEY: A little more Medicare Advantage.

MS. TABOR: Yeah. But, again, we did strive for 50-50.

And for the dual eligibles, there were more -- much more Medicare Advantage beneficiaries than fee-for-service.

DR. RILEY: Okay, great. Thanks. That's helpful.

Second question. Have you looked at the sort of velocity of fee-for-service to Medicare transitions and also the velocity of Medicare Advantage back to fee-for-service transitions? Is there any data on that?

DR. SMALLEY: So that's a good question. It's not -- I would say it's probably not a good focus group -- focus groups are not well placed to answer a type of question like that.

DR. RILEY: Right, correct.

DR. SMALLEY: Yeah.

DR. RILEY: But in the background work, obviously, somewhere.

DR. SMALLEY: Right, yeah. That's something that we can take a look at elsewhere.

DR. RILEY: That may be helpful to know.

DR. SMALLEY: Yeah.

DR. RILEY: And then the home visits, am I to interpret that that's usually done by nurse practitioners, PAs, LPNs that you mentioned?

DR. SMALLEY: Yes. The home visits that clinicians talked about?

DR. RILEY: Yes.

DR. SMALLEY: Yes, they --

MS. TABOR: I would say over the years when home visits have been brought up, it is by NPs.

DR. RILEY: By NPs.

MS. TABOR: Yeah.

DR. RILEY: And my recollection, it could be wrong. Please correct me. It's been a while since I looked at this, but home visits are paid through Part B, or are they traditional?

MS. TABOR: I think the home visits that we traditionally hear about are from MA plans. It could be either, but I would say it's generally in the context.

DR. SMALLEY: Yeah. The context of that quote was the MA plans sending NPs or RNs to do health assessments in people's homes.

DR. RILEY: Right. And sometimes they're marketed as a benefit that, hey, we'll send the nurse to give your annual flu shot, et cetera. But is there less of that with just, you know, what we call straight Medicare A and B?

MS. TABOR: You know, you're raising some good points, Wayne. I think that probably next year, we can try to dive into this more.

DR. RILEY: You can look at that. Okay, great.

MS. TABOR: Yeah.

DR. RILEY: That's helpful. Thank you.

MS. KELLEY: Brian?

DR. MILLER: So I have a little bit of a tough question. I do like qualitative surveys. So please don't think otherwise from my question here.

So I read the data, and I read through the methodology a bit, and I saw that there was a comment about the non-requirement for internal referral by physicians on page 4. And I read that, you know, saying that this survey

says that that was the majority of surveyed clinicians, which I can tell you, as someone who practices and talks to clinicians, that is literally the opposite of basically every other practicing physician I know who works in a regional or large health system.

The other thing that I noticed when I was looking at this is that 73 beneficiaries were surveyed and that 28 specialty physicians were -- and I looked this up because I was curious. There are over 135 specialties listed by the American Association of Medical Colleges.

And then there wasn't clear differentiation in the survey about procedural and surgical from, say, the intellectual diagnostic specialties, which then gets me to a couple questions, which is how did NORC decide sample size, right, for all of these groups? Was this randomized? Like, what was the methodology here? And I looked at the methodology, but it wasn't clear about the methodology here compared to other surveys done by other government agencies, companies, and researchers. And as someone who worked at the FDA and reviewed clinical development programs, I was a little bit worried about the methodology.

And then my follow-on thought is this is good

that we have Commissioners have access to this. My thought is since we are a taxpayer-funded organization and the NIH, for example, for taxpayer-funded research requires a lot of transparency, I think that we should publish the methodology and publish this as an appendix to our annual report.

MS. TABOR: I can respond to a couple things. So this is a nuance, but I do just want to say that these are focus groups. And the Commission does have a beneficiary survey --

DR. MILLER: Right.

MS. TABOR: -- that Rachel has been working with contractors to conduct, and the Commissioners will hear more about that in December. So I do want to distinguish that the focus groups in the survey are separate. They're meant to complement each other, but they are separate and have different power, if you will.

DR. MILLER: Right.

MS. TABOR: And we fully recognize that we are talking to a small sample, but we still, you know, I guess, appreciate the value to be able to report out to Commissioners the experiences and being able to really dive

into the how and why.

And I think to your last point -- well, two more points. One is we are also a small agency, and we have so much money to spend on this project. You know, I'd love to do more focus groups and talk to more people, but we are limited.

And then, lastly, we are going to be publishing this report on the contractors' part of MedPAC's website in like two weeks. So it will be out soon.

DR. MILLER: Excellent. Thank you.

MS. KELLEY: Larry.

DR. CASALINO: Yeah. Three quick things. One is I agree with Brian's comment about the section about -- the chapter. I noticed this, too, that says physicians reported they were free to refer. I'm not sure it's legal to require any physician to refer a patient to within your organization. But let's just say there's strong social pressure --

DR. MILLER: Yeah.

DR. CASALINO: -- to refer within your organization. As written, I think that might be a little bit misleading.

The other two comments are -- one is just on the writing. And this may sound picky, but I actually think it's really important. It comes up for me all the time when junior faculty are writing up qualitative research, which I also like. But there's a lot of places where the word "some" is used, and in fact, there are two consecutive sentences where one says, "Some people said others said." And I think -- I realize this is not a survey. This is not quantitative. You're not going to say 75 percent. But I think language can be more like most or nearly all or a few or about half or one, you know, some kind of things that you could easily, quote/unquote, "calculate" that would give us a sense of is this kind of split down the middle? Is almost everybody saying one thing? Is this just something that one or two people brought up, but you thought was interesting and should be in there? I think it's pretty easy to use wording that can differentiate that. So I would just suggest that.

DR. SMALLEY: Yeah. Thanks, Larry. That's a helpful suggestion. I think the reason why in some cases, we didn't, you know, try and quantify-ish in that way is because a lot of these things are things that come up in

the context of conversation. So not everyone opined on it. So we have no way of saying most or all or a few.

DR. CASALINO: Yeah.

DR. SMALLEY: So I think that's part of why we're careful in the focus group context.

DR. CASALINO: No, I understand that. Since not everybody's talking, you don't really -- if you can give some sense of how widely a view seemed to be shared or whether there seemed to be, you know, really conflicting views on it, that would be helpful. I think probably you could do a bit more of that. It is a problem always writing this up.

And the last comment is -- yeah, I guess this is a Round 1 comment. So it comes up often when we discuss access and when we're talking about physician payment or whatever in December and January, that many Commissioners seem to often feel like the report on how good access is, is not what we experience ourselves or hear from friends and family or patients, and again, here the benes report pretty good access. The people in the focus groups, I should say, report pretty good access.

But I think the people in the focus groups, first

of all, they agreed to participate, and secondly, I think if I read correctly, they're already in some kind of panel where they can be approached by NORC. Is that wrong?

MS. TABOR: They have signed -- so the focus group research firm has a database of people who have signed up to participate in focus groups about any topic, and they kind of pull out people who are 65 and then see if they're eligible.

DR. CASALINO: So I guess I would --

MS. TABOR: No, the -- for clinicians, yes, it is, but not for beneficiaries. Yeah.

DR. CASALINO: I guess I would just say I think it's maybe worth keeping in mind that, first of all, people who sign up and, secondly, people who sign up and participate may be a bit more organized and better at getting access than people who don't. So I would just take -- I would keep that in mind when we're considering the remarks about how easy it is for them to find care or not.

MS. KELLEY: Gina.

MS. UPCHURCH: Larry just teed me up here.

So, on page 8, you talked about excluded people who were confused by what coverage they had. So, you know,

you didn't -- if you didn't know if you could put them in if they're a dual or if they're in a Medicare Advantage or if they're in traditional Medicare. So it just gets to that point of a lot. I think of some of the people included in the discussions were people who kind of knew what was going on and what kind of coverage they had. Is that true?

DR. SMALLEY: Yeah. I just want to be careful about that. I think that is for the surveys in which NORC tallied up, in particular.

MS. UPCHURCH: Trying to put you in one bucket or the other?

DR. SMALLEY: Right. The things on page 8. We didn't exclude people from the focus groups. We just -- when it was unclear which --

MS. UPCHURCH:

MS. TABOR: Okay.

DR. SMALLEY: -- bucket they belonged in, we didn't add them in the tallies, I think.

MS. UPCHURCH: Okay. Well, related to that, in Exhibit 3, it looks like they're a little bit younger than the traditional Medicare. Is that true that they're

younger?

MS. TABOR: They are. And we do try to recruit a wide range of ages. But I think to everybody's point, a limitation of the focus groups is you're not going to be able to get some of the old beneficiaries.

MS. UPCHURCH: So I guess the point I'm trying to make, as a senior pharmacist, the agency that I run. So we help people pay for medicines up to 250 percent of the federal poverty guidelines. We're secondary to Medicare. We are the SHIP coordinating site. So we'll counsel over 1,500 people.

All I kept thinking as I was reading this report was amen, amen, and amen. So it really syncs with what we hear every day. I mean it hit home big time, and I didn't really -- there was nothing there I had not heard and that we hear frequently. So I thought, you know, it did a good job of pulling things out.

On page 9, just a question. You talk about duals that have Medicaid. We really struggled in trying to help people sort through. You cannot easily find out when you see a D-SNP or dual special needs plan. Does it mean they have to be full dual, or can they be in a Medicare savings

program? So, the first thing you can do is look at an SOB, summary of benefits, and it's still hard to see. And then you have to go to the EOC, which is over 200 pages long, evidence of coverage.

So you're trying to counsel people in an efficient manner, and you really can't find out, even if you know that person has MQB-Q or E. You can't know what insurance.

So we had a lot of people this past year. We enrolled, got them enrolled in a plan. They were super happy with it. And then they get a letter in January, "You're not eligible to be enrolled. You only have MQB-B, not Q." We did our best. So that needs to be way more transparent, and I think that that comes out here. People don't know what they have. We need to make it clear, not only to people what they have but what their choices are.

So I've got some comments. Time 2. Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks both for a great chapter. The information contained in here is super valuable, and I think it provides important context as well as helps flag potential issues that we need to keep our eye on.

One question I had -- and I don't know whether it's something that could be teased out in the existing data, or this is sort of future-looking for future focus groups and work, but I did not see any breakout between those who are disabled and under 65 and non-disabled.

And I know my group has done a lot of work in this space, and we see significant differences in those two populations. So I think that would be helpful moving forward.

MS. TABOR: Thanks. We can think about that for the future. Yeah.

MS. KELLEY: Kenny.

MR. KAN: Yes. On page 32, you cited that participating ACO physicians saw few benefits for their patients and which pretty much limited financial rewards for them. I'm just trying to think through what that means in terms of quality and possibly any reduction in cost of care. Any color on that at all? I was just curious.

MS. TABOR: I don't think that we can provide much more than what the report says on that topic.

MR. KAN: Okay.

MS. TABOR: Yeah.

MR. KAN: But perhaps if we can gauge the beneficiary experience for the December report or --

MS. TABOR: We have organizations, and we have stopped because we were finding that consistently beneficiaries didn't know what they were, and even trying to explain to them what an ACO is took a lot of time and away from our ability to ask other questions. So it is something we can continue to think about, but it is a challenge to get more information about in the focus groups.

MR. KAN: So would it be a fair presumption to assume that physicians that participate in ACOs have to do so either because they are affiliated with a health system that probably are part of the ACO, or -- that was one. And then, obviously, it's kind of a cost of doing business, and then it sounds like for the additional monitoring involved, it's like more work for less pay, essentially.

MS. TABOR: I think we present the findings for you all to interpret and discuss.

[Laughter.]

DR. CHERNEW: I think in the ACO space, what you said, I think is right. We have struggled and had

discussions about how to tell people if they're in ACOs or not, and that, in general, is a very challenging thing to do for a bunch of reasons. But I think there are, for example, a lot of independent physician groups that participate in ACOs. There's conveners that enroll them. So there's a lot of ACO work that can be done. It's just a question of how much you can get at it through various types of focus groups.

It just, you know, there's a whole separate dramatic interest in alternative care models, but I -- well, I actually have Paul. Paul, I think, is next. I could --

MS. KELLEY: Josh is next.

DR. CHERNEW: Okay.

DR. LIAO: Great. I just want to echo the Commissioners. Thank you for this chapter. I very much respect the thoughtfulness in prior comments about sampling and limitations and wording. I also acknowledge the inherent nature of qualitative research, which is not to generalize. So thank you for that and giving us illustrative kind of texture.

Just two very quick clarifications. On page 48,

you mentioned in talking about telehealth that there may be some nuances in billing that clinicians didn't understand and so would, for example, think that they couldn't bill for audio-only when perhaps they could.

Any granularity there about was that a misunderstanding of Medicare policy? Was that a sense of, in general, all payers say we can't do it? What was driving that a little bit?

MS. TABOR: My sense was when that did come up, it was more confusion, not so much what Medicare was doing, but also their health systems themselves making their own rules about payment, like we're not going to do telehealth anymore or we're not going to pay for audio only. Perhaps future work and future cycles could be to kind of tease that out more, but that was a takeaway of mine. I know that there is a lot of confusion about telehealth payment, and it's not just Medicare related. It's commercials in there too.

DR. LIAO: Got it. Thank you.

The second one is related to access. Lots of really nice topics there, and I read that with interest. And I noticed we thought about in terms of visits, wait

times, physical distance. Anything that you picked up related to portal messages or telehealth as a dimension of access that might affect some of the things you reported?

MS. TABOR: Thanks. Yeah, we did ask about that, and we did find -- and, actually, I can speak to trends since I've done this project for a while, that people are increasingly using the portal. And we did hear from beneficiaries that they liked it because they could get some responses. I think there's quotes in the report, but we didn't call them out in this slide.

So we'll continue to ask about this in the future because we know that portal use is increasing over time.

DR. LIAO: Thank you.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks so much for sharing this work. So I just wanted to clarify some sort of meta pieces here, because I think they've come up in some of the Commissioner comments.

In some sense, as we think about representativeness of this group, intersecting with the size of what we can do through focus groups, am I correct in groups not necessarily to say, hey, we have a

representative population of benes, or we have a representative population of clinicians?

DR. SMALLEY: That's correct. This is not a representative sample, and it's not intended to be.

DR. NAVATHE: I have a couple more questions. Okay. And I think the other kind of dimension that to me was helpful to think about is we do see some beneficiary characteristics in like a Table 1, basically, in the group. They're not at least kind of proactively contrasted with what the population is. Larry brought up this point about this could not only, on observable characteristics but things that we wouldn't observe, this could be, again, there could be some sampling bias essentially in who decides to participate.

So I just want to take a step back here, and Ledia, you kind of pointed out that there were other reasons besides misrepresentativeness that we do this work, and I was hoping either or both of you could just take a step back and say, what is the other work that we do that kind of touches on these different pieces, and in that sense how do we place this appropriately in the context of other things? What does it add, and in what instances does

it not add?

MS. TABOR: Yeah. I don't necessarily want to go topic by topic, but to me I think three things. One is all the claims analysis that all of my colleagues behind us do, to look at things like hospital and outside of claims analysis, to look at telehealth use, for example. We can look at claims to see how telehealth is being used. But on claims you can't ask, well, what did you use telehealth and what are your feelings about it, and what did you think about your visit? So that's where the focus groups come into play.

I think in the survey, the beneficiary survey, we've added some new questions about telehealth, where we can ask do you want to use telehealth in the future, and that is a representative sample. So we can get at perceptions in a different, or I guess, expectations in a different way through the survey. So that example is helpful in kind of thinking it through, and focus groups was just one of the little pieces of work that we do.

DR. SMALLEY: Yeah, and I agree with everything that Ledia said, but I also might add that I think of qualitative research like this as being a really good

companion to the quantitative work that we do, both from understanding the quantitative work, understanding and being able to interpret those findings, understanding the "why" behind them, like Ledia mentioned. But also a lot of our ideas for new analyses and things to pursue on the quantitative side also kind of bubble up from underneath, from what we're hearing from beneficiaries and clinicians directly.

DR. NAVATHE: Great. Thank you. I think in some sense, if I think about it from an academic colleague, academics in general, I may think about qualitative work as being helpful in terms of some of the things you mentioned, like hypothesis generating can give us a sense of mechanisms that might be underneath it, or highlight things that we wouldn't have otherwise thought of. This seems to intersect nicely with that. Thank you.

DR. CHERNEW: That was the end of Round 1?

MS. KELLEY: That is all I have for Round 1, but we did have a little -- Scott, did you want to go ahead?

DR. SARRAN: Yeah. Great work again. Quick question. Care coordination, you know, care management, those kinds of services, did you hear anything from either

beneficiaries or providers either about the need for that in fee-for-service Medicare or the value proposition delivered on that in MA? I'm just curious if that came up at all.

MS. TABOR: We did hear about care coordination and the fact that some beneficiaries have access to care managers. We heard about this mainly from the clinicians. And they did report out, I think, that there was not -- they didn't integrate into part of their practice most of the time. But this is something we can kind of continue to think about. I wonder if there might be some limitations again of the type of people that we're able to recruit for the focus groups, but it's important that we kind of keep thinking about those things.

DR. CHERNEW: So we're about to jump into Round 2, and when we do I think Brian is going to be first, but I'm not sure if that's right. But beforehand let me say, the theme of what's going on here, just to reiterate, we do a lot of different types of analysis. There is not a direct line from any one of those types of analyses to what we're ultimately going to do one way or another. I think we would claim this is more of a triangulation exercise for

all of those reasons.

And I think it's easy, particularly in the focus group space, to say yes, but it doesn't mean this. And if we were just going to go from focus group to recommendation, I would fully understand.

But I think what I've been mostly looking for, and it was mentioned on some of the specialty referrals, are there things that are really jumping out that people are saying that we don't know, or are there other things that are so ubiquitous in the world, people have a hard time choosing, that we can say, you know, as much as us thinking that through, there are a lot of people that seem to be having that problem, which can sort of direct us to where we go. So I think that's useful.

In all honestly, I think some of the sort of color commentary can add an oomph behind a point that's supported otherwise, that would be harder to make if you just did X, Y, or Z. So I think you really do get a sense of the emotion, the challenge, for example, people have when they're choosing, and their sense of overwhelmingness in certain ways. You could have done that in a bunch of ways, but I think doing that in the focus groups gives you

sort of a richer sense of that.

But in any case, I just wanted to emphasize we are not going to take any of this and say, oh, therefore we will do just policy or that policy, but we do like to know what people are thinking. And I think it gives us the opportunity to pick other topics that we otherwise, use of portals. Otherwise, we wouldn't have been able to get it.

Anyway, with that I think, Brian, you were going to start.

DR. MILLER: Thank you. So first a comment and then my thoughts. One is there was the mention about ACOs, and I think it's important for us to mention -- and I do agree that we should survey, if possible, although it sounds like technically it's not feasible for this -- ACO, benes separately. I also wanted to note that while beneficiaries do elect and give consent to join a Medicare Advantage plan, they do not give sent, or are not asked to join an accountable care organization, which violates the ethical principle of autonomy, which is important to me as a practicing physician.

I think what I took away from this, one, I think qualitative research is extremely important. I am very

glad we do this. Despite my questions about methodology, I think this is an important adjunct to the quantitative work.

And I guess I would push us more on the quantitative work, because from the survey came the question about months, or even 6 to 12 months to see a specialist. Well, what happens if you have cancer or you need a new hip? You don't want to wait half a year to have a resection, and if you can barely walk, let alone get up the stairs in your house or out of your house because you need a hip replacement, 6 to 12 months is a long time. Even 2 months is a long time.

So I would push us to say for our survey we should have quantitative information from quantitative questions to start to measure those and other things.

Looking at the sort of anecdotal parts of the survey, I think that there were some interesting things that challenged me, and hopefully it will challenge all of us. So I have long been very skeptical about brokers, which is probably, I think, many of us are very skeptical about brokers. And I've heard many comments over the past year that indicate appropriate curiosity.

But the comments in here made me rethink it a little bit. So one of the comments said, "I spoke with an agent, as well, and I don't know how I found him. I think God sent him. He's wonderful, and he represents other companies, but he determined that Plan Whatever was the best for me, and I've been really happy with it." Now that's probably not my response if I were dealing with a broker, but it made me think that brokers are conflicted.

Rather than think of them as a problem, and sometimes they can be problematic, maybe it's more like the oven salesman or the car salesman, when you go to the shop, you buy a car, or you're going to buy new appliances. So they are biased. They have biases. Can we make it so that consumers are more aware of what those biases are?

Also in here came something that I've tried to think about more but I think would be good to remind us is that there are problems with both Medicare Advantage and with fee-for-service. I think as a Commission we tend to talk primarily about problems with Medicare Advantage while forgetting that there are problems in both.

On page 19, for example, we talked about problems with Medicare Advantage and why people chose traditional

Medicare, and they said, well, perceived narrow provider networks, or my primary care physician doesn't accept MA and therefore I took traditional Medicare and a supplement.

But then on page 17, interviews also denoted problems with fee-for-service. They say it's really hard to figure it out because there are different parts of Medicare, A, B, and D, and lots of options for supplemental coverage, and I have to make multiple decisions instead of one decision. And then one of them even talked about calling the Medicare number, and they said if you have a question, you call Medicare, they won't answer you. They tell you it depends on the code, and they don't know what the codes are, so they can't tell you whether something or not is covered, and I found that annoying.

So some of these, I think, should encourage us to think more about problems with fee-for-service and Medicare Advantage in tandem, as opposed to just problems with Medicare Advantage writ large, which seems like a lot of conversations and questions have gone. Because different programs might be better for different beneficiary populations. For some beneficiaries, fee-for-service with a supplement is going to be the best choice for them. For

other beneficiaries, Medicare Advantage might actually be a better tradeoff. So I think we should try and be more balanced as a group in our approach to both of those programs, recognizing there are different ways of Medicare beneficiaries getting their health benefits as opposed to one is good or one is bad.

And then one concluding thought. As I was reading through this, I was reminded of the fact that beneficiaries do need better information in a transparent fashion that doesn't necessarily come, of course, from a broker, and that fixing the plan finder could actually include fixing the provider directories, which has been a longstanding problem for decades in the managed care industry of inaccurate provider directories. Many of us, or friends, colleagues, hospitals, doctors, have been subject to this problem.

You should be able to go on Medicare.gov, pick your plan option, be it fee-for-service with a supplement and a Part D plan, compare that the Medicare Advantage option, look at whether your drugs are included, whether your doctor or hospital is included, and then look at what your monthly cost is going to be. Because right now it's

hard to do that, because that information doesn't exist in one location, and that's why a lot of people are dependent on brokers. And I'm not saying that brokers or SHIP counselors or family members or health care proxies will go away, but I think that is a core thing that we must do.

And I note that my colleague -- and I've said this a couple of times before in meetings -- Lisa Grabert wrote a great short paper on this, "Medicare Must Provide Additional Cost and Access Information to Enhance Decision Making Around Trade Offs Between Medicare Advantage and Medigap." And she worked at the Centers for Medicare and Medicaid Services, the American Hospital Association, and House Ways and Means Committee. I think that's someone whose perspective we should value. Thank you, and thank you for doing this work.

DR. CHERNEW: I just want to jump -- I know we're going to go to the queue, but I just want to say one thing. The broker point is actually quite important, Brian, and we have a whole separate sort of focus set of groups to go out and do a more deep dive in how the broker system is working. And I think I agree with you that there are pros and cons of it. If it was all good or all bad it would be

a lot easier to figure out what to do. But I think that's why, in addition to all the other work, both choice, in general, and brokers, in particular, are high on our agenda for focus groups, so thanks for raising that.

Okay.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you, and plus-one on brokers. Thank you for this work. I'm very grateful that you also included NPs and PAs in this.

This has been said before but I think it's really important that we underscore that this is not a representative sample, because readers will think it's not "a" story or a slice. It's "the" story.

And I want to particularly underscore something that I've shared with Ledia and Paul, a piece of, in my view, in precision in a little, tiny footnote. Arizona is a full-practice state for nurse practitioners, PAs is reduced, and Texas is a restricted-practice state. That means if you want to practice as a nurse practitioner in the state of Texas you have to find a physician and pay then. It's a pay-to-play, kind of a tax or a dowry. And the person who is doing this may or may not be in your

specialty. Like if I'm doing primary care and you're a cardiologist, or whatever.

The reason I shared that --

MS. BARR: [Inaudible.]

[Laughter.]

DR. RAMBUR: Well, I was trying to go further. I was trying to think, like dermatology, you know. Forgive me. Well, you get my point.

And then Pennsylvania, as a reduced-practice state, I did do a very small sample, a convenience sample. The dowries range, or whatever it would be, tax, from $50 a month to $5,000 a month. Some physicians charge 5 percent of revenue. That's a usual. But it could be really challenging if you're trying to not do incident to billing, because it's 85 percent.

But interestingly, most of the people who do this are independents who are wanting to supplement their income, because they're trying not to be amalgamated. Again, small sample size.

And then Arizona is a full-practice state, and that just means that nurse practitioners can enter the market without having to find or pay someone to be their

partner in this.

Actually, if it's rural partnerships I'm very supportive. I'm very concerned about these relationships where there is a person doing work, the other person is getting a kickback and they're really not involved with the practice at all, which, of course, we would never do, right.

The other thing I wanted to mention, there was a physician who commented, sounded a little disparaging on the scope. But if everyone were handed top of the license their scope should be different. An MD should be working with the most complex, nuanced, difficult, for lack of a better word, persnickety cases. And I would also just point out that PAs and NPs do have, although they both do primary care, PAs tend to be more procedural oriented, and nurse practitioners are disproportionately prepared in primary care, which doesn't mean they don't do procedures.

So it's kind of like, oh, they don't do as many procedures. It reflects a particular set of individuals or practices.

I just think it's really important. And initially I thought these three states were taken because

they had different scope of practice, but that wasn't why. So, a small thing.

I was not just surprised to see that there's less turnover among nurse practitioners and PAs, or that wasn't an issue, because most are prepared closer to their local communities and go back to serve their local communities. That's often why they did it, went on for more education.

And then I just wanted to follow up on Wayne's comment about home care. Wayne, you mentioned LPNs in the home, I think, and I think it would just be really important to be clear that LPN's scope of practice is very different than an RN's, and an RN's is very different than a nurse practitioner. And there's a lot of blurring, even on people who are very sophisticated in health care and health policy.

So thank you very much.

MS. KELLEY: Larry.

DR. CASALINO: I just want to emphasize Brian's point about in the surveys maybe asking the questions a little differently about access. I may be misremembering or thinking of other surveys, but do we actually ask about how long do you have to wait, or do we ask about are you

satisfied with your access? Because that may differ by income group or class.

MS. TABOR: It's a good teaser, because the beneficiary survey that MedPAC does every year, that you'll see the results of in December, we do generally ask about do you feel like you got needed care. But because of the Commissioners' discussion, Rachel has worked to add in questions about wait times. Those are questions that are being tested, but she'll have the results for you in December.

DR. CASALINO: Both are interesting, but if you could only choose one, I think actually trying to get their estimate of the actual wait time would be more helpful.

Second point in terms of questions to ask. Yeah, I think it would be great if you had the time in the beneficiary surveys, or focus groups, I should say, to try to get at a little more is care coordination real. You do have some of that in the chapter. Did you hear from someone, from the health plan or whatever, or was this helpful? My personal experience is very much not, but I may be an outlier.

Anyway, I think if you can have time to get at

that a little bit more it would be interesting, and you might hear some more richness.

And the last two things, that has come up just now. I think understanding the role of brokers better is really a very, very worthy thing to do. I mean, they're so important. And I'll just leave it at that. I think it would be a real contribution if we can ourselves understand more about what brokers do, how they do it. See if there's anything that Medicare maybe would want to think about changing with regard to brokers.

And then the last point is, so it really is stunning, in the focus groups, at least, how few beneficiaries, like one, I think, used the state health insurance assistance program. And that one didn't even know that they were doing it. So I guess I'd like to know more about, and maybe Gina can help ups with this now, but why aren't they more used, and again, is that something we or Medicare or Congress want to try to do something about. Because again, going back to this morning's discussion, having just done this myself, it's very hard to get a clue what you're choosing and how to choose, and especially the fact that I don't think people, in general, know that when

they join MA that they're going to be there for life, in most states, because it's just too expensive to try to switch back. So learning more about the state health insurance assistance programs I think would be useful. I would like to hear what Gina has to say about why they're not used more and what we might do.

MS. KELLEY: Gina is actually next in the queue, so you queued her up nicely.

MS. UPCHURCH: Larry and I have care coordination going on right here between us. Okay.

[Laughter.]

DR. CASALINO: But we charge for it.

MS. UPCHURCH: Yeah. This is my general take on SHIP, and I know this is happening in North Carolina, but it -- SHIPs. In North Carolina, we have S-H-I-I-P, but nationally it's S-H-I-P, Seniors Health Insurance Program.

And I would like to know the state of things nationally, but in North Carolina, this is my general understanding. When you're a SHIP coordinator, you're a volunteer. There's usually a host agency. You train volunteers, and they used to talk to you about supplements. They got standardized with the Clintons. So you could do A

through J at the time, you know, and then they got rid of the J's and then the F's. So that's what they had to deal with, and then came the drug benefit, and then it got more complex, and then all the Medicare Advantage plans.

So what's happening is that some SHIP volunteers are leaving. It's too much. Many counties in North Carolina used to have -- don't have SHIP programs anymore. If they do, they're very weak, and some of them are weak, and instead of using money to sort of train volunteers, they're finding somebody on staff to do it, because it is a full-time job to keep up with all of this. So it's professionalizing SHIP a little bit more over time.

And so I don't think -- I mean, even though there's outreach -- so when you call 1-800-MEDICARE and say you live in Durham, you get a senior pharmacist's phone number, because we're the SHIP coordinating site, if you want to talk to somebody locally. If you call the state office, you can get the local.

Let me tell you the key to the local counseling. Number one, we know local networks. I can tell you the three programs that are out of network at our local hospital, right? A lot of times, people don't know that if

they're counseling you at the state level or the national level. It's not clear, as Brian alluded to, you know, on the websites. So local networks, it's really, really important. If you call 1-800-MEDICARE, if you call the state office, they may not know.

Number two, the reason it's important to use SHIPs is we're not selling anything. We don't get a kickback. I don't care if you join a Medicare Advantage plan, fee-for-service, a supplement, or which plan. It's a moot point to me. I'm just trying to make sure that you're in something that fits your needs at an affordable price for you. So it really is a neutral place to get this done. They try to keep us up to date on everything, but it's becoming where you have to professionalize SHIP to keep up with all of these minutiae changes. So that's my general take of the SHIP program and what's happening.

And in many communities, when we tell people, oh, just call your SHIP people, they're like, yeah, we need to talk to you. I mean, they really are not getting the help that they need because we're underfunding what we -- you know, you get what you pay for, and we're hardly paying SHIP programs. Okay.

We get -- it costs us about $250,000 to do the work in a year, and we get about $25,000. So it's a tithe for what it costs us to do it.

So I just also wanted to just point out -- and somebody said in one of these interviews that, you know, something was free. And I just -- we always have to constantly remind people in Medicare Advantage plans, it's pay as you go. Yes, you may not be paying anything monthly, remember when you need the care, and it's hard for people to imagine needing that care in many ways if they've been well. So it's just a caveat that we run into a lot.

And in regard to brokers and agents, I think many of you know this, but one insurance company, Wellcare, this year, will not pay brokers for enrolling people in standalone drug plans anymore. So they're only paid -- well that may just be a North Carolina thing. They're only paid when they put you in a Medicare Advantage plan.

So there was already every incentive in the world from brokers and agents to people in Medicare Advantage plans. But if you're getting insurance companies to not even pay you to put you in a standalone drug plan, you can imagine more and more people getting enrolled in Medicare

Advantage plan.

So I think the thing that I really care about is that it becomes more transparent, that people know. You could tell that nobody in these focus groups knew that those -- they were like I don't know how they help me. It's from God. No, they made $611 at a minimum for enrolling person in that Medicare. It's God with payment. Every year when you renew it, you get a -- you don't do a thing. You get 300-something, it's going up next year. So that just needs to be known. When you sign on the dotted line, you need to say -- and it's not -- it's a jobs program. I mean, that's fine, but we just need to be transparent about it.

The other thing I would just say is that it would be nice to know how much money that these insurance companies have to pay their agents, brokers, and third-party administrators. There's a lot of money that goes into that. Of all the health care dollars that goes to Medicare Advantage plans, what percentage of it is going to brokers, agents, and third-party administrators? I think that would be super -- in other words, could we take some of that money and pour it into the SHIP program when

somebody is not selling you something? I mean, what is the magnitude of those dollars that are going there?

And, again, I do think many agents and brokers are doing a fine job, and people need the help. So I think they're doing a fine job. It's just it needs to be transparent in many ways.

And the last thing I'd say, on page 58, it talks about real-time benefit tools that consumers are supposed to have. I was like -- I was asking everybody I know, what are these things? I don't know what it even means. In 2023, supposedly, real-time benefit tools were supposed to be available to consumers. I have no idea what that is. I've asked the other SHIP people.

We think insurance companies are supposed to have something on their websites to help people. We know the plan finder tool is not real-time benefit. So I don't know what that is even referring to in the report.

MS. TABOR: Just for clarification for the audience, this is for prescription drugs, real-time benefit tools.

MS. UPCHURCH: Sorry.

MS. TABOR: Yes.

MS. UPCHURCH: Right. But I don't even know what that is. I mean, because I don't know that that exists.

DR. CHERNEW: I think they're supposed to be tools where if you get a prescription, you can tell in real time what you will have to pay. Oftentimes, it's a better, cheaper alternative because your deductibles and stuff are changing based on what you're doing.

MS. UPCHURCH: Right.

DR. CHERNEW: So it's meant to help you make efficient choices.

MS. UPCHURCH: I've never heard of them existing or anybody ever using them, and I've asked other people, and nobody knows. And they were supposed to start existing in 2023.

We know providers are supposed to have in the EHRs, and we know they're lagging. But I just have not heard of them being used, don't know anything about them, but it'd be good to know more.

Thanks.

MR. MASI: And on a prior point, I just wanted to flag for Commissioners' awareness that the Commission did make a recommendation, I think, in 2008, with respect to

SHIPs, to increase funding for SHIPs. I think the Commission did not talk about how that should interact with broker compensation or not. But just on the narrow point of our footprint in the SHIP area, I wanted to surface that for people.

MS. KELLEY: Stacie.

DR. DUSETZINA: Thank you. Might be time for an update to that 2008 recommendation.

I'll plus-one a lot of things that others have said previously, but I will say that there were a couple of things that really just stick out here that I think we already know a lot about. Everyone's confused. No one has the information they need. They get overwhelmed, and they're like, you know, send someone from God. They're literally praying for someone to come to their house and help them figure it out, and sometimes that happens.

It makes me think that there are a few things. I'm not sure about digging in on the qualitative side, but it did make me think of some of the quantitative elements and whether we could add them to a wish list, or maybe they already exist.

And one is, like, do we know anything about how

people got into their plan? So, like, you know, we know brokers get paid. We know some people come in through SHIP. We know some people, like, enroll on their own. If we actually knew in the Medicare enrollment claims data, like, the source that got you into your plan, that could be really valuable, I think, for understanding this broader dynamic and even thinking about a pathway for, okay, well, if SHIP is doing a tremendous amount of this work, if there's compensation for bringing people in and educating them, like, that would just be one mechanism to even know the scope of those different activities.

Like Gina mentioned about the differences in payments and the changes in the way that people get paid for keeping people in or moving them around, there are a lot of changes happening in the Part D market this cycle that I think will just further encourage brokers to have -- you know, like, no financial incentive to keep people in traditional Medicare. And I think that people should have all of the choices available to them. If you're sitting down with someone to help you understand all of your choices, like, they should all be on the table, and you shouldn't be financially harmed as a broker for not picking

or helping them pick the thing that works best for them. So I think any information we can get on that in the broader sense would be really great.

I think it was mentioned in the chapter, the provider directories being out of date. This, to me, is like it's unacceptable. Like, you're going to shop and try to get this information, and most people say they want to know their doctors are in the network of the plan. And if that information at baseline is not going to be accurate, it's like you can't make an educated and informed decision with or without help if that's the case. So that should be totally unacceptable.

I was trying to think about how could you get better at this, and maybe Medicare does some of this, so -- or CMS does some of this. But, you know, I don't know when you get your first welcome to Medicare packet. Like, how close to 65 are you? It sounds like you're close. But, like, what if you had on your 64th birthday, like, guess what's happening next year? Here's all the things you need to start thinking about. And give them information about tools available through CMS, SHIP counselors, like the independent groups that they could talk to. In just a

short preview of, like, you've got a lot of choices coming up, you should start, like, thinking about that well in advance of the time when you really need to be signing up.

This was wildly entertaining, some of these quotes. I will say I will give a shoutout to the person who picks their plan based on the gym membership features of the plan. I hope that when I enroll, that is my focus as well.

MS. KELLEY: Tamara.

DR. KONETZKA: Yeah, thanks. I agree. Very entertaining, but very interesting chapter.

I have a very kind of big-picture comment and suggestion that would apply to future focus groups, and probably also to the survey, and that is, you know, in all my experience doing qualitative work, I have found that some of the most interesting things we learn are the things that we actually didn't anticipate and failed to ask about. And, you know, so if we ask about finding plans, you're going to hear a lot about frustrations about, you know, information and finding plans. If we ask about prior auth, we're going to hear a lot of complaints about prior auth.

And so maybe you guys do this, but it didn't

really come out in the results. But I would love to see broad questions about, you know, in the spirit of sort of improving the Medicare program as a whole and filling in some of the other things we do quantitatively, questions about like unmet need, you know. Are there things that you're -- you know, that we're not asking about that are really sort of health-related frustrations in your life? Or, you know, a sort of cliche kind of question, like, you know, if you could, like, choose one thing that you could change about the Medicare program, what would you change? Right? Because that'll give us a sense, then, of the sort of relative importance -- again, not sort of quantitatively from these focus groups, but, you know, really get a sense of what is frustrating people and what are they happy with.

Thanks.

MS. KELLEY: Amol.

DR. NAVATHE: Thank you so much for this work.

So I have a lot of plus-ones, which I won't go through in exhaustive detail, because obviously, that'd be very repetitive. I do like Stacie's idea of -- not specific to this focus group work, but of understanding kind of from a data perspective, what the source of

enrollment would be, because I think that'd be very powerful to study in the Medicare claims or together with the Medicare claims and enrollment data.

The couple things -- I think one of the things that you teed up is, what are other things that we could ask focus groups about? I think there's kind of two things that pop out to me. One is the transition into Medicare. Obviously, this may be a little bit less relevant for somebody who's been in Medicare for a long time, but for those who are transitioning in or who have recently transitioned in, in understanding any disruptions that they faced, you know, maybe related to clinicians, maybe related to prescriptions or otherwise. But I think focusing kind of on that transition would be interesting to learn more about.

And then the other piece is understanding the role of caregivers and how that might play a particularly important role in some Medicare beneficiaries' lives.

Thank you.

MS. KELLEY: Josh.

DR. LIAO: So I just wanted to add maybe four incremental things to consider for future focus groups

based on what was presented here today.

The first is, I kind of mentioned portal messaging. You know, I think some estimates say increase of 160 percent. As a general internist, we see this a lot, qualitative as well. Not just the kind of implications for access, you know, how that alongside things like scheduling, which you mentioned, I think are relevant, but also kind of downstream things such as expectations. So what are health system setting? How is it being transmitted to patients? The appropriateness piece, which some of your illustrative comments highlight. What are clinicians and organizations doing to address those, either through AI technology, through billing, et cetera? I think that would really bring to life a lot of things that would intersect well with what other Commissioners I've mentioned.

The second area is I really also appreciated the point about the NPs and the PAs and how they work with primary care. If I kind of abstract away, I heard a lot about autonomy and being valued in the team. It left me wanting more about -- so what is the kind of care model? How do they collaborate? And if we can kind of paint the

contours of that going forward. And really, kind of to Betty's point, NPs being more in the kind of cognitive specialties that I live in and PAs -- maybe looking at that for PAs versus NPs would be nice.

The last thing is -- and I'll quantitate this without inferring or kind of generalize, but I was struck in the ACO section that more than one in five PCPs, a number of specialists, NPs and PAs, didn't know if they were in ACOs or if they had been approached by that. Again, I don't know the scale of that, but I think it would be nice in future focus groups to tease that out a little bit, not just in the entry into it, but were they in one and maybe they were taken out of the roster and didn't know that, so would love that to be brought out a little bit more, if possible.

Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you very much.

And, you know, I can tell you what I like about, you know, focus groups in particular is that you can take some of the data that we have and then the deliberations and the themes that come from our conversations and connect

it with these focus groups, and it can really serve to kind of validate certain information and to keep the conversations moving forward. In some cases, you have to kind of put them on a little bit of a shelf.

I think some of the things that resonated with me that were rather validating includes, you know, the comments around, you know, supplemental benefits. The fact that, with the exception of dual eligibles, some patients look at supplemental benefits being the icing on the cake but not what necessarily drives their decision, the physician relationships, the provider relationships are still critically important. The out-of-pocket costs for drugs are critically important. They're probably not going to necessarily choose supplemental benefits for vision, dental, and hearing alone. They're going to have other priorities. So that was helpful.

The other thing, too, is for those that are able to switch back for fee-for-service -- and if you think about the reasons why individuals might do that, which is, you know, a new condition, for example, where they may be having difficulty finding, you know, treatment and, you know, subject-matter expertise for that, then they may, in

fact, have trouble finding Medigap coverage, right, at an affordable cost for them. So that's not surprising, but it's also something we should keep in mind as we start thinking about how difficult it sometimes is to switch back and forth between those two different types of models.

The other thing that we commonly speak about here, which the focus groups have, is the whole challenge with preauthorizations, denials of care, delays in care. That was also validating, and of course, the comments around the limitations with quality metrics and can we actually risk-adjust appropriately.

There are other comments there that I do think that we should take a step back and just be kind of cautionary about, you know, not thinking of them as too much as necessarily factual. They may, in fact, be an individual's experience, but we have to put them in that context.

One of the comments was, for example, the MA plans may send in individuals to do home visits and are not quite integrated with the primary team. I believe that's fundamentally true, but I think you could say that about probably a lot of health plans, both commercial and

governmental. So it's definitely an opportunity for improvement, but I don't think it's unique to Medicare Advantage.

The other comment around ACOs and that some clinicians were seeing few benefits for their patients and few financial rewards, that may be true for some experiences but not necessarily universal. So I would put that into some context.

And we certainly have talked about coding intensity, and so the fact that some clinicians feel that there's an overemphasis on coding, I think, still is cautionary, just based on even my experience. If you're calling out certain physicians for not doing their documentation and not keeping up with their medical records and they have to do their billing, some may receive that in a different way. And it may come across as, well, I just want to take care of the patients. What's the deal with the documentation? But you have to do all of that, right?

And then the other thing, too, I think that we should keep in mind, because I don't know exactly what the reality is versus the perception, is this whole idea of contracts getting terminated on beneficiaries that are

participating in Medicare Advantage and then leaving the providers and the beneficiaries kind of in an awkward position.

I think there are growing stories about Medicare Advantage, you know, provider organizations terminating contracts. I'm not sure if the rate is any different than any other type of health plan contracts, but because we're so early in the journey with Medicare Advantage, then it's something that we need to kind of keep in mind and kind of track over time to see if more and more beneficiaries are being disproportionately impacted compared with other types of plans, both private and governmental.

But nevertheless, I think a lot of the comments were really, really good, and others, we have to not get into, like, a group think about, too, you know, because it fills our own sort of personal narrative.

But great work, and I like the way this was done, and it was packaged together quite well.

MS. KELLEY: Lynn.

MS. BARR: Thank you. This has been a really interesting discussion. It's really gone all kinds of places. I guess when you do focus groups, there's a lot of

things to comment on.

Just following along with some of the other people, when we're talking about the issues about physicians, the networks not being updated, this is not a -- this is maybe more related to PECOS and providers, you know, and how providers actually update their data. So I just know that as an ACO convener, we had incredible brain damage just trying to get PECOS updated every year. So it may not be -- it may be a provider issue that we just haven't fixed yet -- or maybe we have.

About the brokers, I just -- I think it's very obvious that we're a capitalistic society, and we keep forgetting that. But we should pay the brokers the same if they put them in MA or fee-for-service. And today now -- and this is -- I think this is new -- in fee-for-service, you have to contact a broker to figure out your supplemental insurance.

I had an enormous number of supplemental plans. The range on prices were ridiculous, but the benefits were exactly the same. How in the world could I interpret that? I could pay twice as much for a plan, but, you know, do I go for the cheap plan? Do I go for the expensive plan? I

went for the middle one, because I didn't know what else to do, and I didn't want to call a broker.

So, anyway, I just think we really need to think about we're capitalists, and we need to treat people like capitalists, and stop pretending that they're going to do things from the goodness of their heart.

And then final is about the questions on drive-by. As you know, there's a huge think, a group think in Washington about people drive by rural hospitals because they're crap. You know, I hear it all the time, and I don't see any evidence of that. So it would be very helpful for us to provide the evidence and say, yes, people are driving by because of quality, or people are driving by because of complexity.

And all of the data that's been published is actually about people driving by due to complexity that I've seen, and so it would be very important for us to re-inform the policymakers of the real reason for drive-by, because drive-by is not good for the hospitals, not good for Medicare. We pay more to support cost-based reimbursement when volume goes down, but we also don't want patients going to cause for strokes, right? And so if

they're logically using the -- not using the facilities, that's great. Why don't we repurpose and add more type of low-level services to these facilities? But think about it as a policy and not just say, oh, you know, they're driving by because of quality without any evidence. So I would appreciate if you could add some to the beneficiary survey and maybe even like, you know, did you drive by, check one of these, all of the above, none of the above, and get some quantitative data as well.

Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks. I'm really pleased to hear you are going to get some additional information on wait time. I think that's a really important issue, so I'm looking forward to hearing about that information.

I want to double down on my earlier comment about for future rounds trying to collect some information for the disabled population versus the non-disabled.

And I will plus-one on the range of comments around brokers and their role and kind of how they're being used and that whole space, and getting a better understanding.

One thing that I wondered whether there's an opportunity for in the context of these interviews with beneficiaries is trying to get at some understanding of their financial literacy, because this relates to their ability to make informed choices. And so there's some research out there about financial literacy, and I think if we could explore that space a bit more, I think that could be helpful to understanding some of the challenges people face in making these choices.

Going back to wait time, and I know you guys have limited resources, I think another mechanism, if you've not used it in the past, is using Secret Shopper to try to get an understanding of what these wait times are.

And then lastly, I thought the text in the focus group summary about how consumers think about these extra benefits, and that it's not a key factor in selection a plan was really interesting, as well as their lack of awareness of these benefits. And I think this is a segue into our next topic in terms of how often these benefits are actually being used by consumers.

MS. KELLEY: Paul.

DR. CASALE: So adding my thanks for great work.

Just three brief comments. One on the ACO comments that were made. I wouldn't quite give up on the question to the beneficiary yet. I know it's really challenging, but I think CMS continues to increase the requirements around notification to beneficiaries about the ACO, that they're in an ACO, and there's more around voluntary alignment with an ACO. So I think it's something to potentially trend, to understanding the challenges around that.

Plus-one on the specialty referral comments that have already been made and quantifying some of that, since presumably for an elected type of specialty referral, presumably the wait times for that would be very different than an urgent, so understanding that would be helpful.

And then the final is around care coordination. I recently co-authored a study which surveyed Medicare beneficiaries living with dementia and their caregivers around their perception of coordination of care, and not surprisingly, most felt their care was not well coordinated. And the survey was done by the actual care coordinators in my health system. So the coordinators then offered care coordination to the beneficiary, and mostly the family member. And I was a little surprised, but most

declined it.

So I think there's more underlying this perception from the beneficiary of what care coordination is and what's the benefit of it, even if it comes from within their own health system. So any questions, again, in the future that may help us understand their view of what is care coordination I think might be interesting.

MS. KELLEY: That is the end of my Round 2 list.

DR. CHERNEW: Perfect, because that is the end of our time. I'm going to summarize quickly and then we'll take a quick break, and then we're going to come back to talk about supplemental benefits.

In quick summary, first a very small point. There's also lock-in in Medigap plans. If you choose a Medigap plan, it's not easy to just switch to another one. There are a lot of choices, just to be clear if it wasn't.

We are very, very interested in aspects of choice and how to make it better, and there's a lot of interest around the table in that, and I think those aspects of the focus groups that can help that.

My general reaction is, first of all, thank you all for your comments. Second of all, there is a lot to

learn. Third of all, some of that can be learned in focus groups. And fourth, and several of you said this very politely, and I do appreciate it, you acknowledged that we have limited resources. So we will be focused, in our focus groups, if that makes sense. We're never going to go directly from a focus group to decide, oh, this is what's going on, for all the reasons that people said.

But I do think it does highlight issues that we need to delve into deeper, and things of that nature, and raise questions that you otherwise might not have known, to the point of like should we just ask broader questions and things to understand what people think. And I think we will continue to do that, particularly in areas. Again, since so much came up on brokers, when there is an area of particular interest where it's going to be important, we will try to then add beyond sort of the normal focus grouping type of things. And even though we haven't necessarily had a focus group session in the past, many of the comments that have come up, for example, around the physician workbook that relate to where some of this focus groups stuff is, it enabled us to change some of the aspects of things that we're trying to do.

So let's take a break until 3, and then we'll come back and we're going to talk about supplemental benefits in the Medicare Advantage program. Thank you.

[Recess.]

DR. CHERNEW: To let those of you online listening know, we have spent a lot of time and interest on the Medicare Advantage Program broadly, and a lot of what we've been interested in is how the -- what the value we're getting from Medicare Advantage broadly, acknowledging that the Medicare Advantage program offers a lot of benefits that otherwise might not be available or you would have to pay for, and so we are beginning, again, at the beginning of some work to really try and understand that, and this is the first foray into providing some data on supplemental benefits in MA.

So I'm going to let Stuart take us through what we know, and we'll go from there. So, Stuart?

MR. HAMMOND: Good afternoon. This presentation will provide an overview of the supplemental benefits offered through 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.

Today's presentation is the first of two presentations about MA supplemental benefits planned for this meeting cycle. Today we will focus on the financing of supplemental benefits and provide an overview of what benefits MA plans are offering.

In the spring, we plan to present analysis based on MA encounter data. The material from the two presentations will be combined and included as an informational chapter in our June 2025 report to the Congress.

For today's presentation, we'll begin by reviewing Medicare's payments to MA plans with a focus on the rebates that are used to finance supplemental benefits. We'll provide an overview of the types of supplemental benefits MA plans can offer and present results from our analysis of MA bid and benefits data. We'll discuss what can be known about MA enrollees' use of supplemental benefits and conclude with a discussion of the data limitations that hinder our ability to answer important questions about the benefits used.

The MA program gives beneficiaries the option of

receiving benefits from private plans rather than from the traditional fee-for-service Medicare program. MA plans are required to cover basic Medicare Part A and Part B services but may also provide supplemental benefits to their enrollees.

For beneficiaries, a primary tradeoff in choosing between MA and fee-for-service is access to the supplemental benefits that plans provide versus a broader choice of providers and minimal utilization management in fee-for-service.

Over the last decade, enrollment in MA has grown significantly, and a majority of eligible beneficiaries are now enrolled in MA.

Medicare pays MA plans a fixed monthly amount for each enrollee. The payment is determined by comparing a plan's bid to a county-specific benchmark. The bid is the amount the plan expects it will cost to cover basic Medicare services. The benchmark is an amount based on fee-for-service spending in the county. When a plan bids below the benchmark, as most plans do, it is paid a base rate equal to its bid plus a rebate that must be used to provide supplemental benefits. The rebate is calculated as

a share of the difference between the bid and the benchmark. The share is based on a plan's quality rating and is typically around 65 or 70 percent.

MedPAC's previous work has shown that various aspects of MA payment policy have contributed to a gradually widening gap between bids and benchmarks, particularly for some plans, leading to larger average rebates.

This figure shows that the average annual rebate paid to MA plans has increased over time. The dashed dark blue line shows the average annual rebate paid to conventional MA plans; that is, non-employer, non-special needs plans. The solid orange line shows the average annual rebate paid to special needs plans, or SNPs. Between 2014 and 2018, conventional plans and SNPs received similar rebates, and the per-enrollee rebate grew relatively slowly.

Starting in 2018, rebates began to grow more rapidly and to diverge for the two plan types. The average annual rebate paid to SNPs has grown particularly quickly and is now more than $700 than the annual rebate paid to conventional plans. Since 2018, the average rebate per

enrollee more than doubled for both types of plans.

Due to the rapid growth in rebates and rising MA enrollment, Medicare's spending on MA rebates has risen considerably. In 2024, we estimate that Medicare will pay MA plans a total of approximately $83 billion in rebates.

In the bids they submit to Medicare, MA plans are required to estimate how much of their rebate they intend to allocate to one of four broad categories of supplemental benefits: Part D benefits, reduced cost sharing for Medicare-covered services, non-Medicare services, or reduced Part B premiums.

Plans can also use a portion of the rebate for administrative costs and profit margin, and plans generally allocated about 10 percent of the rebate to such purposes in 2024.

It is important to keep in mind that plans' rebate allocations are a projection of how the plan anticipates rebate dollars to be used and so may differ from how funds are ultimately used. Nevertheless, the projected allocations can provide some insight as to how plans anticipate using the rebates they receive from Medicare.

As mentioned in the previous slide, supplemental benefits can be sorted into four categories. Supplemental Part D benefits typically include lower Part D premiums, reduced cost sharing for Part D drugs, or coverage of additional drugs.

In 2024, about 75 percent of MA enrollees are in a plan that includes Part D drug coverage and charges no Part C or Part D premium.

The reduced cost sharing category includes any reductions in cost sharing the plan provides for Part A and Part B services relative to the amount that would be charged under fee-for-service Medicare. This includes the effects of the maximum out-of-pocket limit that plans are required by law to provide.

The non-Medicare services category refers to services not covered by fee-for-service Medicare, such as dental, vision, or hearing coverage. A wide range of services are permitted to be offered under this category.

Lastly, plans can use rebates to reduce the basic Part B premium for their enrollees, though this is relatively rare, and most plans do not provide large Part B premium reductions.

Plans have gradually shifted how they expect to allocate rebates across the four supplemental benefit categories. This figure shows how plan projections changed between 2018 and in 2024. Data for conventional plans is shown on the left, and data for SNPs is shown on the right.

Conventional MA plans have traditionally allocated the largest share of rebates to reducing enrollee cost-sharing. However, plans have gradually decreased the share of the rebate that they expect to allocate to cost-sharing reductions, shown in orange in the figure. For conventional plans, the share of rebate allocated to reducing cost sharing fell from 52 percent to 39 percent over the 2018-to-2024 period. SNPs generally allocate a much smaller share of rebate to cost-sharing reductions because many of their members have their cost sharing covered by Medicaid.

In contrast, plans are projecting a growing share of rebates will be used to provide non-Medicare services, as shown in dark blue in the figure. For conventional MA plans, again, shown on the left, the share of the rebate expected to be used to provide these benefits roughly doubled between 2018 and 2024. The share for SNPs, shown

again on the right, are generally higher and also grew dramatically during the period. In 2024, SNPs project using 85 percent of their rebate to provide non-Medicare services.

As Medicare spending for MA supplemental benefits grows, it becomes increasingly important for policymakers to fully understand their use. Although we know how much Medicare pays for plans to provide supplemental benefits, available data tells us little about MA enrollees' use of the benefits and how much it costs for plans to provide them.

The data that Medicare collects are insufficient for examining the use of the services provided as supplemental benefits, and the lack of reliable data makes it impossible to answer many important questions about how the rebates Medicare pays to MA plans are used. For example, we do not know how much plans spend on each type of benefit, which enrollees used each benefit, or whether service use differs by factors such as age, sex, race, disability status, or geographic area. Without this information, it is difficult to assess the potential value of the benefits to MA enrollees and the taxpayers who fund

the program.

Complete and accurate MA encounter data would be the best tool for collecting information about enrollees' use of MA supplemental benefits, but gaps in the data limit their usefulness. In lieu of reliable encounter data, we must rely on plans' bid and benefits data submitted during the annual bidding process to learn about supplemental benefits.

Bid data include estimated utilization rates and spending data at a highly aggregated level. The level of aggregation makes it difficult to answer many important questions about supplemental benefits. Plan benefits data can be used to assess what supplemental benefits are available to enrollees but include no information about enrollees' actual use of the benefits.

In the next few slides, we present our analysis of these data sources with a focus on what we can learn about the cost-sharing reductions that MA plans provide and the types of non-Medicare services they cover.

First, we'll discuss the cost-sharing reductions. Although we cannot directly observe what cost-sharing MA enrollees pay for services, we can use bid data to gather a

sense for how MA plans expect to use the rebates they allocate to cost-sharing reductions. In their bids, plans estimate the amount their enrollees will pay in cost-sharing. Because the estimates are done separately for several broad service categories, they can give a rough sense of the services for which MA plans expect to use relatively more rebate dollars.

The table on the left side of the screen shows plans' estimates of how cost sharing for their members will differ from the cost sharing that would have been charged under fee-for-service Medicare. The data show that plans anticipate spending more rebate dollars on professional services, such as primary care and specialty visits. For home health and ambulance services shown in the last two rows of the table, the values are negative because plans tend to charge higher cost sharing for these services than would be charged under fee-for-service.

Ultimately, the total value of cost-sharing reductions for any given MA enrollee depends on the mix of services the enrollee uses, whether they receive the services within their plan's network and other aspects of their plan's benefit design. As such, these figures tell

us relatively little about how cost-sharing reductions may affect MA enrollees.

Now I'll turn things over to Pamina.

MS. MEJIA: Next, we'll turn our attention to the non-Medicare services plans offer as supplemental benefits.

For many years, CMS required that these supplemental benefits be primarily health related. This included benefits like dental, vision, and hearing coverage, but also allowed for things like transportation to and from medical appointments.

We analyzed plan benefit data and found that the share of enrollees in conventional MA plans offering dental, vision, hearing, and transportation coverage has increased significantly since 2014. In 2024, almost all MA enrollees are in a plan that offers such coverage. Your reading materials include more detail about each service category.

The extent of coverage for each category varies across MA plans. Plans can decide which services to cover within each category, can cap the coverage they offer, or restrict coverage based on whether a provider contracts with the plan to offer the services. There is limited

evidence available about MA enrollees' use of these services. For dental services, numerous studies have suggested low rates of utilization, but several of the studies use data from earlier years in which dental services were less frequently covered. We know little about enrollees' use of vision, hearing, and transportation services.

CMS and the Congress have gradually increased MA plan flexibility and expanded the types of non-Medicare services that MA plans can offer. Originally, supplemental benefits were required to be primarily health related and offered uniformly to all enrollees, as mentioned before.

Beginning in 2019, CMS expanded its definition of "primarily health related" to include a wider array of services, allowing plans to provide services such as in-home support services and home modifications. CMS also expanded its definition of "uniformity." Under the new interpretation, MA plans can target services to enrollees with a particular health status or disease state.

Furthermore, starting in 2020, plans were given the flexibility to provide benefits targeted to the chronically ill that do not have to be primarily health

related. These benefits are known as special supplemental benefits for the chronically ill, or SSBCI, and can include things like food and produce, non-medical transportation, and pest control services.

Additional flexibility is available under a demonstration called the Medicare Advantage Value-Based Insurance Design, or VBID model, which lets participating plans target services based on socioeconomic status. The demonstration is scheduled to continue through 2030.

As a result of these changes, MA plans can now provide a wider range of non-Medicare services and can target them to subgroups of enrollees.

We also assess the extent to which plans are offering the newer benefits allowed under the recent flexibilities. A large share of MA enrollees are in plans offering coverage of other primarily health-related, non-Medicare services. The figure shows how the share of MA enrollees in plans offering various primarily health-related benefits changed between 2018, shown by the orange squares, and 2024, shown in the open circles.

Our analysis finds that in 2024, fitness benefits, annual physical exams, and over-the-counter items

were among the most common benefits offered, and that the share of enrollees in plans offering these benefits has increased since 2018.

The Bipartisan Budget Act of 2018 gave MA plans the ability to offer non-primarily health-related items or services to chronically ill enrollees starting in 2020. These benefits are known as special supplemental benefits for the chronically ill, or SSBCI.

The figure shows how the share of MA enrollees in plans offering SSBCI changed between 2020, shown by the orange squares, and 2024, shown in the open circles. SSBCI are generally non-medical benefits. In 2024, the most common SSBCI were food and produce and general supports for living, which may include benefits such as plan-provided housing support and subsidies for utilities. However, the share of MA enrollees in plans offering SSBCI remains low relative to other types of benefits.

Since 2021, MA plans have increasingly offered combined non-Medicare services in which enrollees can select services from a plan-provided list. These services are often delivered in the form of a flex card or a pre-funded debit card, which enrollees can use to purchase

items or services up to a plan-designated spending limit.

First, as shown in the top two rows of the table, the share of enrollees in both conventional plans and SNPs offering any combined benefit has increased dramatically from 2021 to 2024.

Spending limits for combination benefits have increased significantly for certain combinations. For example, the average spending limit in plans offering a combined dental, vision, and hearing benefit more than doubled between 2021 and 2024.

Some plans provide cards that can only be used for over-the-counter items or non-medical items offered as SSBCI, including food or produce, housing, or utilities. Average spending limits for these combinations are quite a bit higher and have risen from $447 to roughly $1,500 in 2024.

CMS is implementing new policies to collect and improve data on MA enrollees' use of non-Medicare services.

MA plans are required to submit encounter data for all items and services provided to enrollees. However, until 2024, CMS had not prioritized collection of encounter records for non-Medicare services. In 2024, CMS announced

guidance for submitting encounter records for these services and has developed a method for identifying the services in the encounter data. Additionally, the encounter data system has been updated to accept submissions of encounter records for dental services. These data will not be available to researchers until 2026 or 2027.

Next, starting with the 2024 plan year and as part of the Part C reporting requirements, CMS will also begin requiring MA plans to report aggregated information about their enrollees' use of services and their spending on those services. However, the usefulness of this new data will be somewhat limited because it will be reported at the MA plan level. We anticipate that this data will be available for analysis sometime in 2025 or 2026.

Overall, our analysis of the available data about MA supplemental benefits shows that spending for these benefits has increased significantly in recent years, reaching approximately $83 billion in 2024. A rising share of that spending is expected to be used to provide non-Medicare services.

Medicare does not currently have good data about

MA enrollees' use of these benefits, which makes it difficult to assess the value they provide to enrollees and the program.

Recent actions by CMS may improve our understanding of supplemental benefit utilization, but those data are only just starting to be collected and reported to Medicare.

In next steps, we plan to explore the extent to which MA encounter data include records for supplemental benefits and to assess how those data could be used. Our analysis will focus on vision, hearing, and transportation services, but we will evaluate whether the data include records for other services as well.

For Commissioner discussion, we welcome your questions and feedback on the materials. As a reminder, the material from this chapter and the analysis of encounter data will be included in our June 2025 report to the Congress.

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

DR. CHERNEW: And thank you both. I think there's going to be a lot of interest in this general work.

And, Dana, you're running the queue, and I

thought Larry was first, but I could be wrong.

MS. KELLEY: Larry.

DR. CASALINO: Yeah, I think a quick question. The SSBCI, so plans are responsible for deciding who is eligible for that. Is that correct?

MR. HAMMOND: That's right.

DR. CASALINO: And, by the way, really nice work on this. It's such a complicated topic. I understand a lot more than I did before I read this. Still probably a little bit more to understand.

So is it pretty easy if plans want to for them to broadly classify a lot of people as SSBCI, and it's kind of really up to them how broad they want to be about that? Or is it rigorous for them to make that classification?

MR. HAMMOND: So each plan can propose to CMS how they want to make the determination of whether beneficiaries are eligible for those benefits, so it does vary across the various plans. But generally it requires some diagnostic information in most cases.

DR. CASALINO: So the relatively low use so far, if I got that right, is really at the plans' discretion. I guess they're just kind of feeling it out, or what's your

thought about that?

MR. HAMMOND: So we don't know very much about enrollees' use, but we know that a relatively low share of plans are offering those types of benefits. And we have read some interviews with plan sponsors about why they have been relatively slow to implement those, and I think there is a mix of factors. One is that plans are working with a set pool of rebate dollars and they have to pay for those benefits somehow, and so they might be hesitant to discontinue any benefits and pivot those rebate dollars towards something new. So that might be one piece, is that they are kind of making those calculations Special Agent they go along and making space to provide the benefits if they're interested.

The other part is that these are relatively new types of services for a lot of the plans to offer, and so they are, over the last few years, been going through the process of working with vendors, figuring out what is the actual added value, at least in their estimation, to the beneficiaries and to the plan, and figuring out what vendors to work with and how to deliver that and target to the right enrollees.

DR. CASALINO: Very helpful. Thanks.

MS. KELLEY: Brian.

DR. MILLER: Thank you. This was fun work, very detailed and I appreciate it. So some thoughts to make it more accessible. One is I think for readers, specifying who is a Medicare provider, and I know that sounds silly but, you know, we all know doctors, physician assistance, nurse practitioners, but the broader public who is reading this might not know how a dentist or an optometrist, for example, is treated. So I think adding that in could be helpful.

I think on page 25, where there's that table about cost-sharing reductions, which was extremely well done and very helpful, it would probably help the reader if we added a percentage, just to make it easy. Because I struggle with arithmetic and was able to do it, but some of the readers might struggle like I. It took me a moment.

And then just a couple of thoughts. On pages 5, 7, and 15, we talked about tradeoffs, and at various points the discussion of tradeoffs between MA and fee-for-service gets a little garbled. So on page 5 we talk about access to supplemental benefits. On page 7 we sort of reference

an any-willing-provider network. And then on page 15 we talk about savings from additional program spending and not plan efficiencies.

I think all of those are correct and also wrong at the same time. I think it might be easier, instead of if we describe it, put it in a table. And the essential tradeoffs, if we put it in a table, it would make it easy for people to see and read, and then the tradeoffs then, we're not going to have a debate about this sentence said this or that sentence said that, which is a waste of all of our time. Because the tradeoffs are if you're in fee-for-service you get the any-willing-provider network, where you can see 97 percent of docs in the U.S., and you have almost no utilization review.

If you go into MA, you accept a provider network HMO or PPO. You accept you are UR, which could be moderate or it could be heavy UR. And you get, as you mentioned in other parts in the chapter, you basically are getting Medigap coverage. You're getting a MOOP, you're getting a reduced A and B cost sharing, you're getting often frequently a Part D plan at no additional cost, reduced D premiums, and then supplemental other vision, dental,

hearing, transportation, et cetera, which we can rightfully debate as to what the value of those are.

If you put that in a table, one, you'll save a lot of language throughout the chapter, which will give you less of a headache. And if you put it up front it will make it very clear to the Hill staffer or policy analyst, whomever, who is reading what those tradeoffs are.

I think the other thing that might be helpful is occasionally -- and as I said, this is amazing analytical work. I can only imagine it probably took at least six months of working 10 to 12 hours a day, 5 or 6 days a week to do, plus giving up vacation. Occasionally there are some sentences in here that I don't think were intended to come across this way but they come across as overtly negative towards the program. So I would just go through with a quick tonal edit and take a look and delete some of those. As I said, I don't think that was the intent.

But overall this is a phenomenally done chapter, and I think with some of those technical tweaks -- I mean, it's already 4 1/2 stars. It could be 5 stars or 6 stars on the 5-star rating scale. So thank you for this work.

MS. KELLEY: Gina.

MS. UPCHURCH: Thanks. Really, really good work, and it's just a lot. It's a lot for Medicare beneficiaries and those trying to help them to sort through.

So just a couple of quick questions here. On top of page 11, you say that certain benefits can come. They are targeted benefits for people with certain health conditions or disease states. I know from counseling that it's not apparent who is eligible for those things. You can look at the Summary of Benefits. It's hard to find. Then you go look up the Evidence of Coverage, and it becomes clear or you can take time to call the insurance company. But you're in the middle of counseling and you have lots of people coming in, or the older adult.

So do you know if there is any effort to make that clearer, like who is eligible for what, ahead of time, before people enroll instead of after they enroll?

And then the second part of that is, you know, CMS requires the plans to then document how they determined if the person is eligible for the benefits. So that means they have to, in many times I know providers have to certify that that person has that problem. And that just seems like administrative headache. Do we know anything

about that? Do we have any data about that, about the transparency and/or the certification process?

MR. HAMMOND: So I don't know that we have a lot on specifically when in the process beneficiaries necessarily would become aware of their eligibility. Certainly, like you described, there is some documentation when they are enrolling in the plan that certain groups of people might be eligible for the benefit. But people can learn new things about their health status throughout the year, so that makes it difficult to be entirely prospective.

Starting, I believe it's this year -- or sorry, I believe it's next year, plans are required to give beneficiaries a midyear notice of unused supplemental benefits that they might be eligible for, so that might be one way in which --

MS. UPCHURCH: It starts in 2026.

MR. HAMMOND: Right. Sorry. Next year. I'm already looking at 2025. Yeah, so that might be one way in which there is some additional effort to make sure enrollees are aware of their benefits.

MS. UPCHURCH: Yeah. I would just put out there

that a lot of people think they're going to be eligible for it and then they dig into it after they're already enrolled and they're stuck in it, and they can't really do anything about it.

The second question I have, first of all, I think the footnote on the bottom of page 5 was for me, where you're explaining why you're calling it supplemental, because that's what it's called in the law, and I keep complaining about it. So I will be quite about calling it supplemental benefits now. Thank you very much.

But page 18 footnote, it sounds like plans put a bid in, then the benchmarks get known, and then they can put in an updated bid. What can change between Bid 1 and Bid 2?

MR. HAMMOND: Yeah, good question. So the benchmarks for most plans are announced ahead of them bidding, and they are able to bid against that benchmark.

MS. UPCHURCH: Before the first bid.

MR. HAMMOND: That's right. So the benchmarks are announced early in the year. Initial bids are due the first Monday of June in the year, but there are certain types of plans, particularly Part D plans and regional

PPOs, for which they need information about the bids of all the plans in order to set certain parameters of how those plans will be paid. That information generally comes out later in the fall, because they need to collect the initial bids, do the analysis, and then release the kind of national average bid amounts and things like that.

So when that comes out in the fall there's a separate process in which plans can look at what is the actual Part D premium for the year, how much did they allocate of their rebate towards the Part D premium, and then reallocate part of their rebate in response to that new information.

There are a set of very complicated rules that CMS provides in order to make sure that there are not large changes in the bid, that go along with that process, and it's reasonably tightly regulated. And we can pass along the information on what is allowed to change during that. But it is mostly in response to changes in the Part D premium information.

MS. UPCHURCH: Okay. Great. Thank you. I'll also have some Round 2 questions.

MS. KELLEY: Tamara.

DR. KONETZKA: Thanks. Great work. Clearly a lot of interest in this area, and clearly to answer the questions we want to answer we really need that good encounter data, and that may still take a while. So I was just wondering, in the meantime, I'm guessing the answer is yes, but have you looked into whether you could get any of this data through surveys? Like does MCBS ask about this? I know that Health and Retirement Study and NHATS probably don't specifically. They're not that granular in how you get these benefits. But even those, if you connected it to claims you could identify who is in the plans that offer supplemental benefits, and then see whether their utilization. You know, we won't know the mechanism, but whether their utilization of dental or vision is different from people who are not in those plans.

MR. HAMMOND: Yeah, thanks for the question. So there have been a set of efforts to use some of these survey data tools to look at supplemental benefit use. Several studies have used the MCBS, one recent study used the MEPS to look at dental spending, and at least one study has used the HRS to look at dental spending.

So there have been efforts. We are exploring

whether those are things that we could use in the meantime while we wait for the better encounter data to become available. But we haven't done that work yet.

MS. KELLEY: Larry. Okay. Betty.

DR. RAMBUR: Thank you. I really appreciate this, and it goes far towards my wish that Medicare Advantage is really transparent. That's been the most important thing to me, is people know what they're getting and not getting.

I just want to make sure I'm clear on two things. So this is in light of what we hear about the net denials and the prior authorization. The dental and the vision and the hearing is really all a defined benefit plan in this sense, right, prescribed defined benefits rather than what we might think about conventional insurance. Is that correct?

And then the second part of that, I'm looking at things like food and produce and non-medical things. Those have spending limits in the plan, per month, per year. How does that work to kind of keep that moving in the right direction?

MR. HAMMOND: So plans have a lot of flexibility

with how they can offer both the dental, vision, and hearing, and those other benefits that you mentioned. Some plans do offer a reasonably open-ended dental benefit and charge some degree of cost sharing while others would offer it as what you call the defined benefit or where they put a limit on the plan liability.

On the other types of benefits, it is very common, especially for things like the Flex cards, for plans to put a spending limit on how much a beneficiary can use that card. Those limits take a variety of forms. Sometimes it is when both the plan sets a cap on how much you can spend, but they have some flexibility over is that an annual limit, a monthly limit, a quarterly limit, and different plans take different approaches.

DR. RAMBUR: That's very helpful. Thank you. And one other quick comment, I guess. I finally wound my way through understanding better the financing of rebates, on page 6. But if it's possible and not too much effort, a diagram or something would be very helpful. Because I think the casual reader thinks about a rebate as something the purchaser gets back. So it took me a while to swim my way through that.

But overall, really great work, and I appreciate it.

MS. KELLEY: Robert.

DR. CHERRY: Thank you. This is well done, and I would say, you know, educational. A nice little primer too.

My question was more on page 56 of the chapter, because I'm not really clear exactly in terms of the new CMS policies regarding submitting of non-Medicare services exactly what they're asking for or they're not asking for. In other words, in the chapter it says that they're starting to create these default codes for dental care. When are they creating the default codes for other types of services like fitness, transportation, and the usual dental, vision, and hearing? That's not quite clear there in terms of when those are starting.

And there's nuanced words there where CMS is providing guidance on how to submit these codes. So is this still like an optional thing, because if it's optional and they're giving guidance and instructions, but really forcing the MA programs to submit the data, then we're still at square one.

That may be helpful to kind of understand that a little bit better, you know, with the chapter, and you could certainly speak to this.

And also trying to interpret what the plans are submitting is not going to be helpful unless we understand what the plan benefits and their offerings are. In other words, if someone is offering transportation, and they're not utilizing, let's say, other supplemental services, it's good to understand what their out-of-pocket maximums are. Is there an out-of-pocket maximum just for transportation, or is it for all non-Medicare services, and what does that exactly look like to the enrollee? Because I don't think it will make sense if we're just looking at the default codes.

So I think just providing some additional detail on how this is supposed to work, and most importantly, how it doesn't work, would be helpful in that particular section. But feel free to clarify any of that.

MR. HAMMOND: Sure. So up until now plans have been required to submit encounter records for all items and services provided to enrollees, but CMS has said that they recognize that there are some supplemental benefits for

which plans might not have all of the information to populate a full encounter record. So this would be some of the things that might be non-medical, for which there are not common codes and things like that.

So starting with plan year 2024, those are the types of services where CMS is started to provide those default codes. So that is kind of everything except dental. On the dental side, dental providers submit their claims to the MA plans, using a specific dental claims format, and the encounter data processing system that CMS uses to collect encounter records has not previously been configured to accept that format of claim, and so many plans have not been submitting the dental encounter records for their enrollees.

Starting with plan year 2024, CMS is now accepting that claims format for dental encounter records, so plans should be able to submit encounter records for all of their dental services.

So I think there are two parts here. One is they are now accepting the dental records, and then the other part is for the services that used to be difficult to populate an entire claim, they're providing those default

codes. And in addition, they're asking the plans to use a particular field on the encounter records to indicate which specific benefit is this record corresponding to in your plan benefit package.

So it should allow some of that linkage that you're describing of this service has this default code, and it should, according to this plan, link to this part of their benefit offering. Some of this is spelled out in the guidance that CMS is giving plans, but I think we'll need to wait to see the data to see how it actually all fits together.

DR. CHERRY: Right. That's helpful. So there's really two different data fields, one just for dental and then for everything else that's non-Medicare is coming in through the default codes that they're creating. So that's good. And maybe if there's an opportunity just to provide that degree of detail, including the fact that it's linked to the plan benefit offering, so that the information can be interpreted.

Thank you. I appreciate the answers.

MS. KELLEY: Josh.

DR. LIAO: Stuart and Pamina, thank you for this

informative information. I guess a really quick R1 question here. You lay out very nicely, starting on page 53, kind of all the limitations and the data that we have on the prevent maybe analysis. I really appreciated you contextualizing the VBID model within the broader changes in supplemental benefits.

Are all the limitations you've highlighted for encounter data, reliability, the lumping of service categories of bid data, et cetera, do those all apply to VBID as a model, or could we expect there to be some things under innovation model authority that we might see there, earlier than some of these broader data issues?

MR. HAMMOND: So the VBID program has been around since 2017. It has expanded both in scope and in types of benefits that can be offered under the demonstration since then. The information that is available in the evaluation that is ongoing for that model does include some additional information. And so there are things like interviews with both parent organization administrators or beneficiaries about how did it work to provide that benefit, what have been some of the things that you have observed among your enrollees that are popular, what hasn't been popular,

things like that.

So there is a little bit of more granular data, especially qualitative data, in those evaluations for the demonstration. But with regards to how does it fit with the kind of general data sources we have for the MA program as a whole, the plan benefits data that plans submit as part of the annual bidding process do include quite a bit of information, where plans indicate how they're participating with the VBID model or not. But otherwise I think a lot of the same limitations could continue to apply.

DR. LIAO: I appreciate that. That was my conclusion, as well, I think. Making that clear might be useful, just to say that even though that's an innovation model, the limitations still hold in terms of looking at impact and use.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks for this great work, wonderful reading materials and chapter. I found figure 10, in particular, to be super helpful and the reading materials, which basically lays out the kind of progression of the flexibility and timing of when the different types

of benefits became feasible under MA as supplemental benefits.

So I had three questions. One is maybe somewhat related to Robert's question, but I was curious for, in particular, dental, vision, hearing, but kind of curious a little bit more broadly than that also, but let's just start with those three. I'm curious how they're administered. So are they -- are all of them administered by the MA plans themselves? Are they contracted out to, you know, traditional dental, vision type of providers? And to what extent are those actually vertically integrated?

MR. HAMMOND: So it varies across plans. I do think a lot of plans use some type of vendor, particularly for the vision or hearing side of things. The dental benefits are often offered through a dental network, where a set of dentists have agreed to participate in a network, and then the plan is contracting with that network.

And then to the extent that it is vertically integrated, I don't think we have a lot of clear information about the extent of vertical integration and how much plans are just offering some of these services or

benefits directly, but we can look into that and see what we can provide.

DR. NAVATHE: Great, thanks.

So I guess somewhat relatedly, the next question I had was -- so, you know, we talked about the different types of data. The bid data are one source of information, and I was curious. They're submitting aggregate data through sort of the data around the supplemental benefits that they're submitting. I was curious. What level of granularity of actuarial guidelines are there basically on how they're supposed to price, at least in the construction of their bid, each of these supplemental benefits? My question about vertical integration is sort of stimulated by wanting to know more about that, but I was just kind of curious. Is there a lot of guidance around that, or is there a lot of flexibility for them as they think about the different supplemental benefits that they could offer and how those end up being constructed into their bid?

MR. HAMMOND: So, generally speaking, the supplemental benefits that are reported in the bid are reported under, I would say, four broad categories, maybe five. There is a separate line item in each bid for

dental, for vision, hearing, transportation, and then all other essentially. And so I think -- I'm not sure how that fits with your question about actuarial precision, but the base period data on which the bid is supposed to be based, meaning what was your experience with these benefits in a prior year, that needs to be reconcilable with the plan's financial statements. They convert that information to a per member per month basis and then use a set of projections and assumptions to update that information, to reflect changes in their population, changes in their benefit offerings, things like that, to actually construct their bid. So for some of the supplemental benefits, it's done at a higher level of precision than the others.

In our conversations with plan actuaries, our understanding is that they are doing a lot of their projections at a much more granular level and then rolling up that information to the level that is required for the bids and then putting it in there. So I think what we end up seeing is somewhat more aggregated than how the projections are actually done by the plans, if that helps.

DR. CHERNEW: Can I ask a follow-up question? I guess I can't.

DR. NAVATHE: I guess I'll turn my mic off.

[Laughter.]

DR. CHERNEW: I'm sorry. You can continue. I can stop your clock, and then you can start it again.

DR. NAVATHE: Go ahead.

DR. CHERNEW: Some of this relates to how well the actuarial value calculator is sort of working. Is it fair to say that there's just a lot of play, different actuaries, different companies? CMS has some oversight, but there's a lot of noise -- and maybe "noise" is the wrong word -- in the extent to which you really could verify, if you will, that the actuarial value is what the actuarial value is or the cost of what it is in the process, because a lot of that information is coming from the plans. CMS is sort of judging it for reasonableness, but you can't get into the granular type of things that Amol was asking about. Is that basically the right understanding?

MR. HAMMOND: And are you asking kind of specifically about the non-Medicare services?

DR. CHERNEW: I was, but that's just sort of, in general, that's my sense of how actuarial value oversight

works.

MR. HAMMOND: I think that's generally right, that we are working with plan-reported information.

Maybe part of the question is, how well does the projection match the actual spending? Is that some of the question?

DR. CHERNEW: How well CMS could really know that, but yes.

MR. HAMMOND: So the bids are subject to bid auditing, and so CMS can request to audit various bids if they have questions about how the plan is constructing the bid. But, generally speaking, they're going to work with the plan-reported data. That's right.

DR. CHERNEW: Kenny?

MR. KAN: Great question, Mike.

[Laughter.]

MR. KAN: Generally speaking for dental, vision, and hearing, actually, Stuart, welcome to the Actuaries Hall of Fame. Always knew you were a closet actuary.

But actually, Stuart pretty much nailed it. Basically, for dental, vision, and hearing, for the most part, that's fairly rigorous, because for those three types

of benefits, there's a lot more robust data. So you have to trend forward prior experience data and then make some assumptions about trend, and then, like to Stuart's point, you also have the risk of getting audited, and actuaries have to comply with certain requirements, because they're basically certifying the bids in blood.

So where there's a little bit more subjectivity is really on the non-medical, and that's going to depend on the benefits that's being offered, because for some of the non-medical, admittedly, the literature on that is a little bit soft and squishy. But what the actuaries do try to do is that they do talk to their health econ, and their health care folks, and say, hey, this is what the literature says. What do you think's going to happen? So there is a little bit more subjectivity in that area.

DR. NAVATHE: So I guess to continue this line, just to make sure I understand -- so, basically, for vision, dental, hearing, the projections should actually fairly tightly match, except for the fact that they're projections, of course, the use that we end up seeing, and that experience, basically, is then being projected forward. So that element is there.

In the non-Medicare services, at the granular level, there might be greater variability between what is kind of in the aggregate bid for that set of services, relative to what actual use ends up being. Is that basically a reasonable way to recap that?

MR. HAMMOND: I think that's right, generally speaking, and when we've looked at the bid data, we've seen kind of reasonable rates of that and to project and what they end up reporting as their experience in the subsequent years.

We haven't done that analysis super deeply, but we've done kind of preliminary analysis, and it does seem like they have a basis for projecting some degree of accuracy.

I do want to clarify one thing. I think throughout the report, we use the term "projection" and "allocation" with regards to how plans are allocating their rebates, and that is a separate process from how they are projecting their actual utilization. So if there is any -- there is a difference in how we're using the term "projected" in the paper.

DR. NAVATHE: Okay, thank you.

My last question is, in figure 2 of the paper, there's basically a sort of description of the different supplemental benefits, and there's -- in the SNP part of that chart, there is -- the top couple of deciles basically do have -- or top few and particularly the top one has a "substantial amount," in quotes, that is for reducing the Part B premium. And I was curious if that is entirely coming from outside the D-SNP side, and that's reflecting that there's other SNPs besides D-SNPs, or is that at all reflecting state-by-state variation in how the Part B premiums are covered at the state level?

MR. HAMMOND: It's a good question. We haven't looked specifically at that, but we can look.

DR. NAVATHE: Okay, thank you.

MS. KELLEY: Wayne.

DR. RILEY: Pamina, Stuart, great work.

One of the supplemental benefits that at least in my observation becoming increasingly in vogue are these flex cards, and you referred to them earlier, right? How are these cards -- first of all, are they more like SNAP cards that are limited to certain categories of food, or are they pretty open like a Visa gift card, that you can

buy gasoline, you can buy groceries, you can buy pet supplies, you know, with a Visa gift card-type thing? So tell us more about how these flex cards have restrictions or don't in terms of how they can be used by the beneficiary.

MR. HAMMOND: So there are some limitations that CMS requires. For example, the flex cards cannot be used for purchasing tobacco or alcohol, but other plans have -- or some plans work with different vendors that enable them to put different levels of kind of restriction on what can be purchased, and different plans get different amounts of information about what is being purchased with the cards.

DR. RILEY: So apart from alcohol and tobacco and nowadays cannabis, I guess, those would be restricted. So when you swipe the card, it would not -- the transaction would not go through, but just about anything else would?

MR. HAMMOND: I think it varies across plans.

MR. POULSEN: That's defined by the plan as opposed to defined by the requirements imposed on the plan, right?

MR. HAMMOND: That's right.

MR. POULSEN: Thank you.

MS. KELLEY: That is all I have for Round 1, and so I will move to Round 2, Mike?

DR. CHERNEW: Yep.

MS. KELLEY: And I have Stacie first.

DR. DUSETZINA: It might go there. It might go to Round 3, 4.

DR. CHERNEW: [Speaking off microphone.]

DR. DUSETZINA: Well, there was no one else in the queue at the time, so I thought I could get philosophical. I apologize in advance.

This is exceptional work and so well presented, so kudos to you both for this.

I had -- the first thing I just want to note, I was looking at figure 7 in the report showing this growth in all of these different categories of other services, and I think it brings up two things. One is this -- this is where I get the philosophical is -- are these services that we want to be spending -- like using health insurance to cover?

And then another broader issue that I think that really is the heart of this chapter is, what does coverage actually mean? So, like, if I'm actually picking a plan

based on some of these services, do I even know that I have real access to any of these things that are being advertised to me?

And I think that not knowing that part of the equation is really problematic because maybe I am trying to shop for a plan because I want acupuncture services, and then I find that there's just none available.

I think there's one thing you highlight in the chapter that I think super important about the plan finder tool and the fact that you get a checkmark for having the service if you have any component, and you gave such a great example. So you said if there's a hearing exam, it gets counted as a checkmark, the exact same as if you had a hearing exam, a fitting, an evaluation for hearing aids, and the hearing aids also themselves covered, that you get the exact same presentation of information for a beneficiary. And that's kind of ridiculous because that's a big difference in the benefit.

So I think, to some degree, there's the -- we need to fix the shopping problem for people so that they actually know what they're choosing and can pick the plan that fits their needs best, and then knowing for sure that

they actually get that coverage when they sign up for it, that that is real, you can use those services. Those are big problems to fix.

But the other two statistics that just really stand out to me around this broader -- should insurance be what pays for all of these services -- you say in the chapter that fee-for-service beneficiaries will finance $13 billion in MA rebates for services that they don't receive. That's a big number for people who are on Medicare who otherwise don't get any benefit here. And then that these services cost $83 billion.

And I just can't help but notice we start the day talking about this massive gulf of coverage for some of the most intensive care needs that we'll have in our lives, like nursing home care, care that I think many of us would give up having help paying for gym memberships in lieu of having this greater support.

And I know that this is why it's probably like already in Round 4 with this, but this chapter couldn't help but highlight to me some of those things.

So great work. Thank you for letting me philosophize a bit.

MS. KELLEY: Scott.

DR. SARRAN: I'll be brief in high level. First, thanks, guys. This was great work, because I think your work framed it so nicely and told a story. I'll also be able to be brief, because I think we're going down the right road in terms of transparency here. But I'll emphasize that I think this is taxpayer money. We have an absolute right to full transparency on how that money is being spent.

The key thing in my mind -- and again, this is staying high level -- on slide 18, "Recent actions by CMS may address some shortcomings of the current data." So, in my mind, the key word is "may." I would predict we will not get either the quantity nor the quality of data we would like to exercise prudent and comprehensive oversight, and we will need to keep our foot on the gas on that. So I think we're going down the right road. I think you teed up the need for that in the next steps really, really well. I just think we all need to be cognizant and observant of how much data we do get, how much information that data enables, right, and continue to ask for more until or unless we reach the point in time where we feel confident

that we are understanding all those questions that you begin -- you guys teed up so nicely, I think on slide 9, that what do we -- what do we want to know?

So thanks.

MS. KELLEY: Brian.

DR. MILLER: Hi. I will be focused but probably not brief. Be forewarned.

I want to respond to Stacie's comments briefly first before I share my thoughts. One is that for fixing the shopping problem, we have two excellent examples in the ACA exchanges and the FEHB marketplaces, which do a great job of laying out choices and trade-offs. So we can look there.

The $13 billion in fee-for-service reported as not getting any benefit is not true, because they're getting the benefit of any willing provider network, which the MA beneficiaries are not. So, again, that's not a one person gets this, another person doesn't. It's trade-offs.

I'd also leave the $83 billion for another chapter. I think that number is subject to debate.

So back to my comments that I wanted to share, this is sort of ways for us to think about Medicare

Advantage. I think we need to think about framing as a holistic health benefits package, because if you are old, you have medical problems. You need to have drug coverage. It's pretty clear, like, you need drug coverage. It's not optional.

It's also not really optional to have Medigap. Like, not having a maximum out-of-pocket is untenable. And if you have heart failure, you have diabetes, if you don't have a maximum out-of-pocket cap, you're in deep kahuna. So we should start to think more about how is the beneficiary going to construct a holistic health benefits package, right?

In fee-for-service, they buy Part B, Medigap, and D. In MA, they make one purchase and get them all, and there are trade-offs there. It's something that our first MedPAC chair, Gail Wilensky, often talked about it. It's about trade-offs.

I think one thing that's really interesting about this chapter is it made it pretty clear to me and hopefully to all of us that the benefits that people get are real. I just want to enumerate a couple of them. One is the $18 billion in Part D premiums, $24 billion in Part D reduced

cost sharing, which is a total of $38 billion extra prescription drug benefits.

Page 40, 89 percent of Medicare Advantage beneficiaries have over-the-counter drug coverage. If you have osteoarthritis, I can tell you that Tylenol and lidocaine patches from CVS are a much better treatment than prescription opioids.

I think the same thing is true with technology and innovation. So 87 percent of Medicare beneficiaries have access to remote monitoring and remote access technologies, 46 percent have access to acupuncture, which has good randomized controlled trial evidence for a variety of conditions. Other things that matter, if you age, 36 percent have access to in-home support, 31 percent have access to personal emergency response systems. If you fall down the stairs alone and no one is there with you, because our society, a lot of folks are aging alone now, and so this is a holistic health benefits package for folks. And if you're poor and you're old and you don't have much in terms of resources, you don't have much in terms of income, the $175 for Part B premium, the $55 for Part D premium, and the $200-plus for Medigap before incurring any

expenditure is very expensive. And that's getting in any willing provider network.

On page 27, we saw that the majority of Medicare beneficiaries have access to an MA plan with zero C or D premiums. So we had the IRA pass recently and increased prescription drug plan premiums, and now there's a demo that's subject to debate.

I think that the other thing to think about is that benefits innovation is a real thing, and we should collectively as Commissioners sort of stop poo-pooing it. Prescription drug benefits were around for the predecessor for Medicare Advantage for three-quarters to four-fifths of the beneficiary in the '80s. So I was born in the '80s. The prescription drug benefit became an option as a standard benefit for fee-for-service 20 years later. So benefits innovation is not just something that we're writing on a corporate pamphlet. It's a real thing for the Medicare beneficiary.

And then I think the other thing to think about is, who is in Medicare Advantage? Again, if you don't have a lot of assets, you're going to pick Medicare Advantage, because it's a great way to get affordable Medigap,

affordable prescription drug benefit, and then maybe some other benefits that you may or may not find valuable.

The Medicare Advantage population is poor, and it's a more minority population. And if we truly care about health equity and health disparities and addressing them, something that the National Academy of Medicine has been talking about for three decades, we need to be thoughtful about how we handle the Medicare Advantage program and not just be suggesting blind cuts and then redistributing money to fee-for-service. We need to think holistically about both programs, what the trade-offs are, who the populations are, and how we can help the Medicare beneficiary.

I practice medicine in East Baltimore. It's not a very wealthy neighborhood, and a lot of my patients might not have the funding to buy Medigap and a Part D on top of a Part B plan. So we should be realistic about how we look at Medicare Advantage. It is functionally the safety net in the Medicare program for the elderly, poor, and minority population.

And then I noticed that over the last cycle that lots of other Commissioners talked about untold billions of

dollars that health plans were making on Medicare Advantage and that the rebate system propelled massive administrative and profit costs. When I looked at table 1 on page 17, it was something that 92 percent of rebate dollars goes to benefits for conventional MA plans and 85 percent for SNFs. That's a lot.

And then people have also questioned about what SNP plans do. And the reason SNP plans have a greater focus on benefits as opposed to cost sharing is because most of the SNP plan members are dual eligible. So they have Medicaid, and so those beneficiaries need additional benefits.

So I just think overall, like, our collective approach as Commissioners to Medicare Advantage needs to be a lot more balanced. We need to think about the financial trade-offs that beneficiaries have, and it's okay to be upset with managed care, and we should be upset with managed care about prior authorization, care denials, and needs for process improvement and Star ratings not being equitable across programs. And that's fine, and I'm upset about those topics too.

But I think we should really stop just bashing

Medicare Advantage plans, even though it's popular to do so, and think about how we can make the program better for the beneficiary across both programs.

Thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: I've got too many comments. One, overall, looking at the chapter, one sort of seemingly contradictory finding sticks out to me, and that is beneficiaries are attracted to these extra benefits and may join Medicare Advantage because of them, and yet the evidence kind of shows that use of these extra benefits is low. And I think sort of building on what Stacie was saying, I think that we need to try to figure out why, as we pursue this research. We need to figure out why. Is it because they're looking at, yes, oh, there's vision here, or there's dental, and then they find that the benefits actually don't amount to much, or is it because they have trouble finding providers in their network and using that benefit, or they were kind of mistaken about how important that is relative to the other health care they need. I think it's important to figure out why, why we have that contradiction.

The other main comment is that it's well established that a large swath of Medicare beneficiaries have unmet long-term care needs, that they would like to see more in-home care, that they have health-related needs but because Medicare traditionally doesn't pay for those things and because most Medicare beneficiaries don't qualify for Medicaid, which is the payer of default for these services, they just don't have those things.

And I was struck in the chapter, I mean, I sort of know these supplemental benefits have been emerging, but that a third of MA enrollees are now in plans that offer some kind of in-home supports. Now, that may be like home modification. That may not be actual in-home care. Like there's probably a wide variety of what's offered in those. But I see this as a real opportunity, as we get the appropriate data, to sort of treat this as an experiment and see how access to those kinds of services plays out. Do people use it? Does it affect their other Medicare utilization?

We know, for example, from our own work, at least preliminarily, that people have been sort of using home health, especially community-initiated home health, as a

kind of substitute for long-term care, to the extent that they can. And we find that people who then get access to in-home services through Medicaid don't do that as much. There's a substitution there.

And so I'd be really interested in following who uses these benefits, how it affects their outcomes, how it affects their other utilization, and also sort of dividing that out by Medicaid. Because to me I know there's probably good motivation for starting with dental, vision, and hearing as things to focus on, that have been around longer, but I would really love to follow up this data and treat this as an experiment to see what we can learn, given kind of growing interest in how Medicare might try to address those unmet long-term care needs.

MS. KELLEY: Gina.

MS. UPCHURCH: Just to clarify one thing first. A Medicare Advantage plan is not a Medigap policy. It's not a zero-premium Medigap policy. It's a totally different beast. When you have traditional Medicare and a Medigap, you don't owe things as you get care. When you're in a Medicare Advantage plan, you pay as you go. So you can't have both. You can't have Medigap and Medicare

Advantage. That keeps getting thrown out as zero-premium Medigap. It's not true. They're different things.

Second thing, just thinking about the purpose of managed care and Medicare, it makes perfect sense that we want a more efficient, effective system. So we've taken that money that could potentially be saved and we've added these benefits. And I have concerns that that's where we should put these benefits. Running them through insurance companies and health systems and underfunding SNAP benefits and home aid services for the Department of Social Services. You know, is there a better way to get these benefits to people than through these insurance companies? It's just a big concern of mine.

If you say to people who have limited incomes, on average, you're potentially eligible for $2,500. Our analysis of plan rebates shows that in 2024, Medicare plans, approximately $83 billion, or about $2,500 per enrollee, about 17 percent of the payments from the Medicare Advantage plans equals the $2,500, to provide supplemental benefits, up from $21 in 2018.

So in six years we went from $21 to $2,500. So the people that I know that enroll in these plans, say

we'll just give you $2,500 and let you spend it the way you see fit, whether you're poor or not poor. People want to be able to spend their own money in ways they find reasonable.

So I just think it's sort of paternalistic to say, well, let's give you this plan, and this plan, and make you jump through all these hoops to get these benefits. Give them the cash. Just give them the cash. And we're making it so complicated for them to access these benefits, that many of them aren't directly health related.

Lastly, because of these added benefits you've made it so complex for people -- I say you, we collectively, have made it so complex to try to help people. And I went through this, I think, last year. But when we're helping someone, we're like, here's traditional Medicare, here's Medicare Advantage. Not right or wrong. Two different things. We help people make that decision. The minute you go on Medicare Advantage, PPO or HMO, and we put in your drugs. Are you drugs covered well? Your doctor? How much is your hospital?

What we're finding this year, looking at a lot of the Medicare Advantage plans -- I'm just talking about in

Durham, because they are by county -- you look at them, they're almost identical. One insurance company has almost identical, all those things. You're in Medicare Advantage, you're in a PPO, the drugs are covered the same, you're A and B benefits. The only things that are different in these 10 plans are these extra benefits.

So all of a sudden, we're having to learn all of these little nuances. And I say just give them the cash. It's getting too complicated for people.

So I just go back to one of the reasons I came on this Commission. I'm all about making Medicare better for people, and I think we can do it by making it simpler and making it transparent. And we're not doing that with all of these benefits. We're doing the opposite of that. And I just want to state that because we try to help people with it, and it's just too complicated. Thanks.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks, both, for a great chapter. I think this is an excellent start to setting the table for a lot of work that's going to be coming down the path. And I fully support MedPAC examining this space in greater detail and making information more transparent in terms of

who is using these benefits and how they're using them, and trying to come up with some assessment of the value of these benefits, from the consumer perspective and the taxpayer.

A couple of things came to mind. I realize there's kind of this long trajectory before you get your hands on the quantitative data to be able to do some of these analyses. And I was wondering if, in the very near term, do you have any ability to work with CMS to start looking at the data that's coming in, to have some assessment of the quality of that data and what you can expect to receive when you sit down to do those analyses in the future?

MR. HAMMOND: Are you asking about the new encounter data for supplemental benefits?

DR. DAMBERG: Yeah.

MR. HAMMOND: Not that I'm aware of, but we can certainly ask.

DR. DAMBERG: Yeah. Because I think if it's not going to be as fulsome as we would like it to be, it might be nice to be able to work with CMS to figure out how to improve the data submission, sooner than later.

The second thing that I was wondering about, whether there's an opportunity -- and again, I realize you have limited resources and time. But is there any work that has been done, or could be done to interview plans and try to understand how they operate in this space, and where the uncertainties are and kind of all this actuarial value calculus goes on?

MR. HAMMOND: So we have conducted a series of interviews with MA actuaries, and that has informed our work here a little bit. There are also some published reports where folks have done the interviews with other plan administrators or folks involved in plan benefit design, and we can share those reports, because they give some qualitative sense for how folks on the plan side are thinking about these decisions.

DR. DAMBERG: Yeah, that would be helpful.

And then a couple of other comments. I want to plus-one on Stacie's comment about making it easier to compare coverage. I guess I was kind of shocked to know that there is a checkmark for dental. It could mean many different things as a consumer.

I want to plus-one on Tamara's comments in terms

of really trying to understand why use is so low and what people actually understand about these benefits.

And then I think this chapter just really underscored for me some of these issues of fairness and inequalities between fee-for-service and MA, the sense that people on fee-for-service are kind of underwriting the provision of these benefits on the MA side.

And then also I just think the growth in the size of rebates really reminds us of a conversation we've been having around the benchmark and how we're thinking about benchmarks and how to set them in the future.

MS. KELLEY: Josh.

DR. LIAO: Thanks again for this chapter. I just echo very quickly what other Commissioners have said. I think it's an important direction, and this chapter is helpful in laying out where we're going, not just that you will get into encounter data and we'll have an informational chapter but also kind of a sentence on page 50 which really captured it well, which is that policymakers don't have good information about whether the spending provides good value to MA enrollees and the taxpayers who fund the program. So I very much appreciate

the direction we're going.

I also recognize that you've helped set the table around the time delay and the timeline for getting these data. I hope as we do that, whether it's in highlighting gaps, creating a framework for that, we're actually getting into the data that we don't become, I think, what someone called kind of a chimera. Like take the clinical side. I would never say you have patients with kidney disease or not, and that's good enough. We have CKD 3 and 4 and 5, and we have information about that.

I think one of the things that jumps out to me is we want to avoid that kind of monolithic approach to some of these categories. It's not just transportation. It's emergency, non-emergency, to plan-approved sites, other sites. And I think getting that granularity is helpful, so that we don't come up saying transportation or housing yields good value. I wouldn't know what to do with that. And I think the chapter does a nice job of that.

The other example would be housing, you know, kind of where you talk about plan provider support, you know, the housing consultation, the utilities, the rent itself, or ALF. The more I think we can do that, the

better we'll be, again, to spotlight the gaps or to get to that point about gaining information about good value. So thank you.

MS. KELLEY: Larry.

DR. CASALINO: Well, so as it sometimes happens, I started off with I signed up for Round 2 with one comment, but now I have three, but the two additional ones are pretty brief.

One is when Stacie writes, beginning to use the word "philosophical," it made me think of something that hadn't occurred to me before. Back in the day, you don't see it much anymore because it's so far advanced, I think, but there was a lot of discussion of the medicalization of non-medical things, which was generally considered a bad thing.

And actually a lot of the supplemental benefits -- I hadn't thought of this until Stacie said what she did -- supplemental benefits, to some extent, I'm not talking about vision and dental in here. I'm talking about things like food or transportation or housing. These are non-medical things that we are medicalizing them by making them supplemental benefits in MA. And not only are we

medicalizing them and putting them in the hands of the medical care system, but we're putting them in the hands -- I mean, the biggest MA insurer, right, I believe, is UnitedHealthcare. That is as big as Exxon Mobil, almost. So we're medicalizing into that side. Anyway, it makes me less enthusiastic about some of these non-medical benefits.

The second comment, that I didn't have to start with, was I like Brian's comments. I take Brian's comments about Medicare Advantage and the supplemental benefits as a safety net program for low-income beneficiaries quite seriously. And, in fact, since the last meeting I've had it on my to-do list, "think about Brian's comments about MA as a safety net program." I haven't done it yet, and it's been a month, but it's there. So I did take it seriously.

But, you know, there is a counterargument that I think we've shown that it costs more to Medicare for beneficiaries in MA than for similar beneficiaries in traditional Medicare. And one could say, staying within the medicalization paradigm, if we took these excess dollars that MA is getting from the fee-for-service system, it could be a safety net program for low-income beneficiaries, as well.

Anyway, those were my two additional comments. My comment I started off with is pretty short, and I'm just going to read it to be careful about what I say. I do think it's important to provide some context for supplemental benefits in our discussions and in what we write. They're important in themselves, but also they are a major political issue right now, right, because we have VMA and insurers saying if you cut your payments to us you're going to be hurting the most vulnerable beneficiaries who really value our supplemental benefits. And as has been pointed out, these are about $2,500 per beneficiary, per year.

You know, in this chapter we say, on page 15, the rebates Medicare pays to MA plans are largely financed by additional program spending and not by savings derived from plan efficiencies. And then in the report, in March, to Congress that we published, higher MA spending increases Part B, as has been pointed out by a couple of Commissioners today. Higher MA spending increases Part B premiums for all beneficiaries, including those in fee-for-service who don't have access to the supplemental benefits offered by MA plans. Recent estimates that these premiums

will be about $13 billion higher in 2024 because of higher MA spending.

So I think it would be possible to make some reasonable calculations about how much the average taxpayer and how much the average traditional Medicare beneficiary, or any traditional Medicare beneficiary, are paying per year to subsidize these additional benefits. So I'd like to see what I, as the traditional Medicare beneficiary, how much am I paying to get to that $2,500 a year for all MA supplemental benefits. So how much am I paying as a taxpayer, and how much am I paying as a traditional Medicare beneficiary.

I think with the information you have you could make those calculations pretty easily, and it would be interesting to see them, and worthwhile, I think.

DR. MILLER: I have one -- can I comment on this point?

MS. KELLEY: Betty and Brian both have something. Why don't you go ahead, Betty.

DR. RAMBUR: It's very brief. I couldn't help but comment on this. I agree with the medicalization of normal human phenomena like birth and death. That is a

real problem. I have a bit of a different view on this now that we know about upstream social drivers of health. And so in a fee-for-service system we're just reactive and we wait until the illness emerges.

And so to have a little bit different view on this, if it's just for marketing I have a concern. But if you're taking long-term accountability for the cost and outcomes, I think then you have to start thinking about some of the upstream drivers.

So I agree with some of what you've said, but have a different perspective on the other.

DR. CASALINO: Can I add a response to this, Mike?

DR. CHERNEW: [Inaudible.]

DR. CASALINO: Yeah, two sentences. I see what you're saying, Betty, but we do know that we spend a lot more on medical care than any other country, and they spend a lot more on social services, other countries. And it might be better to provide these benefits that way rather than medicalizing them.

DR. CHERNEW: So we are in a Round 3 discussion in the middle of Round 2. So Brian, you go quickly, and

then we're going to get back to Round 2. We can go a little bit long, but understand we're not --

DR. MILLER: It's a brief on-point comment. The $13 billion, it's not that the fee-for-service spendings are financing MA because the fee-for-service benes are also getting an any-willing-provider network with 97 percent of physicians and almost no utilization controls. So there is a tradeoff between that and the MA beneficiary who is getting Medigap, Part D, et cetera.

So it's not that Part B, the fee-for-service benes, are paying for MA. It's that there is a tradeoff. So if we wanted to make that comparison, we'd need to value the value of the any-willing-provider network versus the narrower network of MA, plus the utilization review component. So it's not just that Part B pays for the MA, and MA gets all the stuff and fee-for-service doesn't get anything. Like fee-for-service is getting a lot, like any-willing-provider network and no utilization review.

DR. CHERNEW: We are now going to move back through Round 2, where right now I appreciate the interest in philosophy. We are just trying to document what it is that the plans are offering. So since we're basically near

the end of our schedule time, and we will go late, let's move on.

I think the next person in the queue, if I have this right, is probably Amol.

DR. NAVATHE: Pamina and Stuart, thanks. Obviously, as we've heard from our fellow Commissioners here, that it's a super important topic. The expansion of benefits that we've seen over time is really impressive, obviously enabled by Congress over time.

I think within the categories, I think also the innovation is impressive, and I think from a principles perspective I do think that continuing to push on the kind of dual principles of value and transparency, given that this is a federal program, is really important for us as a Commission. And I think, by and large, it seems that Commissioners are aligned on at least those two principles.

What's striking to me is that it's obviously very complicated. You know, there are the points that some of the Commissioners have made around checkboxes and actual benefit variation, which is, I think, fundamentally important. There is the question of network level variation and whether there are providers within the

networks that actually accept those benefits. There is the question of choice, and that, I think, plays out in a number of different dimensions.

So for example, we are laser focused, I think, from a data perspective, very appropriately, but we are laser focused on this question of can we really measure use. But one of the things that I think is important, if we think about this in any sort of insurance-like construct -- we tend to buy insurance for things. Oftentimes we buy insurance for things that we're really hoping that we don't have to use. And so I think we should just be mindful about use in that context, of kind of will I end up needing it, or will I not end up needing it.

There is also some signaling value as well as competition. So what do I mean by that? To the extent that the supplemental benefits here are financed in generous enough of a way that we have pretty much homogeneity in terms of the reduced premium part of this, whether it's Part B premium reductions, zero on the Part C, and zero on the Part D, then where are we going to end up having choice variation and potential competition? We're going to have it on these extra benefits. And even within

those extra benefits I think we're starting to see that there are some of them that get checkboxed out, and then there are other ones.

So I think it's a wonderfully -- not wonderfully, depending on your vantage point -- complex landscape, and I think it's hard to pick one thing and say, you know, if we fix this it's going to fix the problem overall. I think there are a lot of challenges, a lot of heterogeneity.

Another piece I wanted to ask in a sense is there's also a lot of plan-level variation. We have done some work on this previously in reports that we submitted to Congress I think in June of this year. I think it would be incumbent upon us to continue exploring the plan-level variation that exists across these different dimensions. I know some of that work, just networks and such, is planned, but I strongly support us continuing to push down that path, as well as kind of thinking about the transparency piece of this.

I think it is notable -- one of the reasons that my sort of series of Round 1 questions really focused on the bidding part of this, is to try to get this transparency part. And if we can really understand what

are the assumptions that are baked into what we're actually seeing in terms of bids and pricing and costing and such.

So it would be, of course, very interesting to see what we get in terms of new data, the new encounter data from the use perspective, and potentially form an opinion, as a Commission if we can, around what are the types of additional granularity across data, for example, or granularity of big data, that would really help us better understand as things like encounter data hopefully get better over time.

So that's kind of my macro point here. It is striking to me; I think some of the comments that have been made by Brian and others. It is true that in MA there are richer benefits, in general, that has attracted an on-average sicker population, on-average lower income population. That's really important for us to understand. At the same time, I don't think anybody here thinks that it means that we would want to fund things without a sense of transparency and value, and I think that's really fundamentally important.

Thank you so much for this work. I think it's really, really helpful, and a really solid step for us in

the right direction.

MS. KELLEY: Lynn.

MS. BARR: Thank you. A lot of great comments here.

You know, it is disturbing to me that half the Medicare beneficiaries in MA plans, or 46 percent, are in HMOs, when only 13 percent of the rest of the country is in HMOs. How did that happen? All right. It's happening because we're giving them $2,500 of these extra benefits, which is above and beyond our fee-for-service cost. And so why aren't we taking those benefits and spreading them across the entire Medicare population? Why that much? Why shouldn't there be a limit?

I mean, we can afford to pay the Part D premiums for all patients by taking a small amount away from them. I'm not saying take away Part D premiums from MA, but how can we, in good conscience, not give that to fee-for-service patients? How can we give extra money to these other people to control the choices and limit the opportunities for their patients? How can we drive these patients into these plans with money and then deny fee-for-service patients the same rights?

I think this has become, because it has become so large and so powerful, we have to rethink this. There are lots of ways we can do this. And in your research, it would be interesting to know what's the number one driver of them picking those plans. Because what I hear is it's the drugs. It's the drug premium. Nothing else really mattered. It isn't the dental. It isn't this. It isn't that, that we're paying all this ridiculous amounts of money for.

And if we cut off all those other benefits, we could get everybody free drugs in this country. I mean, with all the copays, et cetera, so nothing is free, but it would be equitable. And this is not equitable. Thank you.

MS. KELLEY: Greg.

MR. POULSEN: Okay. Well, this has turned out to be exciting. Let me start off by saying I love HMOs. I do. I love their potential. I love Medicare Advantage. I love its potential. I love managed care broadly. So, okay, have I made my point?

I think that the key, though, is what I love about those things is the concept of proactive care, the idea of being able to take care of people more effectively,

keep them healthier, and deliver a better value for what they're getting. That's different than what we're talking about right now, unfortunately, I think.

And I think that the most important sentence in the whole report was on the very first page. "MA rebates were originally envisioned as a form of shared savings that would allow MA enrollees, plans, and Medicare program to benefit from savings generated by plan efficiencies."

If we could get back to that concept, I think all the rest of this discussion would be way different. I think we would find something that we would collectively -- some people might say, "I'm willing to trade choice for that." And other people would say, "I'll take that in a heartbeat over choice."

But that would be the discussion we're having, whereas right now what we're discussing is should we be paying more money for these benefits, not money saved from other things, but more money taken from taxpayer dollars for these services. And I think that's a very, very different discussion.

I'd remind us that managed care has really been part of Medicare since 1965, and it was formalized in the

1973 HMO Act. And I would argue that the sentence I just read was largely intact until about 2008 or 2010. And if we look at the data and looked at how much we pay per beneficiary, it was pretty close, and there were benefits to being part of those programs that were not based on additional public spending. They were based on additional program efficiencies, and that was a very different world.

So I would love to see us get to where we are reengaged with the approach -- and there are still organizations out there that I believe are demonstrating the ability to proactively help people to live healthier lives, at lower cost. And if that could become the norm, rather than we pay extra -- and I don't want to become quite as controversial as I would be, by saying how I believe we now pay more for MA than we do for others, because we don't do it to all the programs. The data we've looked at suggests that about half of the programs are actually costing us less per beneficiary than traditional Medicare. That's not half the beneficiaries but it's half the MA programs.

If we could reward programs that are achieving that, then I think we'd be in some place where we'd have a

very different MA discussions, and we'd value it very, very differently, and we'd be able to provide enhanced benefits, not at the expense of the taxpayer but through efficiencies.

So that's where I'd leave that one.

MS. KELLEY: Kenny.

MR. KAN: I will try to say my comments in half the time that Stacie did.

DR. DUSETZINA: Right. On the same report?

MR. KAN: I believe that future now -- a great, complicated topic, great discussion -- I believe that future policy analysis of MA and fee-for-service must be holistic. And what does this mean? So in addition to like what Brian said, to analyze program spending, an analysis must consider basically component-by-component costs, and the cost to both taxpayers and beneficiaries, for the construction of a holistic health benefit package in both fee-for-service and MA programs. This could include analysis of taxpayer-beneficiary costs and induce demand, as MA plans buy down Part A and B, beneficiary cost sharing, which is a much greater induced demand from fee-for-service beneficiaries with Medigap, since three-

quarters of all beneficiaries of Medigap are without any cost sharing.

So let us be mindful that, to Greg's point, we should be methodical, we should be proactive in constructing a similar holistic analysis such that we can benefit the nation, given that millions and millions of poor, elderly beneficiaries are impacted. Thank you.

MS. KELLEY: Robert.

UNIDENTIFIED VOICE: Make it good, Robert.

DR. CHERRY: Last word. Yeah, no pressure.

[Laughter.]

DR. CHERRY: Well, it is a fascinating discussion. I think Greg should have had the last word, actually.

But, you know, at the end of the day I think what we're really concerned about is that there are companies using these rebates to generate a margin by growing more membership by offering these supplemental benefits, which then increases the margin and lines the pockets of the different health plans. That's not a good model.

At the end of the day, we do need to perform the analysis to understand what benefits may actually be

necessary for certain patient populations within MA. So I wouldn't necessarily say that a transportation benefit has no value. It may, in fact, have a value to the patient that has a physical disability, or acupuncture may be necessary for the individual that is at end of life with terminal cancer. You know, so there could be benefits to some of these services, but it's not a bottomless pit either.

So we need to understand what drives the care and how we can better utilize these benefits for the members' benefits. Thank you.

DR. CHERNEW: I think that was the end of Round 2, so since we're a bit over time I'm going to try and say something only three times as long as Kenny.

So this has been a great discussion. I think there are a lot of differences of opinion, and I think a lot of passion here, and I think for a session that was meant to provide some basic information about what's going on we ended up having a philosophical discussion about how the entire Medicare program is run. So that's probably good.

I will say there are different threads that come

out of this discussion. One of them is the issue of complexity of offering, so people know what they're getting, what does it mean about choice, and just sort of that basic, oh my God, there's a lot of stuff going on here. And I think that matters, and we have been very worried about choice and how that plays out, and I think you know that.

And that relates to how we communicate what you get, in a whole bunch of ways, and I think, to Stacie's point, there are probably some low-hanging fruit things that could be done to help some of that. And I think we need to think about that.

Then there's the second sort of thread, which is how we measure what we're getting for what we're spending, and then how we understand the value of that. I will add, because it didn't come up, what's the cost of trying to measure all the nuances, particularly when you get the value. It's very hard to understand all the distinctions of the complexity of these benefits, and even you got them how you would communicate them, given their vast array of things. We have to continue focusing on that.

But I will point out, simply, low use of a

benefit is not the same as low value, and high use of the benefit is not the same as high value. So we need to begin to think through that broadly, holistically, about what it is that we want.

And then the third thread, and I will emphasize this was probably better for another conversation, is how much benefit do we want to finance through the MA program and/or the fee-for-service program, and how we want to finance any of that. That last point, which came up a lot towards the end of this discussion, is a really big and broader question. And I don't think that the answer to that question is easy and transparent because it involves a number of things that transcend the question of how much of the rebate is going to dental, hearing, or buying down cost sharing.

So I guess what I will say, to those at home, undoubtedly you are just dying to send us messages, so I hope that meetingcomments@medpac.gov is just lit up with your thoughts. But please really do let us know your thinking on this.

And to the rest, we are going to continue to have this discussion on MA and all of these facets as we move

through the course of the cycle. And it will continue tomorrow, where we have a session on home health and Medicare Advantage. But all of those things matter.

But for now, I think I'll thank all of you for a very thoughtful and passionate discussion. And we are going to be adjourned until tomorrow morning. I think we are starting tomorrow morning -- someone is going to tell me before I get to my page -- at 9:00 we're starting tomorrow morning. And until then, everybody, be safe and come join us to talk about some home health topics, including Medicare Advantage.

Paul doesn't want to add anything, which means we're done. Thank you all, and particularly Pamina and Stuart.

[Whereupon, at 4:44 p.m., the meeting was recessed to reconvene at 9:00 a.m. on Friday, October 11, 2024.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 11, 2024
9:03 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
JOSHUA LIAO, MD, MSc
BRIAN MILLER, MD, MBA, MPH
GREGORY POULSON, MBA
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AGENDA PAGE

P R O C E E D I N G S

[9:03 a.m.]

DR. CHERNEW: Hello, everybody. Welcome back to our Friday morning MedPAC meeting. We have two sessions today, both of them related to home health. The first one is a discussion of our work plan for what will be a mandated report that we're going to do on the recent changes to the prospective payment system in home health.

So Evan is going to take us through that. Evan, take it away.

MR. CHRISTMAN: Thank you.

Good morning. Next, we will look at the work plan for a mandated report about the home health payment system that is due in March 2026.

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.

And before I proceed, I'd like to thank my colleagues, Betty Fout and Karen Stockley, for their contributions to this work.

Today's presentation will have five parts. First, I will provide a brief overview of home health

utilization. Second, I will explain the policy changes the mandate requires us to study. Then I will explain the mandate from Congress for the Commission to assess changes to the payment system. Next, I will review our prior work examining these policies, and finally, I will provide a preliminary framework for the analysis for the forthcoming mandated report.

As a reminder, here is a brief overview of home health care and Medicare fee-for-service.

In 2022, there were about 11,300 agencies participating in Medicare. Those agencies served 2.8 million fee-for-service beneficiaries and delivered 8.6 million 30-day periods of home health care.

Total fee-for-service payments in 2022 were $16.1 billion for home health care.

First, let's review the policy changes required by the BBA, which you can see summarized on this slide. As you can see, prior to 2020, Medicare paid for home health care in 60-day episodes. The BBA required that Medicare switch to the shorter 30-day period. Also, the BBA required that the home health PPS no longer use the number of therapy visits provided during home health care as a

payment factor.

The changes in BBA 2018 reflected policy concerns raised by the Commission and others in preceding years. One major issue was the use of therapy visits provided during the 60-day episode as a payment factor. Since its inception in 2000, the home health PPS had payment adjusters that increased payment when additional therapy visits were provided.

In our March 2011 report to Congress, we found that home health agencies adjusted the number of therapy visits they provided to increase their payments and financial performance. We also found that agencies that provided more of the episodes qualifying for higher payments based on therapy were more profitable, indicating that patients needing these services may have been favored more than other types of patients.

For these reasons, the Commission recommended the elimination of therapy from the home health case mix in 2011.

Separately, the Senate Finance Committee investigated therapy trends in home health and concluded that the inclusion of therapy was influencing how agencies

were providing these services, and the report also concluded that Medicare should move away from using therapy in the payment system.

In 2017, CMS proposed, but did not finalize, a new case mix system that had the two policies later mandated by the BBA.

Let's take a look at those policies, the BBA changes. In 2020, CMS implemented the BBA changes through a new system, referred to as the Patient-Driven Groupings Model, or PDGM. In PDGM, beneficiaries are assigned to a payment group under the Home Health PPS based on five dimensions of severity.

These include the timing of the current 30-day period relative to prior home health services, the source of the referral to home health care, 12 clinical groups based on primary diagnosis, the level of functional impairment, and clinical comorbidities. You can see the dimensions listed on this table, and there is more detail on them in your paper.

Now we turn to the mandate for the Commission. The language for the mandate is in your paper, but generally, the mandate requires us to assess changes in

payments, costs, quality, and any unintended consequences of the new 30-day unit of payment.

The BBA required two mandated reports, one we transmitted in March 2022, and the second, which we are discussing today, is due March 2026.

Today I will present an outline explaining how we plan to conduct the analysis for the 2026 report. We will take this feedback, conduct the analysis in the coming months, and in the fall 2025 Commission meeting cycle, we will present the results for your feedback and discussion.

As I mentioned earlier, the Commission provided a mandated report on the impact of PDGM and our March 2022 report to Congress. The report found that utilization of home health fell in 2020, but that several other factors, listed on the right, likely contributed to the decline.

The share of fee-for-service beneficiaries receiving home health care declined, as did the number of 30-day periods. However, most of the decline in volume was in April and May of 2020 at the onset of the pandemic, suggesting that it played an important role in the drop we observed in 2020.

For PDGM measures of severity, the mix of

patients within each of the timing, source of referral, and clinical groups of the PPS was the same in 2020 relative to the prior year, suggesting that patient severity did not change significantly.

Finally, we noted that assessing quality was challenging due to the disruption of the pandemic.

Our interim assessment also noted several factors that limited our analysis. First, this analysis relied on only one year of utilization data. Second, there were, of course, the disruption of the pandemic and workforce shortages; and finally, there were other factors affecting home health care in 2020, such as a trend of secular decline and utilization that predated PDGM and also other changes in fever service, such as lower enrollment as folks switched to MA and declining hospital discharges. These other factors limited our ability to conduct the analysis for the interim report.

Another change we noted was the average visits per 30-day period declined in 2020 relative to prior years. Comparing 2019 and 2020 on this slide, you can see that there was a 1.0-visit decline in the number of therapy visits in 2020, accounting for most of the decline in this

year. Note that since 2020, the number of therapy visits has not changed much.

In 2021 and 2022, the total number of visits continued to decline. You can see that on the top row. In this period, most of this decline was accounted for by nursing, which you can see on the third row.

This pattern, an initial decline in therapy in 2020 with a decline in nursing in 2021 and 2022, accounts for the majority of the changes in visits per 30-day period since PDGM was implemented. The mandated report for 2026 is an opportunity to better understand this pattern.

Before we turn to the plan for the 2026 report, it is also important to place PDGM in the context of the Commission's financial analysis.

While the changes required by BBA 2018 substantially altered the home health PPS, they were not designed to reduce Medicare's payments for home health care, which have substantially exceeded costs since the PPS was implemented in 2000.

Fee-for-service margins for home health agencies were high before and after the implementation of PDGM, exceeding 22 percent in 2022. We recommended a 7 percent

reduction to the base rate for 2025. At the December Commission meeting, staff will present updated fee-for-service Medicare margins for 2023.

Turning to the March 2026 mandated report, recall that our mandate requires us to assess cost, quality, and unintended consequences of the 30-day unit of payment. Because the new unit of payment was implemented at the same time as other changes, our analysis will include an examination of the new case-mix system, including the illumination of therapy.

We plan to do this using an interrupted time series model that uses pre-PDGM data from 2016 to 2019 to estimate a counterfactual of what would have occurred in 2020 to 2023 in the absence of PDGM. This approach is useful because it allows us to construct a baseline for comparison in the absence of a randomized control group, and it allows us to account for pre-2020 trends that may have affected outcomes in the PDGM era.

We plan to include control variables to account for non-PDGM factors that could affect outcomes, such as changes in fee-for-service enrollment, beneficiary characteristics, local market factors, and other factors

related to home health care use. The model will separately estimate annual effects for 2020 through 2023 to estimate the post-PDGM trend after accounting for all other factors.

We have identified several candidate outcome measures in three domains for our regressions. Note that these measures may be modified as we proceed with our analysis.

For the access to care and utilization domain, we are planning to assess three primary outcomes: how the probability of receiving home health care changed after PDGM, the number and mix of visits in a 30-day period, and the length of a home health stay.

For quality of care, we plan to assess four measures: within-stay potentially preventable hospitalizations, discharge to community, and changes in functional impairment for mobility and self-care. We also plan to assess changes in the payments and costs for home health stays.

In conducting this analysis, we plan to examine how outcomes have changed for specific beneficiary populations and other factors. These include such categories as race, ethnicity, and geography. We are still

working to identify subpopulations, but they could include such categories as community-admitted users of home health versus post-hospital users, beneficiaries with clinical functional characteristics that indicate a high need for home health, dual-eligible beneficiaries, beneficiaries with characteristics associated with high-therapy needs, and beneficiaries that were discharged from the hospital with a home health referral but did not receive it.

We may also examine how changes in outcomes were related to selected home health agency characteristics, such as size, ownership, and the amount of therapy services provided prior to 2020.

The approach I have outlined seeks to make the best of the available data, but it will have some limitations. First, as I mentioned earlier, PDGM was implemented for all beneficiaries in 2020, and so we cannot rely on randomization in forming a control group, and we will have to rely on statistical controls.

As I noted earlier, many factors can affect home health utilization. Our models will include controls where we can identify them, but they may not adequately account for these factors. And, of course, there may be unmeasured

factors that we have not accounted for that could affect our results.

We will have to consider these limitations when presenting results and making conclusions about the impact of PDGM.

This completes my presentation. Please let me know if you have any questions or comments. We plan to present our analysis in the fall of 2025 and transmit our findings to Congress in March 2026. Thank you.

DR. CHERNEW: Evan, thank you. I know this is going to be a challenge because of all the things that were going on, which just makes evaluations challenging, but we are going to, nevertheless, say something about it.

And so to let you all weigh in, we'll start with Round 1, and I think Tamara is first in Round 1.

DR. KONETZKA: Yeah, I had a quick question, Evan. First of all, thank you for this great work. I really value your expertise in these data.

On page 5, the definition of community admitted versus institutional for these late periods, I was just very confused by the text there. If somebody goes to the hospital, gets discharged to home health, has a 30-day

episode, and then has an additional episode, that's a late episode. But since the original one was a hospitalization, is that still considered a post-acute?

MR. CHRISTMAN: The answer is no. You have to think of each period as you look immediately before that period to determine what box it belongs in. So for the second 30-day period, they would look in the preceding two weeks before that second 30-day period, and since if there's no hospitalization there, it would be a community-admitted episode.

DR. KONETZKA: So to be considered post-acute care, even if, let's say, they went to the hospital for a stroke or joint replacement or something, they had a 30-day episode, they would have to have gone back to the hospital in order to consider that late episode another post-acute episode?

MR. CHRISTMAN: That's correct.

DR. KONETZKA: Okay.

MR. CHRISTMAN: The intention of that adjustment is that the research shows that post-hospital patients use more visits in a period. So what they're trying to capture is what immediately happened before the period that's being

billed for.

MS. KELLEY: Lynn.

MS. BARR: Hi, Evan. Great, great, great beginning. Looking forward to the data.

So, in rural America, of course, we struggle with a lot of people in rural say they can't get home health. The data says everybody gets home health. There's a lot of regional and geographic variations. There's some states that are under a demonstration plan because of their high home health utilization. Some cultures use it as -- you know, it's just incredibly varied culturally how it's rolled out and who gets it and who doesn't throughout the country.

We have, as far as I know, never really been able to get our arms around that as a Commission, and I'm just wondering, as you try to do this analysis, knowing that you have that noise in the data of just, like, not a consistent way that it's applied across the country, have you had any thoughts about how you might be able to address that in this analysis?

MR. CHRISTMAN: Every day and often.

[Laughter.]

MS. BARR: You can call me because I'm up thinking about it.

MR. CHRISTMAN: I would say that in structuring this analysis, we're going to definitely look -- we're going to endeavor to look at degrees of rurality and not just urban/rural, for example, and think about how to appropriately account for the geographic variation you're talking about.

I think we -- you know, we recognize that utilization varies across the country. You heard me say many times, part of our challenge in looking at rural at some of the lowest-using and highest-using areas.

MS. BARR: Right. And if we average them, we miss the data.

MR. CHRISTMAN: So I think trying to think about factors that are useful for differentiating among these areas will be something we're thinking about, and if I get what I want for Christmas, we'll hopefully be doing some of this work at the county level. We'll see. Other things have to cooperate.

MS. BARR: What do you want for Christmas?

[Laughter.]

MS. BARR: Just kidding.

MR. CHRISTMAN: But ensuring a reasonable set of controls so that we are able to make useful distinctions across the different geographies and different utilization levels without sanding off some of the very nuance we're trying to measure is something that we're talking about.

If there are specific ways of distinguishing among geographic areas or groups that you would think would be useful, we're definitely open to that. Responsibly capturing some of that variation and seeing how it's changed and maybe looking at factors that might affect it is definitely something we hope to get something of a window on.

There's many other thrusts to this work. So I'm not going to promise you a final answer, but I think we can get -- you know, if we can identify areas that have unique problems, that might suggest areas that the Commission might want to address through policy changes.

MS. BARR: Thank you very much. I'm excited to see it.

MS. KELLEY: Gina.

MS. UPCHURCH: Yeah, thanks so much, Evan, for

this work. I'll leave the analysis details up to other people, but just a couple quick questions. I just want to make sure.

When somebody receives home health, if you're the beneficiary, you don't -- so A is after acute care. So whether it's coming from a skilled nursing facility or a hospital and there's no call sharing, and if it's paid for by Part B, you've not come from an acute care and home health is covered. And there's also no cost sharing, whether you're in traditional Medicare or Medicare Advantage. Is that correct?

MR. CHRISTMAN: So I'm going to answer for fee-for-service Medicare, there is no cost sharing.

MS. UPCHURCH: right, right.

MR. CHRISTMAN: For Medicare Advantage, they may charge cost sharing, and I think the answer to that, of course, is sometimes. It varies.

MS. UPCHURCH: Okay. So we see that, like, when we're looking at co-pays, physical therapy, $20. So I just want people to keep that in mind, because I think that's important if we're diving into this a little bit, the cost sharing and what it means for the beneficiary to have to

keep paying for that. So that's first thing.

Second thing is -- and I'll plead ignorance here because I don't do it, but on table 4, at the bottom, there's a footnote about medication management, teaching, and assessment. Is that mainly about med reconciliation, or is it about disease state, like interventions?

MR. CHRISTMAN: It is intended to capture when home health services are being provided to help beneficiaries with managing chronic conditions, I guess, is the best way to put it.

MS. UPCHURCH: Okay.

MR. CHRISTMAN: I would say that in -- knock on -- I guess this table is wood. If you talk to home health agencies, medication reconciliation should be a part of every home health day.

MS. UPCHURCH: Absolutely.

MR. CHRISTMAN: And so I think what those categories were intended to -- think about is that there are some patients, and those are like the five musculoskeletal -- where it's clearly like they're in here for a primary clinical medical diagnosis.

MS. UPCHURCH: Right.

MR. CHRISTMAN: And then when it's sort of these other activities they wanted to capture that sometimes -- and Medicare covers this -- these people are in here for assistance with their chronic care activities or some temporary acute condition where the home health agency is providing those types of services.

MS. UPCHURCH: Okay.

MR. CHRISTMAN: It's for teaching and assistance and so forth.

MS. UPCHURCH: Okay. So who does that? Who does that?

MR. CHRISTMAN: It's a nurse. I mean, it's primarily through a nurse, but of course, as you guys probably appreciate better than I do, when it gets to medication and who can order it, who's ordering it, it's a team effort. They're talking to doctors and so forth.

MS. UPCHURCH: Okay. I didn't know if pharmacists were required or engaged in any way. Okay.

And do you know if this -- you can include transitional care or chronic care management codes when doing this, or is that -- you can't do that when you're actually the home health agency?

MR. CHRISTMAN: The home health agency provides -- I would say the transitional care codes you're talking about are for Part B providers, and so I think a physician or other advanced practitioner who's permitted to do so could bill for those services.

MS. UPCHURCH: At the same time, home health agency is supposed to be doing it?

MR. CHRISTMAN: Yeah, yeah.

MS. UPCHURCH: Wow. Okay.

And then the last one -- so, you know, everybody, I think, knows this, but there's a medication therapy management benefit that was supposed to be a part of Part D, but there's certain triggers for it, high-drug spend, lots of medicines, you know. So are these tied in any way? In other words, if I go into somebody's home, I'm a home health agency and Ms. Jones is a mess, like, there's polypharmacy, it's a mess, can that trigger -- is that in any way related to MTM and CPT codes with MTM or --

MR. CHRISTMAN: I'm not aware of any connection as the home health service itself as a trigger for what you speak of. I've not heard that.

These beneficiaries are often above average in

severity. So they may meet some of the other criteria, but I'm not aware of a tight linkage between what you speak of and home health.

MS. UPCHURCH: It seems like it would make sense that it would be, and I think a Medicare Advantage plan would really like that because they have incentive, obviously, to keep people out of the hospital and stuff.

Okay. Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Thank you for an excellent summary for which can be a complicated issue at times. I just have one question regarding one of the data elements that you're planning on capturing, and it has to do with beneficiaries that were referred to home health by a hospital but they didn't receive it. I see it's already giving you a headache.

Yeah, I was wondering, probably predictably, is the reason why they did not receive the service going to be captured, if at all possible? Because there are different reasons, as you know. It could be a patient refusal. Sometimes patients don't want home health inside their homes. Sometimes they're just no longer eligible because

they've just been clinically recovering. It could be a preauthorization issue, or maybe in some cases a home health agency just can't support the service.

So the reason between a preauthorization denial and a patient refusal are totally different, so it could be hard to interpret the results without understanding the rationale in terms of why they didn't receive it.

I'll kick that one over to you.

MR. CHRISTMAN: Right. So just to be clear, this study will be looking at fee-for-service, so for the most part there shouldn't be any preauthorization issues. I think you're exactly right. This population has always been present in the data. This isn't a new trend. And there is no direct data, at least generated by Medicare, that has looked at that population and asked them why they didn't get home health care.

I would say, qualitatively, when you speak with discharge planners or analysts who have gone out and talked to agencies and such, you hear two or three different things. Some are, however you wish to characterize it, refusers or don't want the service. Sometimes we hear about staffing issues. And sometimes it's a minority of

cases, but it's something that exists out there, is that the home health agency has concluded they don't meet standards for the benefit. You know, a hospital can refer someone to home health but obviously, from an administrative and payment perspective, the agency is at risk for making sure the beneficiary is covered. So if there's a disconnect there.

And honestly, the thing that is kind of a wrinkle on this data is that there's also -- and it's a smaller population, but there's also a population of people who get home health after discharge but weren't coded with it. So it just makes you wonder how tightly policed some of this data is. You know, hospitals are trying to code what they think is going to happen next, and this happens outside, off their facility. I believe they make every effort to be accurate in those things.

But I would say you're right, Robert. We'll have to see what we find when we look at the characteristics of that population. I guess there's been a concern that as the number of home health users has shrunk -- it's gone down from like 9 percent of fee-for-service to 8 percent of fee-for-service -- about who is being squeezed out, if that

is, in fact, happening.

So when I looked around at what was in the literature that was one population that presented itself, of maybe these folks, you could look at them. So that's something we're thinking about.

DR. CHERRY: Thank you. Great insights.

MS. KELLEY: Larry.

DR. CASALINO: Evan, thanks. I really appreciate your deep knowledge of the subject, which is just kind of routine for MedPAC staff but still very impressive.

Two quick questions. One is it looks like there are -- and you would think, I would think, looking at this without detailed knowledge, that there's an incentive in the payment system to up-code clinical diagnoses, right, at least those if not other things, but in a crude sense analogous to MA, for example. But it doesn't look, if I understood what you presented, it doesn't really look like that's going on. So that's my first question. Any comment on that?

MR. CHRISTMAN: So I think that was something we were definitely watching for, and for the clinical, it can be assigned to 1 of 12 clinical groups, and what clinical

group you are in didn't shift very much across the years. And I think when I've spoken with folks about this, one thing that folks have identified is that as CMS launched PDGM, there's also been an effort to be more strict about the physician's order and what it indicates about the need for home health, so what will identify the clinical diagnosis. And the clinical diagnosis and the physician's order are supposed to match what is on the claim.

So to the extent that this has happened, it could be one that diagnoses just don't shift that much over the year, but there's also this other issue of agencies will talk about the difficulty of ensuring they get adequate documentation. So I think that maybe having the physician make that indication has curbed some of the things you might normally expect.

DR. CASALINO: Interesting. It's particularly interesting because physicians probably don't pay a whole lot of attention to what diagnosis they're putting down.

The second question is going back to Lynn's question about rural areas. One way to approach it, of course, as you know, is statistical controls like you were talking about, but that can also obscure things, as you

also said. So kind of analogous to what we've recommended for programs that want to measure outcomes by socioeconomic status rather than controlling for SES, stratifying based on SES, and looking at the different strata, does that make sense in this case for rurality?

MR. CHRISTMAN: We can think about that approach. We'll definitely be looking at some descriptive stratifying things and thinking about what that tells us about the difference across areas.

MS. KELLEY: Paul.

DR. CASALE: Thanks, Evan. Great work. I had the same home health referral question that Robert had, so thanks for that answer.

The other question was I noticed one of the outcome measures was potentially preventable hospitalizations. And I may not just be aware of the literature around that because in my experience that has more to do with the primary care team and the care coordination within the primary care team. I mean, home health, obviously, theoretically, can identify an issue, but sometimes there are challenges to communicate back, et cetera. So I'm just curious about that as an outcome

measure.

MR. CHRISTMAN: Yeah. I can definitely read up on that measure and give you a better answer than the one I'm going to give you now, but that is a measure that CMS developed, and it's sort of gone through the NQF process and things to that effect. And I believe the intent was to identify measures that a home health agency that is seeing a patient two to three times a week or more should be able to prevent, on average, for a patient. And I do think that in that work, though it's not measured directly, I think there is some assumption that for some patients they have other sources of care that they're using. But your point is taken, that it's part of a larger care system.

MS. KELLEY: Betty.

DR. RAMBUR: I just wanted to plus-one on Larry's point but also ask, is it possible to also look by population density, or is that just too much of a lift? You don't have to answer now. I think about frontier areas. They are going to have a very different dynamic. But wealthy frontier areas might look very different than other ones. So if that's possible, I think population density would be helpful.

MS. KELLEY: Okay. I think we're ready for Round 2, Mike.

DR. CHERNEW: Yeah. I'm going to say one thing just to kick us off. I think we have about five or six people in the queue.

So this is obviously going to be a challenging thing to do with the data because of all the things that was going on. I think that's one of the themes of what Evan said, in case that was missed. I appreciate all the various comments that came in Round 1 about stuff we could do.

I will say sort of two things. One is the staff -- and you could tell from Evan's answers -- spent a lot of time talking to folks. So while a lot of this discussion has been quantitative, there is going to be some qualitative just understanding of what's going on, and we're very interested in what the industry and others have to say.

The second thing is the presentation -- and I think, in general, our charge is to do an evaluation. We will do an evaluation, and that's fine. The evaluation typically tries to answer the question, what was the impact

of X, which is fine.

One of the things I think we're going to be particularly interested in, which is slightly different, is was the impact of X really bad, or was bad in a way that we can figure it out. So we might not be able to precisely, it should be, given all that was going on, what this actually did, but I do think it's particularly important to understand if we thought there was something bad happening now, with all the stuff that was going on, could we uncover that through this process. And that's a little bit different than sort of a straight, it did X, because again, as Evan said in the presentation very clearly, there's a lot going on. And we are going to be limited. I appreciate all the subgroup analyses, but we're going to be limited a little bit in the main analysis.

Anyway, that was my prefix, or whatever, to Round 2. And now we will do Round 2, and I think Stacie is number one in Round 2.

DR. DUSETZINA: Great. Thank you. As others have said, this is really excellent work, and I also note the struggle of trying to do an analysis that crosses 2020, or trying to figure anything out.

My comments are really about thinking about that analysis and the interrupted time series. And I realized when I was looking back through my notes, I wrote like three different times, "I would exclude 2020." "I would exclude 2020." "I would exclude 2020." So I would exclude 2020, is what I've come up with.

You know, I think you could use it as a transition year and not an analysis and not have its direct effects. And maybe it's like a tailored March 2020 through March 2021, or something like that, that gets a little bit at when we were really resistant to have people come into our homes. So that's one thing.

And along the kind of COVID and what was going on for people, even being willing to have somebody come into their space, trying to think through could you use some of the geographic variations. I appreciate what Lynn said, because I wasn't even aware of all those other things going on, geographically. But from the COVID perspective there were some areas that were much more clamped down and others that were less. So maybe even just controlling for some level of geography would be really important, for COVID, let alone all the other reasons brought up.

And then the last thing I was trying to think through is are there any conditions where you could look at that particular set of conditions where you think that home health services would need to keep carrying on without as much disruptions. But I worry about something that's respiratory related, where maybe there's even more resistance to having someone come into your space. So again, just trying to get at some of the COVID effects pulled out of your analysis.

I think it's a great plan, and we're all struggling with these same things. Thank you very much. I'm looking forward to seeing the analysis.

MS. KELLEY: Tamara.

DR. KONETZKA: Yeah. These comments follow on nicely from Stacie's, because a lot of them are about the design, as well. But first I'll say in your preliminary results from 2020, it's not surprising that the number of visits declined. We've seen that in every sector. If you stop paying on that, you're going to see the number of visits decline.

It's also not surprising that you didn't see huge changes, given that the payment rates have stayed pretty

high. So I guess my prior would be you're not going to actually find much here.

But about the design, I think the interrupted time series is a completely reasonable approach, given the limitations of having no comparison group. I think there were a couple of things that you could do around the edges. I agree with Stacie that just dropping 2020 might be the solution.

Also, if you do find differences in the probability of use, pre and post, you could do some matching and just try to look at a similar cohort pre and post through matching on who is in the cohort pre, just to sort of get rid of some of that unobserved heterogeneity.

I'm also, despite what Mike said, very interested in some stratifications. You may or may not have the power to do this in the end, so I want to talk through a couple of them. One, actually for kind of different reasons than Stacie mentioned, I think looking at some subgroups of conditions would be really interesting. And I don't know what these are clinically, but if you look specifically at clinical conditions for which the number of visits might really matter, that seems to be the margin on which we see

change. So if you can identify those conditions, maybe the clinicians can help with that. It would be good to look by condition.

I also think by condition -- and this sort of goes along with the post-acute care versus the community admitted, which I'm always really interested in, because I think those are really different kinds of services sometimes. You know, the person who just needs help after a hip replacement versus the sort of older adult who is suffering from dementia and frailty and sort of gets community-admitted home health to get a little bit stronger and prevent some falls. Those, to me, seem like very different kinds of home health, so I'd love to see some stratifications on that.

And then some of the other ones you mentioned, like dual status, I think is important to look at, because they may be getting other kinds of services from Medicaid that will sort of interact with what they're getting through home health.

So I think the stratifications, if you have the power to do it, could really help give some insights into your overall results.

And then, finally, if you can think of any good ones, given the limitations of these interrupted time series designs, I mean, the validity is going to be very dependent on the functional form you pick to estimate that trend. We can't do anything about that except try to test it. But you might think about some falsification tests. If you can think of services that really shouldn't be affected by home health and see if you plug that into the same model, whether you get sort of spurious changes in these other kinds of conditions.

So those are my suggestions. I'm looking forward to seeing the model and the results.

MS. KELLEY: Lynn.

MS. BARR: Thank you. I'll be brief. So the hypothesis that is out there, or the myth in rural, has been for a long time that home health agencies disproportionately deny their patients because they're more expensive, so they're less profitable because they have to spend all this time driving, and they're not really covered for that.

So if you are going to county-level analysis -- and, of course, like you say, you look at the big picture

and it's all a mess because we've got fraud and all kinds of things in there and we can't really tease it out. But if you do manage to look at county data, and you are looking at Rx for home health and not received, this would probably be the best indication, if you could stratify by county the rurality of the patients in those counties. Because, we have some very big counties that have San Bernardino and Bishop in them. So county, by itself, isn't quite enough.

And maybe we can either put this thing to rest, once and for all, or go, yeah, it's happening in these counties, and this is an agency issue in these counties, but people are really upset about it in those counties and they're talking a lot about it.

I'd love to put this one to rest, because we struggle, as policymakers, in rural. Thank you.

MS. KELLEY: Robert.

DR. CHERRY: Yeah, thank you. This study is going to have a number of limitations, as you know, so we don't envy the work. There will be times where you'll have to be a bit creative at getting towards some of the answers.

One thing I was thinking about, just as a suggestion, along the lines of stratification, is the whole concept that there's 11,300 home health agencies out there. It's a lot. And they range from publicly traded to really small mom-and-pop agencies, so there's quite a spectrum out there. You know, the top five home health agencies actually control about 20 percent of the market share across the country.

So you may want to consider separating out the largest home health agencies, some predetermined threshold, 80/20 rule, something like that, and see if there's actually differences between how the largest home health agencies are handling the new rule compared with the smaller ones. You might be able to look at, indirectly, some answers there, including our prior conversation about why are some patients not getting home health. So I would imagine that the larger agencies would be able to accommodate large geographic areas, where smaller ones may not. Of course, that's not the entire answer. But thinking at least indirectly provide some answers around some really difficult issues here. So that's just one suggestion.

Thank you. I'm looking forward to seeing the results later.

MS. KELLEY: Brian.

DR. MILLER: Thank you for this work. A couple of things to add and a question.

Home health plays an important role in Medicare beneficiaries' lives. There are lots of enterprises that are doing a great job at this. Unfortunately, it's a space that is also rife with fraud, waste, and abuse, and has often been a subject of oversight and bad stories. I think that we should spend a little bit more time talking about that. I know that you have a colleague who previously spent 20 years at CMS and the Department of Justice, who is an excellent resource for some of that history. So we should talk about that, because that's a pretty big concern in this space.

And part of the reason that that happens is the high margins in this space. I'm agnostic as to what a right margin is for an industry, but I think we can all agree that 22 percent is a pretty high margin for a business with little capital infrastructure, mainly a labor component. And one of the things that we have seen in this

space is a lot of private equity investment and roll-up, resulting potentially in consolidation.

So I think that we should look at the consolidation angle in the home health business, in addition to the fraud, waste, and abuse angle, which it sounds like actually might not have necessarily been impacted by the change in payment models, given that the financial incentives still remain. So I think we should cover those topics.

And then my question is, are you concerned that growth of the home health space or expansion of the home health space could worsen the fraud, waste, and abuse consolidation incentives in this sector?

MR. CHRISTMAN: Let me -- I think I'm following two parts to your question, but I'm not sure I'm following the last part there. So let me just say two things and then ask if this is getting where you want.

First of all, making sure the results are not overly distorted by areas that we have concerns about the utilization is something I will be thinking about a lot. Sometimes it's really easy because the areas are well identified, and other times I think it just might be things

we do on the back end, where we throw out geographies and see if the results change very much. And we can identify outliers. We're not a fraud, waste, and abuse. And I take your point about Laurie's excellent background.

I have a timeline of all the fraud, waste, and abuse initiatives that happened in this era, and we're thinking about what we need to do to control for them. So definitely sensitive to that.

In terms of how the ownership, private equity or other consolidators coming into this space affects things, the two things I want to say about that is similar to geographic variation I am incredibly interested in this topic. But I would honestly say that the data that is available for us to analyze ownership changes is its own project. And that's not a knock against the folks collecting it and sharing it with us, but it's just, as you all can appreciate from your professional or personal lives, ownership is very complicated and comes in many different forms. So getting it to a point where you feel like you're consistently measure it is a separate project. Doing it across seven years for this project isn't going to happen. We might find a way to look at snapshots of it,

but I guess I would have to think about that. But I do recognize your point about whether the changing competition of the industry is affecting things.

DR. MILLER: Yeah, and if I may, so on the first one I'm saying I think we should include some of that background about the fraud, waste, and abuse, the prevalence of incidents, measures that CMS and the Center for Program Integrity have taken, along with the Department of Justice over the past couple of years. In particular, I'd say the last two to six years I think there's been a lot of work. I might be wrong on that exact timeline.

And then the consolidation angle, again, it could be private equity, it could be taxes on for-profit hospital, just random investors. Whatever it is, the consolidation then ends up decreasing the choice of home care services for beneficiaries.

And then my follow-on to that was do those factors then mean that growth in this space is potentially concerning?

MR. CHRISTMAN: I think -- that's a very hard question for me to answer, and it depends on the market, it depends on the level of demand. I think you can look at

some markets and you can see they have hundreds of agencies. And one wonders if they need that many. On the other hand, as Lynn and others will point out, you'll find geographies where folks are concerned that supply is not adequate for demand.

So for me, as an analyst, I try and look for factors that try and give us a better answer than that.

But the other question we run into, really some of the two primary challenges in measuring home health access is, one is that agencies vary so broadly in capability and capacity, and there's not a direct measure of that. And the second is -- well, it's related to the first -- is that unlike other sectors we can say that a hospital is at 80 percent capacity. They have so many beds, they turn over so many patients, that data gets reported. We don't have similar capacity measures for home health.

So, for example, a home health agency could be VNS Health in New York and serve hundreds of thousands of people a year, or they could be a very small agency in New York that serves 10, but they're in a geography nobody else goes to.

I guess that's why I'm sort of always looking for factors that help us capture these more granular things, and people have suggested them today, but definitely thinking about how to describe any sort of aberrant fraud, waste, and abuse type patterns and industry consolidation is something we can think about.

DR. MILLER: Thank you.

MS. KELLEY: Cheryl.

DR. DAMBERG: Thanks, Evan. This was an interesting chapter to read, and I appreciate the challenges with the proposed analyses. But I appreciate you laying it out in such great detail.

I'm very supportive of the set of measures you've identified and particularly looking at whether care is shifting between settings. I thought that was good.

I also support a number of the subgroup analyses that have been identified by others to the extent the data will allow. So I'm going to plus-one to Tamara on the clinical conditions, plus one-to Robert on the type of agency.

Also, I think we should be looking at geography, again, to the extent possible.

And then I thought Tamara's comment about matching was really good, so would be supportive of that.

And then I wasn't exactly sure what additional qualitative work you were doing, but I do think qualitative work could be helpful just to add some richness to the quantitative analyses about whether there have been any benefits associated with this change as well as some unintended effects.

MS. KELLEY: Amol?

DR. NAVATHE: Thanks, Evan, for this great work here. I think, first off, I just want to commend you for a very thoughtfully written set of reading materials here. I think it is a very challenging -- you know, we're obviously required to do this work and need to come up with the best approach possible. I think what you've selected is something that's intrinsically practical, given the kind of methodological challenges of the PDGM going in right -- essentially right coincident with the pandemic, so clear methodological challenges, and I think you've outlined it and clarified that very nicely.

I think, very generally speaking, I agree with a lot of the comments. I think one of the things that we

obviously need to be thoughtful about here is particularly in measuring the access piece. If we look at it in a very aggregate level, it might be harder to identify these effects. So I think some of the suggestions around just stratifying or picking particular conditions is going to be something that we should try to dive deep into, so we can detect any changes. To me, access seems like maybe the most important thing that we'll want to be looking for here.

The other thing that I was curious if we had plans to do is -- we being MedPAC here, the greater we -- has identified these differences in the assessment data between hospital discharge and intake for different post-acute settings. I was curious if that's something that we're also going to trend over time, or if that's something that we can at least take a look at over time as we look at the shift to the PDGM.

MR. CHRISTMAN: We can take a look at that. I think that's something we can run the descriptors and see if the population has changed at all pre-/post-PDGM. I think that's what you're describing, is that --

DR. NAVATHE: So, in particular, just how the

assessment data, the sort of differential in what happens, for example, at hospital discharge and the assessment versus intake at the post-acute setting.

MR. CHRISTMAN: So the hard part is that the most interesting stuff isn't assessed at hospital discharge or at least not in a way that it's shared with us. So, for example, the big one is the functional data, what a patient's level of function is, and to my knowledge, there is no standardized functional tool that we get data on for a patient's functional status at hospital discharge.

DR. NAVATHE: I see. Okay. So we can only look, in that case -- the point that you've made in the work plan, is that we can look at intake versus discharge from the home health, basically, or the --

MR. CHRISTMAN: Right.

DR. NAVATHE: --which is different than what I'm suggesting.

MR. CHRISTMAN: Yes.

DR. NAVATHE: Not saying that we shouldn't do that, but okay. That's helpful. Thank you so much.

MS. KELLEY: Josh.

DR. LIAO: Evan, thank you. I'll be very brief,

because I think just want to plus-one a couple of things, one about dropping 2020 subgroup analyses. I also agree with that, and maybe I'll plus-two here, the comment about matching, particularly pre/post, and looking for who matches and doesn't, to isolate new versus older users in the framework you have. So thank you.

MS. KELLEY: That is the end of the queue.

DR. CHERNEW: And that was a 15-second -- we're timing. That was a 15-second comment, just saying, 15 seconds. I spend more time remarking on the comment than the actual comment.

[Laughter.]

UNIDENTIFIED SPEAKER: Isn't it supposed to round down to zero?

DR. CHERNEW: Yeah, I know. We're just befuddled.

Anyway, sorry. I got flustered.

Evan, thank you very much. It is really useful to hear what you're planning, and I think the comments were actually quite useful, both methodologically and to acknowledge the challenges we face. So I think that will actually help us provide a more useful report. So, again,

thank you.

We're going to take now -- we'll come back at, like, 10:05, and we'll go from there. So we'll take a quick break, and then we'll be back.

And I think, Evan, you're going to stay there. You're supposed to stay there. You're going to be joined at least by Betty -- or Andy? Stuart?

[Recess.]

DR. CHERNEW: We're now going to continue our discussion of home health with an analysis of home health care use amongst Medicare Advantage beneficiaries, and this will be our last session of the morning and of the day.

And so who is starting? It looks like Betty. All right. Betty, take us away.

DR. FOUT: Thank you.

Good morning. In this session, we will present initial estimates of home health care use among MA enrollees.

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.

The presentation is organized as follows:

background and prior work, the Medicare home health data sources we use and our methods, estimates of home health care among MA enrollees, and then next steps in our discussion.

Medicare's home health benefit covers treatment for beneficiaries needing part-time or intermittent skilled care who cannot leave their home without considerable effort. Home health care may be used after acute inpatient hospitalization or skilled nursing facility stays or without a prior institutional stay.

In 2021, about 3 million fee-for-service Medicare beneficiaries received home health care, and the program spent $16.9 billion under the home health prospective payment system.

Less is known about Medicare Advantage enrollees using home health care, though nearly half, or 46 percent, of Medicare beneficiaries with Part A and B were enrolled in Medicare Advantage in 2021.

Commissioners have expressed interest in better understanding the home health care used by MA enrollees.

Home health care used by MA enrollees is likely to differ from fee-for-service beneficiaries for a variety

of reasons. MA plans must cover home health care but may use alternative payment models and care management techniques to manage service use and steer enrollees to preferred providers. MA plans might encourage use of home health care to substitute for more intensive and costly post-acute care services, but they may also more actively manage utilization. That is, overall home health care used between MA and fee-for-service can reasonably differ in either direction.

Our goal is to better understand the services used by MA enrollees, which can inform MA payment policy and generate new policy ideas that can be applied across the entire Medicare program.

Several recent studies have examined home health care utilization among MA enrollees with the goal of comparing use and outcomes to fee-for-service beneficiaries. However, these studies rely upon available data that have limitations for drawing nationally representative conclusions.

Some studies relied upon home health assessment data, which must be submitted by home health agencies for all Medicare patients. However, our assessment data does

not contain information on home health visits provided during the stay.

To address this, other studies used proprietary claims for a subset of MA enrollees using home health care, trading off national representativeness for completeness of information.

The findings across the studies were mixed. Most recent studies found lower rates of home health care use among MA enrollees than for fee-for-service, though not all studies adjusted for the different characteristics of MA and fee-for-service beneficiaries that could affect utilization. Findings were also mixed on intensity of care and outcomes between MA and fee-for-service beneficiaries using home health care.

None of the recent publications use MA encounter data to determine home health care utilization among MA enrollees, and some of the authors noted that complete and accurate encounter data would be the best vehicle for learning about the care provided to MA enrollees.

Since 2012, MA plans have been required to submit to Medicare a record of each encounter that MA enrollees have had with a health care provider. MedPAC regularly

assesses the completeness of this data by comparing them with external benchmarks.

As reported in our June 2024 report to the Congress, there have been improvements in home health encounter data submitted by MA plans, and combining this data with OASIS assessment data submitted by home health agencies provides a more complete view of nationwide use of home health care among MA enrollees than using either source alone.

In this presentation, we show the results from combining those data sources to examine overall home health care use rates and the count, length, and type of home health care visits received by MA enrollees.

We now turn to the data sources and methods used for our analysis.

We used the following Medicare data sources on home health care. Fee-for-service home health claims contains case-mix groups, diagnoses, and the dates, types, and number and length of visits for Medicare fee-for-service beneficiaries. These data are required for payment to home health agencies for fee-for-service beneficiaries receiving home health care.

MA home health encounter data has many of the same fields as fee-for-service claims and are required to be completed for MA enrollees receiving home health care.

OASIS assessment data contain clinical and functional information of patients completed by home health care clinicians and is required for all Medicare beneficiaries -- MA and fee-for-service -- receiving home health care.

Both home health encounter data and OASIS assessment data contain information needed for understanding aspects of home health care use. Therefore, we defined three analytic samples based on the MA enrollees' presence in each data source that can be used depending on the research question of interest.

The first analytic sample consists of MA enrollees who had either a home health encounter data record or OASIS assessment in the year. This is the most expansive group of beneficiaries and is used to estimate the overall share of MA enrollees using home health care.

The second analytic sample consists of MA enrollees who had home health encounter data records but may or may not have had a record in the OASIS data in the

year. This analytic sample is used for analyses related to visits since encounter data contain information on the number, type, and length of home health care visits.

The third analytic sample consists of MA enrollees who had a home health encounter record and an OASIS record in the year. Presence in both data sources yields the most information about the patient and the home health care received. This analytic sample is used in our sensitivity analyses described later in this presentation and will be used in future analysis such as assessing the relationship between the clinical and functional status of MA home health enrollees and the number and types of home health care visits they receive.

We construct analogous analytic samples for fee-for-service beneficiaries with home health claims records and OASIS records.

We found that about 2.2 million MA enrollees had a record in either the home health encounter data or the OASIS data in the year. These beneficiaries are used to estimate the overall share of MA enrollees using home health care.

MA enrollees who had home health encounter data

records but may or may not have had an OASIS assessment in the year composed 94.1 percent of MA enrollees with a record in either data source. This analytic sample is used for analyses related to visits received by MA enrollees. It excludes MA enrollees identified as using home health only through having OASIS records, which are 5.9 percent of MA enrollees with a record in either data source.

MA enrollees who had a home health encounter record and OASIS record in the year, which is our matched group, composed 86.8 percent of MA enrollees with a record in either data source.

Presence of both data sources yields the most information about the patient and the home health care received will be used in future analyses. This analytic sample excludes beneficiaries who only have a record in the MA encounter data or only have a record in the OASIS data, which together represent 13 percent of beneficiaries who had a record in either data source.

Nearly all fee-for-service beneficiaries have both claims and OASIS data. The bottom bar shows that 2.7 fee-for-service beneficiaries had either home health claims data or OASIS data, and of these beneficiaries, 98.4

percent had both fee-for-service claims and OASIS assessments during the year. The remaining 1.6 percent of fee-for-service beneficiaries were identified as using home health care only through OASIS. The share of claims-only beneficiaries was about zero percent.

A higher match rate among fee-for-service beneficiaries and a lower one among MA enrollees was not surprising given differences in the processes for submitting data to CMS, which is discussed further in your mailing materials.

Although the encounter-to-OASIS-data match rate of 87 percent among MA enrollees is high, the non-matched 13 percent is not trivially small.

We conducted some sensitivity checks to assess the representativeness of the various analytic samples and address the possibility that the imperfect match means that some home health care is occurring that we do not observe in either data source. If this were the case, we would underestimate the home health care use rate among MA enrollees.

We found that MA enrollees in the various analytic samples were similar on demographic and other

characteristics, as discussed further in your mailing materials. To assess the extent to which underreporting could be affecting the estimates of MA home health care use, we calculate results for subsets of geographic areas for which the match rate was higher. We identified counties with match rates of at least 85 percent, 90 percent, and 95 percent.

As shown on the slide, 77 percent of counties had a match rate of 85 percent or higher, and 41 percent of counties had a match rate of 95 percent or higher.

As another check, we also trimmed out counties for which home health use rates differ substantially between MA and fee-for-service beneficiaries. This was defined as counties for which the home health use rate differed by 5 percentage points in either direction, which was approximately the top and bottom 2 percentile. This excluded about 5 percent of counties.

The results shown in the next few slides include fee-for-service comparisons to provide context. We standardized fee-for-service comparisons by county-level MA enrollment share of national MA enrollment to better resemble the counties in which MA enrollees reside.

However, we understand that MA and fee-for-service beneficiaries differ in many other ways that can affect home health care utilization, and we caution against attributing any differences presented solely due to the payer source. Our results are unadjusted in that we do not yet account for any differences in beneficiary characteristics between MA and fee-for-service home health care users.

In future work, we plan to examine the specific characteristics of MA enrollees using home health care, such as their functional and clinical status and presence of prior hospitalizations. Adjusting for these characteristics will enable us to better understand differences between MA and fee-for-service beneficiaries receiving home health care.

We now present our initial estimates of home health care use among MA enrollees.

Unadjusted home health care use rates were calculated by dividing the number of beneficiaries with any home health records in either the encounter data or OASIS data for MA enrollees or either the claims data or OASIS data for fee-for-service beneficiaries by the total number

of Medicare Part A and B beneficiaries in MA and fee-for-service.

We estimated that 9.1 percent of MA enrollees used home health care in 2021. The geographically-standardized fee-for-service data showed that the fee-for-service home health care use rate was higher at 10.1 percent. However, MA home health use rates tended to be slightly higher among the counties with higher match rates and were closer to the analogous fee-for-service home health use rates. Among counties meeting the 95 percent match rate threshold, the MA home health use rate was 9.5 percent, slightly higher than the 9.2 percent among fee-for-service beneficiaries in the same counties.

Across all the alternative samples we examined, home health use rates were within 1 percentage point for the MA and fee-for-service populations.

To examine the number, length, and type of visits MA enrollees received from home health agencies, we used the second analytic sample containing MA enrollees within home health encounter data record.

We examined the receipt of the six types of home health care visits listed on the slide. So as not to

undercount visits for MA enrollees, we counted visits even if they were coded with non-Medicare codes more typically used in the commercial population. These codes were used for approximately 10 percent of visits. For both MA and fee-for-service beneficiaries, we did not include home health supplies or durable medical equipment, personal care visits not covered under the Medicare home health benefit or telehealth visits, which was not required to be recorded until July 2023. MA enrollees using home health care may also receive supplemental benefits that are not part of these analyses.

We include only beneficiaries with Part A and B for 12 months in our analyses for ease of presentation so that we can report visits per beneficiary for the year.

We recognize that many MA plans may vary in how comprehensively information on visits is reported in the encounter data. Encounter records are supposed to include certain fields that also exist in fee-for-service claims, but since MA organizations may pay home health agencies differently than in fee-for-service, the data may be less complete.

For example, although Revenue Center Code

instructions indicate that units represent 15-minute increments so that one visit may be composed of multiple units, it is possible that MA organizations that pay home health agencies for a package of visits may be more likely to input incorrect units.

On average, as shown in the first row of this table, MA enrollees using home health care received an estimated 20 home health visits per year. Each visit lasted 35 minutes, and the visits spanned three months of the year.

The bottom row shows that unadjusted for differences in characteristics, fee-for-service beneficiaries received, on average, 25.8 visits over the year, each lasting 47 minutes, and visits spanned 3.8 months of the year. As we noted, the differences in visits between MA and fee-for-service beneficiaries may reflect factors such as differences in beneficiaries' health conditions that are not accounted for in these numbers.

The results were almost exactly the same when we restricted the analysis to higher match rate counties or the outlier trimmed counties.

This figure shows the distribution of home health

visits by the discipline of the clinician providing the visit. Among MA enrollees, as shown in the top stacked bar, 42 percent of visits per beneficiary, on average, were for skilled nursing visits. Thirty-seven percent were physical therapy visits. Eleven percent were occupational therapy visits, and 6 percent were home health aide visits. There are very few speech language pathology and medical social service visits.

As shown in the bottom stacked bar, among fee-for-service beneficiaries using home health care, a greater share used skilled nursing services, 47 percent, and a smaller share used physical therapy, 35 percent, on average. The shares were similar for all the other disciplines.

As next steps, we plan to further explore MA enrollees' use of home health care with a matched analytic sample. This includes exploring beneficiary characteristics such as clinical and functional status, stay characteristics such as the presence of prior hospitalizations, provider characteristics such as ownership and the share of MA versus fee-for-service beneficiaries. These characteristics can be used to better

adjust fee-for-service comparisons.

We'll also continue informational interviews with home health agencies and MA plans. These discussions are useful for understanding how variation in home health payment mechanisms and availability of supplemental benefits may affect home health care use, as well as shed light on how plans and providers exchange data and how the process may affect the completeness of the data available in the MA encounter records.

In future work, we will explore incorporating the broader post-acute care landscape by including skilled nursing facilities and inpatient rehabilitation facilities.

For discussion, we'll answer any questions you have and take your feedback for future work in this area, and I turn it back to Mike.

DR. CHERNEW: Thank you.

This sort of brings two things we've been interested about together. It brings together home health and MA.

So I think we will now run through the queue, and the first person in the queue, I think, is going to be Robert.

Is that right, Dana?

[No response.]

DR. CHERRY: All right, yeah. Nice summary. Highly supportive of the work.

Just one small clarification. On next steps, you mentioned that one of the data elements that you plan on pulling is whether or not there was a prior hospitalization present, and I was wondering if you can clarify what that means as opposed to a referral from a hospital, because there's a difference in that. So are you looking for an association with a prior hospitalization, meaning 90 days before an initial visit, or are you actually talking about a referral or both?

DR. FOUT: I think we're going to start with whether there's a presence of a hospitalization, and usually 14 days we use, but it could be a different window, just using the encounter and claims data, viewing the beneficiary's use in the two weeks prior to the home health admission.

Certainly we can include taking a look at referrals, like once that indicated a home health discharge and whether or not that actually occurred too.

DR. CHERRY: In other words, you're using the 14 days as a marker that it was probably a referral from a hospital?

DR. FOUT: Right.

DR. CHERRY: Yeah, okay.

MS. KELLEY: Lynn.

MS. BARR: Thank you.

I'm really looking forward to the analysis, and it's going to be a great chapter.

My concern about this -- and you captured this a little bit -- is the impact of MA plans diverting patients from skilled nursing to home health, and if we look at -- so, anecdotally, I think we would all agree that that's happening a lot. And that a lot of this -- the parity in the usage between MA and fee-for-service, I think if this goes out as a report without first identifying how skilled nursing interplays with that, might be misleading.

I wonder if there's just one way of capturing that in this without doing the full analysis of skilled nursing to the same extent. I don't want to -- is there anything you can think about there? Because otherwise it's going to be like everybody's going to read the report and

go, "Oh, great, it's all the same." And I don't think that's what you're going to see when you look at skilled nursing.

MR. CHRISTMAN: So I think your point about how to characterize home health in MA when we're just looking at one MA, one service, is something we'll be thinking about a lot, and it will be a caution we'll probably offer when we share this data, and I think we plan to look at the SNF data. That's just a throughput issue.

But I think one thing that might implicate what you're talking about is if we see the rate of -- we can compare the rate of people coming from the hospital and going to home health in MA and fee-for-service, and if there is much more of this substitution like what you're finding, we would expect to find a higher rate of post-hospital care in MA. It may not be the only reason, thing that accounts for it.

But I think this is -- we're really just trying to learn how to use the encounter data, and this is the payment system we're looking at. But I think we plan to look at the other systems and recognize that there are kind of layers here.

There's also other challenges such as MA plans may be doing other things with people in the community. So they may be offering other types of interventions that are not classic home health, Medicare home health, but that might be affecting the amount of home health they receive. We wouldn't be able to see that.

So I think as we go down this path, where the Commission's going to have to think about how to contextualize looking at these things this way, when there's some parts of the utilization we can see quite clearly and others that we're still working on or may not be able to measure.

MS. BARR: I think it's a very good idea to be stratifying from source. I think that will tell the story quite clearly, and thank you.

MS. KELLEY: Tamara.

DR. KONETZKA: Thank you for a great chapter. I really enjoyed it. I especially appreciated all that detail in describing your data's construction and analysis, because I think it's really important to understand what goes into these cohorts.

A couple of quick questions about that. So if I

understood correctly, under fee-for-service, home health agencies submit both the claim and the OASIS assessment, right, and they have an incentive to do both in order to get paid. And under MA, the home health agency submits the OASIS, but the plan submits the encounter data, right.

Do they exert any pressure on each other to get those submitted? It's a very weird separation of the incentive. And so do the plans try to get them to submit the OASIS, or how does that work?

DR. FOUT: I don't think that the plan -- and the home health agencies submitting their fee-for-service assessments, I mean, them and their MA get together and they all send Medicaid assessments. I think they have a process that's been set for a long time to submit their OASIS assessments to CMS.

Then the plan needs to submit the home health encounter records to CMS. Whether that link between the home health agency, what data they submit to the plan to have that information on the encounter records to come to CMS, I think can differ by plan. And we've spoken to a few home health agencies about how that process works, and I think there's variation in how much data they provide or

the mechanism which they use, and it really depends somewhat on the information the plan needs to pay them. And we're hoping to still talk to a few more to better understand that process.

DR. KONETZKA: Okay. Thanks. Other question. So you were doing this on an annual basis, matching an encounter record any time during the year with an OASIS assessment any time in that same year, which seems very broad, right. Like what do you do if people have multiple assessments? Which OASIS assessment did you match to which home health claim in that sense? And in that same vein, how do you deal with people who switched between traditional Medicare and MA between those two episodes.

DR. FOUT: Yeah. These are all great questions. We started really broadly to try to understand the home health care use rates. To do that we weren't requiring claim or encounter date to match the OASIS. We just wanted to see who was using home health. And some of that linkage will need to be done for our spring work.

So yes, right now it's kind of a record in each. We did a little bit of cleaning to allow for assessments to be submitted like the month before or the month after the

year, because there are some timing issues there.

With switchers, I can give you more information on how we dealt with them. We used pretty much their enrollment on the date in which they received the home health care or had an OASIS assessment submitted, to identify who was the payer for that month. But surely throughout the year it could change. And for counts, some of our counts are like what happened on July of 2021, so we used kind of the one lump snapshot so the denominator and the numerator could be fair.

But yeah, there are lots of data decisions that need to be made.

MS. KELLEY: Scott.

DR. SARRAN: Great work, guys. Building off of Tamara's last comment, when we look at the completeness data, your Slide 16, for example, are we able to sort that by plan, by MA plan?

DR. FOUT: Yeah, we can do that.

DR. SARRAN: I think that would be worthwhile for us to look at. It may well be that "fill in the blank" large national plan is at 99 percent and "fill in the blank," another large national plan is at 88 percent or

something.

DR. FOUT: For sure, and we've looked at HMO versus PPO.

DR. SARRAN: Yeah, that too. Right.

And then building off of Lynn's comment, there are at least two things going on in the data in terms of MA plans' behaviors. One is that, as Lynn mentioned, there is a lot of push overall down from LTCH to SNF, SNF to home health. And so that can wind up pushing more volume into home health, because there's also a push down from home health to home without home health, discharged home without home health, that could create a diminution of volume.

So it would be interesting to try to get at that in a couple of ways, I think. One is a descriptive pie chart looking at the distribution of hospital discharges between fee-for-service and MA. Ideally -- and we try to be respectful about asking you to look at things that may take a lot of work -- but ideally sorted by some kind of measure of intensity or likelihood of needing post-discharge services or something, to try to get at the picture of, okay, here's how fee-for-service behaves in post-discharge referral decisions, here's how MA behaves.

Because what we're seeing here, again, is the result of a couple of different behaviors that impact that data. So I think that would be really helpful for us to get a bigger picture sense.

MS. KELLEY: Gina.

MS. UPCHURCH: So this truly comes from some experience in Medicare counseling with folks and helping people work through whether they're going with traditional Medicare or Medicare Advantage is network adequacy.

So two things in particular. Sometimes we see health systems carve out home care and infusion. So they'll say, "We'll accept these insurances, all but that." Any particular reason we would imagine that to be?

And the second one, related to network adequacy, is that we've had people say, getting at Lynn's point, yes, it says that they're in the network, but then they don't have anybody that will drive that far to see the person. And maybe when you do some interviews with people you can ask about that, like the network adequacy. Does it mean they really, maybe in these rural areas they couldn't get fee-for-service either. But is there a difference between Medicare Advantage and fee-for-service? So network

adequacy and carving out.

DR. JOHNSON: We do have a body of work we're starting on network adequacy, so we'll have a chance to take a look at that little bit more and just how many different providers are seen by MA enrollees in a county compared to fee-for-service. But we're at the early stages.

MS. UPCHURCH: That would be great. And then the other, just to follow up, some of the Medicare Advantage plans now have six hours of help in the home. I'm assuming that is not considered a home health benefit, and I always am shocked at how much people really want this, to help clean their house or something like that. I'm assuming that's not considered home health.

DR. FOUT: Right.[1]

MS. UPCHURCH: Okay. Thanks.

MS. KELLEY: Amol.

DR. NAVATHE: Thanks, team, for this great work.

[1] Note: Medicare beneficiaries can receive home health aide services in addition to skilled nursing or therapy services under Medicare's home health care benefit. Separate from the home health care benefit, some Medicare Advantage plans offer in-home support services (IHSS), as a supplemental benefit that provides personal care services at home to help beneficiaries with eating, dressing, cooking, and other household tasks.

So one question I had is on Slide 17 we had this 1.6 percent that are in OASIS but not in claims. And I was curious here, kind of in the context of Tamara's point, that they have an incentive to submit the right data to get paid. If they're not showing up in claims, how do we interpret what's happening there? These are not paid visits that are still showing up in OASIS, or is there something else going on that maybe I'm missing?

DR. FOUT: Right. They're not paid. I mean, literally we haven't dug into this 1.6 percent, who are they, because it's so few. But yes, the zero claims makes a lot of sense because they would not get paid without the claim.

DR. NAVATHE: Could it be like a missing bene ID issue?

DR. FOUT: It could be.

DR. NAVATHE: You flagged that somewhere in the reading material.

DR. FOUT: Yes.

DR. NAVATHE: Okay. So it might be like a data problem. Got it. Okay. That's helpful.

The second question I had is kind of similar to

what Scott was saying, to some extent. So when we're looking at these match records, do we have a sense yet if they're evenly distributed across different MA organizations and/or home health agencies, and by ownership, for example?

DR. FOUT: In the spring we're going to look more closely at home health agency level, linking to the home health agency with the encounter records. We have internally taken a look at MA organizations, and I can share any information with you. But we are able to look at those things.

DR. NAVATHE: Okay, great. Thank you so much.

MS. KELLEY: Greg.

MR. POULSEN: I had three really, really insightful and brilliant questions and Scott stole two of them. The third one, Amol also mentioned. But I really do think -- and the results that we're seeing here are very different than the results that I've seen looking at some of the provider-sponsored health plans, which seem to actually have higher home health use than traditional fee-for-service Medicare, in our experience.

So I wonder, you had mentioned we may be able to

look at it by type. I would love to be able to see it between commercial plans and provider-sponsored plans, because I think we might see something that is very different between those two. We may not, but if we did that would be really kind of an intriguing thing to look at. Thanks so much.

DR. JOHNSON: That is something we can do.

MS. KELLEY: That's all I have for Round 1, unless I've missed someone. So shall we go to Round 2, Mike?

MS. KELLEY: I have Scott first.

DR. SARRAN: Given that we know that MA plans behave differently than fee-for-service, at least fee-for-service outside of advance practice models, and given the importance of understanding the implications of that, because it could well be that MA plans are trimming out waste in fee-for-service, and that's all to the good. It could be that they're just trimming without any ability or willingness to discriminate waste from useful care, and we just don't know, but we'd all acknowledge that's a pretty critical question for them, about the policy perspective.

So I think one of the strong points would be to

compare the quality measures that we looked at in the previous presentation, potentially preventable hospitalizations, discharge to community, change in beneficiary mobility, change in beneficiary self-care, fee-for-service to Medicare, probably using only the subset of records where we have both the encounter and the OASIS data, so we know we've got what we need.

The other thing, ideally, and I don't know if we can get this, is there any way to look at the percent of denials, appeals, complaints, some ability to get at the feedback loop, albeit quite imperfect, does exist when beneficiaries and their families believe that they are not getting the care, whether it's the level of care or the length of time of care that they believe is appropriate.

DR. JOHNSON: We are at the early stages of trying to look into denials of care using the MA encounter data, so that is something we'll look into. But I think when it comes to appeals and complaints, sometimes we're limited to how many of the denials are actually appealed and complaints are followed through in some formal process where data is generated.

DR. SARRAN: Even a pie chart showing where the

appeals, where the denials occur in terms of post-acute versus inpatient, et cetera, et cetera, et cetera, might be informative.

MS. KELLEY: Tamara.

DR. KONETZKA: Okay. A few different comments. One, Table 2, where you compare the characteristics of the different analytic samples, I think for these purposes that's great that they look similar. But like most of those are the same people, so of course they look kind of similar. I think it would be interesting, if you have the power to do so, to look at the people who are left out. Like most of the research out there uses just OASIS, for example. And so it would be interesting to see if the people who have OASIS but not the encounter claim are different. So the people who are left out of those samples and their characteristics might be more informative as to who we're missing and who we're capturing.

In general, I like the approach of using subanalyses, where you turn it in certain ways. Certainly I like the first approach, where you look at counties with high match rate, because those are counties where we might trust the data more. The second trim I really don't like,

because this is the one where you exclude counties where the rates of use between MA and fee-for-service are very different. And unless you have some knowledge as to why that might be data errors, I think that's really dangerous, because we might be excluding the counties that are of most interest, where you have very low utilization rates under MA. So I'm not really in favor of that trim because I'm not sure it's data errors.

Sorry. This is sort of methodological detail, but it sounds like you've adjusted for the geographic areas, so you were comparing MA and fee-for-service use in places where there were both, or you were adjusting for where people are, right. So you're not letting it get confounded by geographic area.

I'm not really sure about that adjustment. I would love to see it both ways. And I think it's maybe a little bit endogenous, like where MA is really restrictive is where people might not sign up for MA because they hear bad things about it. And maybe that change doesn't actually happen, but I think where MA beneficiaries might be related to some of these utilization measures. So I'd just like to see it both ways. I think you might be right

in adjusting for it, but I'd like to see it both ways.

And two other points. One, similar to the last session, I'd love to see you drill down in a few stratifications, certainly by duals and not duals, because I think duals may have access to other services that affects their utilization of home health. By community admitted versus post-acute patients, by condition. By maybe those with chronic conditions or not.

And then, finally, I'd love to see some analysis of the quality of the home health agencies that people are going to, because I think that's certainly anecdotally part of the story, that MA is more careful about utilization of home health but also sends people to lower quality agencies. And I would love to see that analyzed as part of this descriptive work. Thanks.

MS. KELLEY: Betty.

DR. RAMBUR: Thank you. I also really appreciated the work and really want to plus-one both Scott's comment and Tamara's, particularly around quality.

My comment is a little different direction. When we talk about network adequacy, we're really talking about the non-physician workforce. It's the agency, but it's

really the non-physician workforce. It's the registered nurses, the physical therapists, the occupational therapists, the medical-social services, which I assume are social workers -- that's an odd term to me.

I don't know how we would do this, but I just want to remind us that we really need to think about this workforce and how that laces in.

At the last session, Brian mentioned the high profits, and yet in home health, at least in the RN workforce, you will be paid less if you do this work because it's less acute, but it’s not less complex. It's actually very complex to go into people's homes and all of that.

So I don't know exactly how we do this, but I hope we can somehow think about that connection to the people actually doing the work.

The other question I have, and this is just a naïve piece on my part, I'm very interested in acute care hospital at home, and I know that's a very different workforce, a different system. Is there any chance of any of the data bleeding or having a less clear image if acute care hospital at home gets renewed in January, the waiver?

MR. CHRISTMAN: So it shouldn't be showing up in the home health encounter data, and the acute care hospital at home is something MA plans are supposed to do if they're doing it under Medicare guidance as a part of the acute care hospitalization. And at least my understanding is fee-for-service, and I would assume, when appropriate, MA does the same thing, all the payment, billing, and so forth takes place under the inpatient PPS.

MS. KELLEY: That's all I have for Round 2.

DR. CHERNEW: Thank you. I'm going to pause for a minute and see if anyone wants to say anything, and I'll summarize, and I think Paul is going to want to say something in a minute.

This is all very useful. I hope it was clear from the set of topics this session the connections between all of these things. So any one thing has a little bit of a standalone approach the way we present, but I think it all fits in. So for example, thinking about the home health payment reforms and MA, and MA and quality in MA payment, all of that is related.

I think one of the underlying things -- now I feel like I'm going to repeat Greg in saying that Scott

said my comment -- I think sort of an underlying concern is where is the really stinting and where is the real efficiency, and how do we know that. And I do think some sense of the sort of clinical underpinning of what's going on, and you guys mentioned, and I think it's right, recognizing that this is one service in a set of services that a bunch of patients might need, and how do we address all of that have somewhat of a whole patient understanding of what's going on and be careful in our interpretation.

But I think there's a lot of underlying data issues here that have to be addressed, and a bunch of other just basic blocking and tackling work. So I think part of this theme of this session, and some of the things we did yesterday, is just to begin to get the data out on the table. So I really appreciate everybody's comments about things that we might do with that, and I hear a bit of enthusiasm to continue and move in this direction. And I think there are a lot of helpful discussions on how we will do that.

That was my segue into what Paul is going to say.

MR. MASI: Thanks, Mike, and I just wanted to add, thanks to all of you for this helpful conversation.

We got a lot of great feedback and ideas for ways to refine and to push the analysis. And we'll take this all back.

I wanted to flag that as you know this is very complicated work, and so we'll think through the pacing of it and how much happens this spring versus future cycles. But I just wanted to flag that. I really appreciate this feedback, and we'll get to work on figuring out how to pace it over future cycles.

DR. CHERNEW: All right. So with that said, thank you, Evan, Betty, and Andy. Thank you to all of the other staff that presented. I really enjoyed seeing you all again, so that's good. Everybody, travel safe.

And for those at home to give us comments on this or any of the other things that happened today, please reach out at MeetingComments@medpac.gov, or reach us any other way. We know home health folks have come in. We have heard from you, so we do appreciate that.

So again, thank you, and we will be back in November.

[Whereupon, at 10:49 a.m., the meeting was adjourned.]

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